Hillsborough County Florida

Board of County Commissioners
Health Care Services Department
Ryan White Part A Program and
Ending the HIV Epidemic (EHE)
Policies and Procedures Manual

601 East Kennedy Boulevard, 16th Floor
Tampa, Florida
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Produced on behalf of The Ryan White Part A Program and EHE Program through funding from the Health Resources and Services Administration (HRSA).

Statement of Purpose

The Hillsborough County Health Care Services Department has developed this manual as a guide for the effective implementation of the Ryan White Part A Program and EHE Program grant management and service delivery business processes. This manual should be used as a point of reference for Ryan White Part A Program and EHE Program and EHE Program staff and HIV/AIDS service funded contractors/providers.

This manual contains a wide array of information to assist Hillsborough County and contractor/providers alike with reporting and daily operational/programmatic requirements of the Ryan White Part A Program and EHE Program and EHE Program. The manual is meant as a stimulus for all contractor/providers and the Hillsborough County Health Care Services Department (County staff) to examine existing methods and to identify barriers to timely and effective service delivery processes, monitoring, documentation, and service follow-up. The manual itself is a work in progress. It will continue to evolve as legislative and program changes occur and County staff further defines the most effective policies and practices for administration and implementation of the Ryan White Part A Program and EHE Program and EHE Program.

Application and Use of this Manual

While the overriding goal of grants management is clear - to facilitate the most effective, efficient HIV/AIDS programs possible - no one individual has the final word on the best way to achieve that end. The care and nurturing of programs, like that of people, requires flexibility and judgment. Program design varies widely in the Ryan White Part A Program and EHE Program and the EHE Program. Therefore, decisions about how to effectively manage contracts are best made at the Recipient level with input from the contractor/provider community.

This policy and procedure manual has been designed as a resource tool for the administration and implementation of the Ryan White Part A Program and EHE Program and EHE Program. Clusters of business transactions and requirements divide the manual. Each policy and procedure contain:

- Policy Statement: Provides a background, description, and intent of the policy.
- Procedures: Action items required for the contractor/provider to be in compliance with the policy.
- The Authority/Oversight: Origin of the policy and the entity that provides oversight for implementation of the policy and procedure.
- Published Date: The effective date of the policy including any revision dates.

The development of Ryan White Part A Program and EHE Program policies and procedures is an iterative process requiring ongoing refinements that could be driven by changes in legislation or County practices, administrative, fiscal, programmatic, or continuous quality improvement. Hence, any updates or revisions to these policies and procedures will be provided by the Ryan White Part A Program and EHE Program Manager in the form of a Policy and Procedure Revised Form identifying the policy or procedure change, the effective date, and changes in the policy. Any revised policies and procedures are to be inserted in the appropriate section of the manual and shared with appropriate staff responsible for implementation of the policy and procedure.

Questions regarding the implementation of the policies and procedures contained herein should be directed to the Ryan White Part A Program and EHE Program Manager. Any exemption to these policies and procedures are to be approved by an authorized agent of the Ryan White Part A Program and EHE Program.

We begin with definitions:

Policies are the rules or guidelines by which an agency operates. They may be general or specific, but always reflect the philosophy, mission, and goals of the organization. Policies are generally approved by the organization's leadership and implemented by management. They define operations such as staff organization, services, hours, and conditions for business transactions. They might, among many other functions, set the criteria for eligibility for services, establish the agency's commitment to confidentiality in all functions, or processes for contract management or monitoring.

Procedures are the methods, the sets of instructions, by which policies are carried out. They give specific steps for accomplishing tasks, handling information, and making service delivery decisions. They may specify, for example, how phones are answered, how appointments are scheduled, who makes record entries, how bills are paid, how grievances are addressed, and what steps are taken in cases of medical emergency or a security threat.

Proposed changes to this policy and procedure manual are welcomed and will be considered by the Department for implementation. Comments, suggestions or feedback should be forwarded to the Ryan White Program Part A and EHE Manager by email at: arnolda@hillsboroughcounty.org.

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I. THE RYAN WHITE PROGRAM

A. HISTORY

The Ryan White Program was enacted in 1990 to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease, those hit hardest by the epidemic. The program is named after Ryan White, an Indiana teenager whose courageous struggle with HIV and against AIDS-related discrimination helped educate the nation.

The AIDS epidemic has taken an unspeakable toll since its onset in the early 1980s. The epidemic has hit hardest among populations at high risk for poverty, lack of health insurance, and disenfranchisement from the health care system. Persons living with HIV disease are, on average, poorer than the general population, and Ryan White Program clients are poorer still. For them, the Ryan White Program is the payor of last resort, because they are uninsured or have inadequate insurance and cannot cover the costs of care on their own, and because no other source of payment for services, public or private, is available.

B. RYAN WHITE CARE ACT LEGISLATION

In response, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in August 1990 to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease. 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 an appropriations bill. Federal funding delivers HIV/AIDS care to nearly 550,000 persons each year.

C. RYAN WHITE PROGRAM EXTENSION ACT

1. **Language:**

   The Ryan White HIV/AIDS Treatment Extension Act of 2009 provides the Federal HIV/AIDS programs in the Public Health Service (PHS) Act under Title XXVI flexibility to respond effectively to the changing epidemic. The Act in 2009 extended the manner in which Ryan White funds can be used, with a continued emphasis on providing lifesaving and life-extending services for persons living with HIV/AIDS across this country.

2. **Key provisions in the 2009 legislation, the final time it was reauthorized**:

   - Minority AIDS Initiative (MAI) funds under Parts A and B will be distributed according to a formula (based on the distribution of populations disproportionately impacted by HIV/AIDS), a change from the former competitive process.
   - Under Part A, the law continues issuance of grant awards to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). For TGAs that lose their eligibility status, the State in which the former TGA is located shall receive incremental transfers of funding for three years.
   - In addition to existing Part A planning council responsibilities, the law adds a new requirement to determine not only the size and demographics of HIV/AIDS infected individuals but also those

individuals who are unaware of their HIV status. One-third of Part A supplemental grants are to be based on the area's ability to demonstrate its success in identifying individuals with HIV/AIDS who are unaware of their status and bringing attention to their status.

- Part A and Part B Recipients must develop comprehensive plans that include a strategy for identifying individuals with HIV/AIDS who do not know their status and helping them seek medical services. The strategy must focus on reducing barriers to routine testing and disparities in access to services for minorities and underserved communities.
- Part A and B Recipients currently using code-based data reporting will have three more years to convert to names-based data reporting. Penalties will remain for Part A and Part B areas that report code-based data in fiscal years 2009 through 2012. In fiscal year 2013, only name-based data reporting will be accepted.
- The law makes adjustments in Part A and Part B unobligated balances (UOB) provisions. It retains the three penalties, but with some changes. The trigger for the penalty provisions changed from 2% to 5% of unobligated formula funds.

Note: The 2009 Act expired on September 30, 2013, and funding is now provided through appropriations bills on an annual basis.

1. Guiding Principles of the 2009 Reauthorized Ryan White Program

The Ryan White Part A Program and EHE Program addresses the health needs of Persons Living With HIV/AIDS (PLWH/A) by funding primary health care and support services that enhance access to and retention in care. The following principles were crafted by HIV/AIDS Bureau (HAB) to guide Ryan White programs in implementing Ryan White provisions and emerging challenges in HIV/AIDS care:

- **Revise care systems to meet emerging needs.** The Ryan White Program stresses the role of local planning and decision making with broad community involvement to determine how to best meet HIV/AIDS care needs. This requires assessing the shifting demographics of new HIV/AIDS cases and revising care systems (e.g., capacity development to expand available services) to meet the needs of emerging communities and populations. A priority focus is on meeting the needs of traditionally underserved populations hardest hit by the epidemic, particularly PLWH/A who know their HIV status and are not in care. This entails outreach, early intervention services (EIS), and other needed services to ensure that clients receive primary health care and supportive services-directly or through appropriate linkages.

- **Ensure access to quality HIV/AIDS care.** The quality of HIV/AIDS medical care including combination antiretroviral therapies and prophylaxis/treatment for opportunistic infections can make a difference in the lives of PLWH/A. Programs should 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.** Programs need to use Ryan White services to fill gaps in care. This requires coordination across Ryan White programs and with other Federal/State/local programs. Such coordination can help maximize efficient use of resources, enhance systems of care, and ensure coverage of HIV/AIDS related services within managed care plans (particularly Medicaid managed care).

- **Evaluate the impact of funds and make needed improvements.** Federal policy and funding decisions are increasingly determined by outcomes. Programs need to document the impact of Ryan White funds on improving access to quality care/treatment along with areas of continued need. Programs also need to have in place quality assurance and evaluation mechanisms that assess the effects of Ryan White resources on the health outcomes of clients.

Note: The 2009 Act expired on September 30, 2013, and funding is now provided through appropriations bills on an annual basis.

D. NATIONAL HIV/AIDS STRATEGY

1. Development:

The National HIV/AIDS Strategy is a five-year plan that details principles, priorities, and actions to guide the national response to the HIV epidemic.

First released on July 13, 2010, the Strategy identified a set of priorities and strategic action steps tied to measurable outcomes for moving the Nation forward in addressing the domestic HIV epidemic. The latest link to the current strategy is National HIV/AIDS Strategy for the United States 2022-2025. The updated Strategy reflects the work accomplished and the new scientific developments since 2010 and charts a course for collective action across the Federal government and all sectors of society to move us close to the Strategy's vision.

2. Goals:

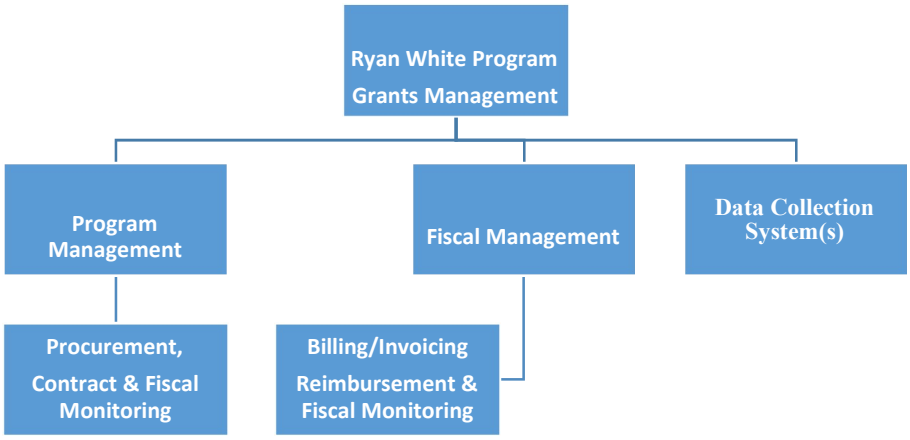
- Reduce New Infections
- Increase Access to Care and Improve Health Outcomes for People Living with HIV
- Reduce HIV-Related Health Disparities and Health Inequities
- Achieve a More Coordinated National Response to the HIV Epidemic

3. Key Areas of Focus:

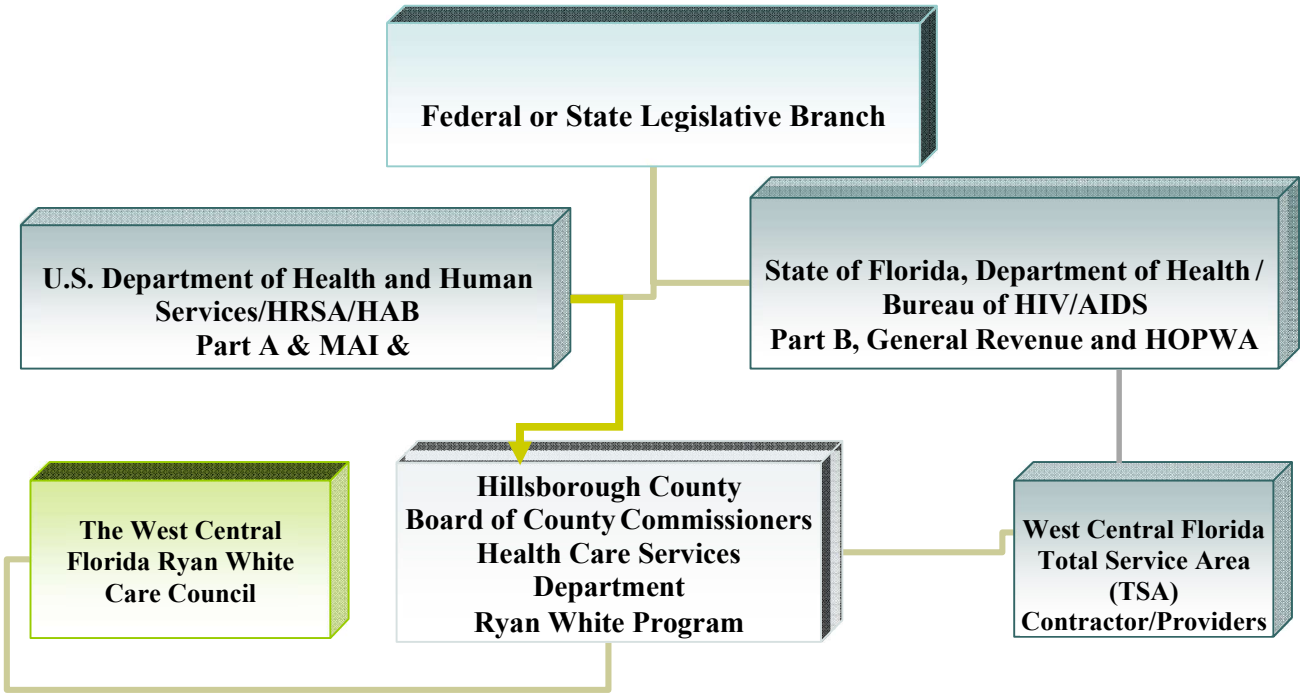
- Widespread testing and linkage to care, enabling people living with HIV to access treatment early.
- Broad support for people living with HIV to remain engaged in comprehensive care, including support for treatment adherence.
- Universal viral suppression among people living with HIV.
- Full access to comprehensive PrEP services for those whom it is appropriate and desired, with support for medication adherence for those using PrEP.

E. Administrative and Programmatic Structure (s)

1. Program Management Structure



2. Funding Structure



The West Central Florida Ryan White Part A Program is funded directly by the U.S. Department of Health and Human Services, Health Resource Services Administration (HRSA), HIV/AIDS Bureau (HAB) as an Eligible Metropolitan Area (EMA) for Part A. The Ryan White Part A Program collaborates with the EMA Planning Council and the Total Service Area (TSA) Consortia, a combined HIV planning body that guides the program's Resource Allocation and Priority Setting. The Contractor/provider Network members are contracted to support the TSA continuum of care. The following is a brief description of the funding streams that support the TSA service delivery system and continuum of care.

HRSA/Part A: Part A and or EHE funds may be used to provide a continuum of care for persons living with the HIV disease. Part A funding is only available in the EMA which consists of Hillsborough, Pinellas, Pasco and Hernando counties. EHE funding is only available in the EMA which consists of Hillsborough and Pinellas counties. The following services may be provided:

- Core Services consists of outpatient and ambulatory health services, AIDS pharmaceutical assistance (local), AIDS drug assistance program, early intervention services, home health care, home and community-based health services, hospice services, medical nutrition therapy, medical case management, health insurance premiums and cost sharing assistance, oral health care, mental health services, and substance abuse (outpatient) treatment.
- Non-core services comprise medical transportation, childcare services, emergency financial assistance, pediatric developmental assessment and early intervention services, housing services, outreach services, permanency, psychosocial support services, referral for health care support/support services, rehabilitation services, respite care, substance abuse (inpatient) treatment, legal services, health education/risk reduction, food bank/home delivered meals, and case management (non-medical).

2. WEST CENTRAL FLORIDA RYAN WHITE CARE COUNCIL

Structure: The members of the Care Council come from very diverse backgrounds, some are PLWH/A (Persons Living with HIV/AIDS), some are contractor/providers of services from a variety of social services (such as health care, case management, mental health, housing and food) while others are legislatively mandated slots such as a Medicaid representative or family or friends of PLWH/A.

The Care Council carefully determines the needs of the HIV community in eight (8) counties (Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas and Polk) by conducting a needs assessment (a series of studies including client and contractor/provider surveys and focus groups). With the information gathered through the needs assessment, and the input of community members that participate in committee meetings, town halls and other community events, the Care Council decides how much Ryan White funding goes to each HIV service within each county.

The Hillsborough County Board of County Commissioners appoints members of the Care Council. The Care Council is not a service contractor/provider, but rather it plans and evaluates services provided within the Eligible Metropolitan Area. The Care Council serves the following eight (8) counties surrounding the Tampa Bay Area: Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk.

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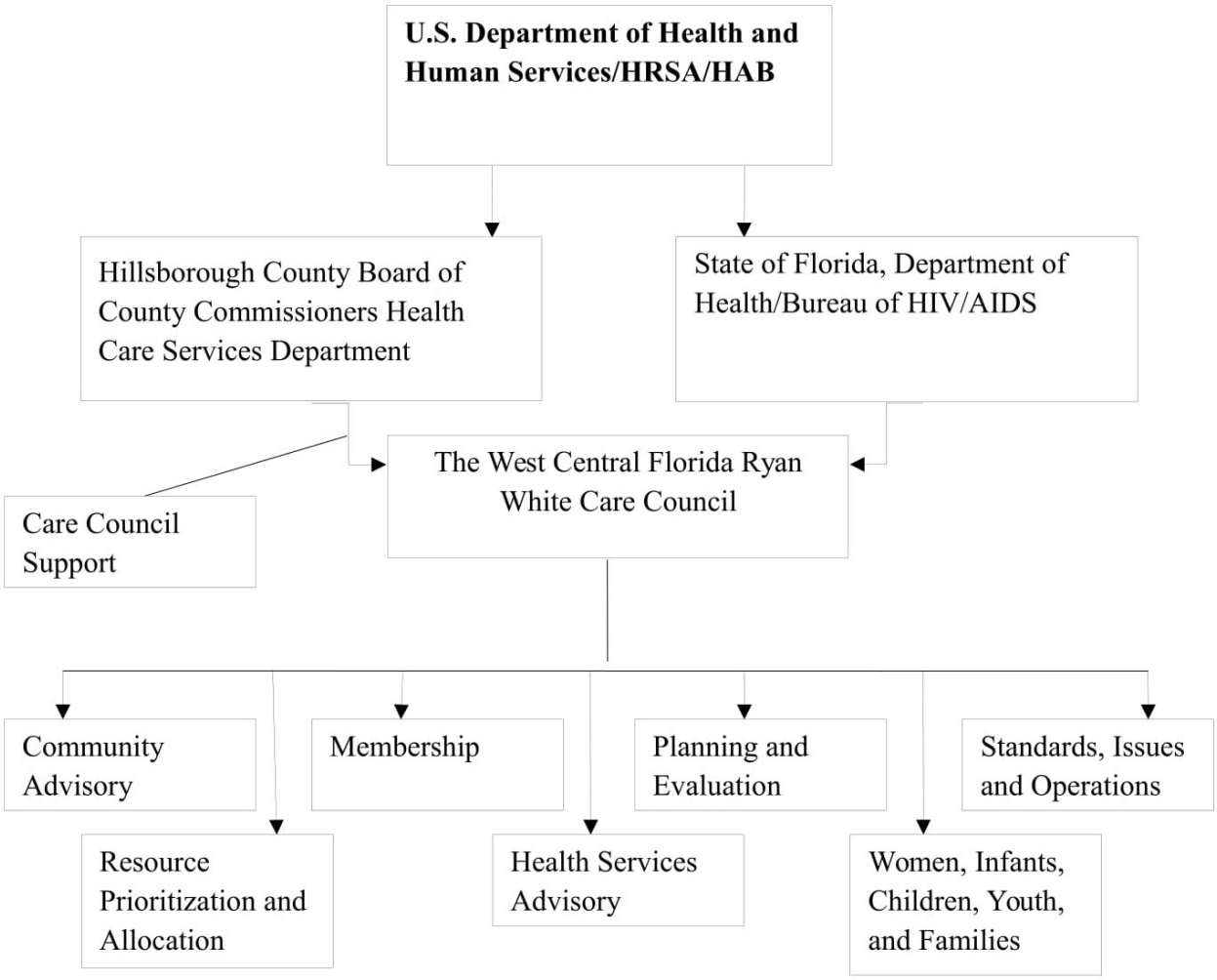
West Central Florida Ryan White Care Council Table of Organization



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Care Council Responsibilities

Care Council deliverables include but are not limited to:

a. Priority Setting: The process used to rank priorities among service categories. These rankings are to ensure consistency with locally identified needs. The process should also address how best to meet each priority.

b. Resource Allocation: The legislatively mandated responsibility of assigning Ryan White Program amounts or percentages to established priorities across specific service categories, geographic areas, populations, or subpopulations.

c. Comprehensive Plan: The process of determining the organization and delivery of HIV services. Planning bodies use this strategy to improve decision-making about services and maintain a continuum of care for PLWH/A

d. Needs Assessment: A systematic process to determine the service needs of a defined population. The needs assessment reviews the extent of HIV and AIDS cases in a service area by population and geographic area and includes an analysis of available services and any service gaps.

e. Statewide Coordinated Statement of Need (SCSN): The SCSN is a written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize Ryan White Program coordination. The SCSN process is convened by the Part B Recipient, with equal responsibility and input by all programs. Representatives must include all Ryan White funded programs and Part F managers, contractor/providers, PLWH/A, and public health agency(s).

f. Special Studies: The Care Council can request for the Ryan White Program Administrator/Manager to conduct any special studies of emerging HIV/AIDS needs within a particular service area.

Care Council Committees

The Care Council has seven (7) standing committees in which the Contractor/Provider is required to provide support.
A description of the committees follows:

Membership and Community Outreach Committee: The Membership and Community Outreach Committee is responsible for understanding the membership process; ensuring that the Care Council adheres to strict legislative membership requirements; ensuring membership application and selection process is effective and administered appropriately; advises governing body in membership issues; works with staff in ensuring appropriate member recruitment, training and orientation, and conducting community outreach. The Membership and Community Outreach Committee is responsible for reviewing and scoring all membership applications. In conducting community outreach, the committee seeks to provide opportunities for PLWH in all TSA counties to participate in the Care Council's planning and decision-making process, regardless of membership status. This committee is also responsible for the nomination and election process of the Chairperson and Vice Chairperson.

Planning and Evaluation Committee: This committee provides input to County and Care Council Support staff regarding components to include in the annual needs assessment; ensures the needs assessment is comprehensive and reflects the components required by the legislation, HRSA, and the State; ensures appropriate populations are represented in data collection within time and resource constraints. This committee is responsible for developing a comprehensive community plan for the organization and delivery of HIV/AIDS services compatible with existing state or local plans regarding the provision of health services to individuals with HIV disease. The committee also develops an implementation plan for the goals, objectives, strategies and evaluations resulting from the final plan. This committee develops program evaluation requirements based on Federal legislation, HRSA guidance, and the Comprehensive Plan program goals and objectives. In addition, the committee ensures requirements are met, reviews results of program evaluation and makes recommendations to the full Care Council for any action required. It revises program evaluations as needed and seeks to include key indicators or evaluation criteria to measure the extent to which pre-determined goals have been achieved, including cost.

Resource Prioritization and Allocation Recommendations Committee (RPARC): This committee is responsible for developing recommendations for the Part A funding prioritization and allocation process. They work in close coordination with County and Care Council Support staff to assure this process reflects the findings of the needs assessment. The recommendations are then brought to the Care Council for approval and presented to the Recipient. The committee also meets at various times throughout the year to re-allocate funds. The committee may also be called upon to participate in standards, issues and operations issue discussions concerning funding.

Standards, Issues and Operations Committee (SIOC): This committee monitors and provides oversight for the Care Council. It develops systems for process review; identifies emerging issues for referral to appropriate committees, and continuously reviews the strategic plan to assure compliance with Care Council goals and objectives. SIOC also identifies, develops and organizes grievance policies and procedures, and as necessary, resolves or recommends means of resolution to the Care Council. SIOC may also convene to act on behalf of the Care Council to respond to emergency Part A program or fiscal developments. Membership is composed of the chairs of each of the standing committees, the chair and/or vice chair of the Care Council and two members representing affected communities.

Health Services Advisory Committee: This committee serves in an advisory capacity to the Care Council on issues related to primary care, dental care, medications, new treatments, adherence and other clinical issues related to the maintenance and improvement of health.

Women, Infants, Children, Youth and Families Committee (WICYF): This committee works to ensure the active and effective participation of women and those who represent infants, children, youth and families in the planning and decision-making process of the Council. To accomplish this, the Committee carefully considers and seeks ways to meet transportation needs of participants, to involve appropriate providers, to continuously identify individuals who are underserved or un-served and to retain these clients in the continuum of care. Finally, the committee acts as a liaison between planning and service provision by working to ensure access and to eliminate barriers to services for women, infants, children, youth and families.

Community Advisory Committee: This committee addresses a variety of issues related to the services clients receive because of Part A funding. It ensures the broadest array of services is provided with the highest possible quality within resource and funding constraints. Works to ensure the needs of minority, underserved, and underrepresented communities and populations are reflected in the planning and decision-making process of the Council. The committee works to improve the availability and effectiveness of needed services in both urban and rural areas. They also seek to provide clients with updated resource references and create opportunities in all Council counties for PLWH/A participation. Finally, the committee acts as a liaison between planning and service provision by working to ensure access and to eliminate barriers to services for minorities, the underserved, and underrepresented populations in both urban and rural communities.

F. PART A and/or EHE FUNDED PROVIDERS- Click Here for current listing of addresses and phone numbers for below providers.

Hillsborough County

Hillsborough County Health Department (Epic Staff) *
Website: Hillsborough County Health Department

Metro Inclusive Health*
Website: Metro Inclusive Health

EPIC at Francis House*
Website: EPIC at Francis House

St. Joseph's Tampa CARE Clinic (EPIC & Metro staff) *
Website: St. Joseph's Tampa CARE Clinic

CAN Community Health
Website: CAN Community Health

University of South Florida Board of Trustees
Website: https://www.ideaexchangetampa.com/

Pinellas County

Metro Inclusive Health *
Website: Metro Inclusive Health

EPIC*
Website: EPIC

AIDS Health Care Foundation (AHF)*
Website: AIDS Healthcare Foundation

CAN Community Health
Website: CAN Community Health

St. Joseph's Hospital Pinellas CARE Clinic
Website: St. Joseph's Tampa CARE Clinic

Pasco County

Metro Inclusive Health*
Website: Metro Inclusive Health

Pasco County Health Department
Website: Pasco County Health Department

EPIC*
Website: EPIC

AIDS Health Care Foundation (AHF)*
Website: AIDS Healthcare Foundation

Hernando County

Hernando County Health Department (Metro staff) *
Website: Hernando County Health Department

Metro Inclusive Health*
4747 US Highway 19
New Port Richey, FL 34652
(727) 494-7625
Website: Metro Inclusive Health

EPIC*
Website: EPIC

***Enrollment site**

II. HIV PART A APPROVED SERVICE CATEGORIES

A. OVERVIEW

The following section is designed to provide a thorough reference guide to support the Ryan White Program's service delivery system and continuum of care. This section includes processes associated with programmatic and fiscal contract monitoring, unit of service costs, standards of care, etc.

B. STANDARDS OF CARE

Minimum standards of care are adopted by the Care Council and used by the Quality Management provider and Hillsborough County to develop measurable outcomes of contracted services. Hillsborough County functioning as Recipient is responsible for assuring that in addition to these standards, all contracts with providers have language requiring the protection of clients' confidentiality and their eligibility for services without regard to gender identity, age, religion, ethnicity, and sexual orientation. Hillsborough County also requires providers to have clear policies and procedures for client grievances and for the assessment of client satisfaction with services. Hillsborough County reports significant or consistent challenges with monitoring of the standards to the Planning and Evaluation Committee or the Health Services Advisory Committee of the Care Council.

Support Services are defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS. Support services must be shown to improve clinical outcomes. Support services must facilitate access to care.

C. PROGRAM SERVICES (PS) POLICIES AND PROCEDURES

The following are Program Service (PS) Policies and Procedures, which include specific service definitions, philosophy, and standards of care the West Central Florida Ryan White Care Council has constructed to guide the delivery of Part A funded HIV services. For any questions or interpretations, please contact Hillsborough County Health Care Services Department/Ryan White Program.

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-1

POLICY TITLE: OUTPATIENT/AMBULATORY HEALTH SERVICES (OAHS)

POLICY STATEMENT

Persons infected with HIV face a complex array of medical, psychological, and social challenges. Persons with HIV/AIDS can live longer, healthier lives because of advances in treatment of HIV infection. However, longer lives are associated with increased prevalence of 1) adverse effects of HIV infection or co-infection, 2) adverse effects of the drugs used to treat HIV, and 3) concurrent medical conditions that would occur in the absence of HIV. These long-term complications have put HIV infection in the realm of chronic diseases rather than infectious diseases, which usually respond to short-term clinical interventions. An effective management of chronic diseases in the primary care setting requires the coordination of interventions that occur at the level of clinical services, the community supports for those clinical services, and the individual patient. While clinical services begin in the primary care clinic, community supports are needed; the patient must be engaged to enhance their self-management skills.

DEFINITIONS AND UNIT OF SERVICE DESCRIPTION

OAHS is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

A unit of **Outpatient/Ambulatory Health Services** is defined as one office visit regardless of the number of staff at your agency who served the client. For example, if a phlebotomist, ARNP and a nutritionist saw the client all on one day, the unit of service equals one. Each lab test is to be counted as a unit under laboratory services, not ambulatory/outpatient medical care.

PROCEDURE

1. Annual Proof of Primary Care.
2. Agency must have on file a copy of the client's current Notice of Eligibility Determination (NOE) which is a standard requirement for both Ryan White Part A and B, consistent with the Florida Eligibility Rule 64-D as amended from time to time.

3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.

CAPS/LIMITS

No caps/limit on office visits or labs.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

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

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential office space for	• Policy and procedures manual • Program monitoring/site visit

seeing clients (e.g. no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential locked location for a period stipulated by law. • Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information policies as stated by the state of Florida.	
B. Agency must have policies and procedures in place that address client grievance procedures and eligibility requirements per federal and state law and local regulations. If a grievance is not satisfactorily resolved, at the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office.	• Grievance procedure posted in visible location • Policy and procedures manual • Program monitoring/site visit • Client grievance form signed by client

The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator level, then the client will be provided information on further grievance escalation at that time. Clients are informed of the client confidentiality policy and grievance policy at first face-to-face contact.	
C. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender, socioeconomic status, cultural background, disability, and religion.	• Policy and procedures manual • Program monitoring/site visit • Training records
II. Personnel Qualifications	
Standard	**Measure**
A. Agency staff are trained and knowledgeable about primary medical care, HIV disease and treatment and available resources that promote the continuity of client care.	• Personnel records • Program monitoring/site visit • Professional License/Certification
B. Agency will ensure that all staff, inclusive of but not limited to, physicians, physicians' assistants, nurse practitioners, registered nurses, licensed practical nurses, and medical assistants providing primary care or assisting in the provision of primary care are licensed/certified to practice within their concentrated area	• Personnel records • Program monitoring/site visit • Professional License/Certification

consistent with city, county, state and federal law.	
III. Client Rights and Responsibilities	
Standard	**Measure**
A. Each agency must maintain their own client rights and responsibilities protocols and documentation in accordance with Rule 64D-4, F.A.C. Client rights and responsibilities must be posted publicly in visible location.	• Policy and procedures manual • Client record • Program monitoring/site visit
IV. Client Eligibility	
Standard	**Measure**
A. Each provider will maintain their own eligibility requirements, but at a minimum, will include standards of Ryan White program Recipient eligibility per Rule 64D-4, F.A.C.	• Client record • Program monitoring/site visit
B. Notice of eligibility every 12 months must be maintained by clients, notify applicable certifying entity of any life changes.	• Client record • As entered in program electronic database • Program monitoring/site visit
V. Treatment	
Standard	**Measure**
A. Providers shall follow nationally accepted HIV treatment guidelines, according to RWHAP legislation, i.e., Department of Health and Human Services (DHHS). Centers for Disease Control (CDC), Infectious Disease Society of America (IDSA).	• Policy and procedures manual • Program monitoring/site visit

VI. Client Transition & Discharges	
Standard	**Measure**
A. Transition and discharge of services should include a written linkage plan maintained by each agency and must include a list of providers available within a client's place of residence. Clients must be provided with their proof of status, most recent proof of Ryan White eligibility, and their most recent labs. Pediatric client files will be kept open for three (3) months and will be considered a successful transition if seen twice by a provider following transition of services. They must be provided with their current prescriptions, all provider notes, and case manager contact information.	• Policy and procedures manual • Program monitoring/site visit
VII. Case Closure	
Standard	**Measure**
A. Adult client cases will only be closed upon death of a permanent discharge from the clinic. Pediatric client cases will be closed after one (1) year without successful client contact or upon successful transition to adult care. Providers must also maintain agency-specific guidelines and must include the date and reasons for case closure utilizing the OAHS Case Closure Summary Form for all closed cases. *Form attached as Appendix 1.	• Policy and procedures manual • Client record • Program monitoring/site visit

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient

STANDARD OF CARE EFFECTIVE DATE

Adopted: 07/11/01
Revised: 12/03/03
Revised: 11/7/07
Revised: 6/17/14
Revised: 7/2/14
Revised: 12/5/18
Revised: 09/02/20

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-2

POLICY: AIDS PHARMACEUTICAL ASSISTANCE (LOCAL)

POLICY STATEMENT

The drug-reimbursement standards describe the appropriate language from the Section 340B program. The Section 340B Drug Pricing Program was established in response to the passage of Section 340B of P.L. 102-585, the Veterans' Health Care Act of 1992. Section 340B of this law limits the cost of drugs to federal purchasers and to certain Recipient/Lead Agencies of federal agencies. Significant savings on pharmaceuticals may be realized by those entities that participate in this program. The definition that follows does not include medications dispensed or administered during the course of a regular medical visit that are considered part of the services provided during that visit, or medications received as part of a Drug Assistance or Compassion Program.

DEFINITIONS AND UNIT OF SERVICE DESCRIPTION

HRSA defines drug-reimbursement as an ongoing service paying for approved medications and providing co-payment assistance for persons with no other payment source. Medications include prescription drugs provided through the AIDS Drug Assistance Program (ADAP) to prolong life or prevent the deterioration of health. Medications listed on the formulary will be reviewed and updated as deemed necessary by the Care Council. This formulary will mirror the medications listed on the ADAP formulary. When a new medication is available on ADAP, it will also be available on the formulary.

A unit of **AIDS Pharmaceutical Assistance (Local)** service is defined as one prescription not to exceed a 30-day supply of prescribed HIV-related medication or prescribed item of related for one eligible individual. **Mailing fee cannot exceed the actual cost of mailing the prescription.**

PROCEDURE
1. Annual Proof of Primary Care.
2. Agency must have on file a copy of the client's Notice of Eligibility Determination.
3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.

CAPS/LIMITS
No caps/limits established.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

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

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

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

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential office space for seeing clients (e.g. no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on	• Policy and procedures manual • Program monitoring/site visit

client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential locked location for a period stipulated by law. • Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information policies as stated by the state of Florida.	
B. Agency must have policies and procedures in place that address client grievance procedures and eligibility requirements per federal and state law and local regulations. If a grievance is not satisfactorily resolved, at the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office. The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator level, then the client will be provided information on further grievance escalation at that time.	• Grievance procedure posted in visible location • Policy and procedures manual • Program monitoring/site visit • Client grievance form signed by client

• Clients are informed of the client confidentiality policy and grievance policy at first face-to-face contact.	
C. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender, socioeconomic status, cultural background, disability, and religion.	• Policy and procedures manual • Program monitoring/site visit • Training records
II. Personnel Qualifications	
Standard	**Measure**
A. Agency will ensure that all staff, inclusive of but not limited to, pharmacists, pharmacy technicians; and medical assistants providing pharmacy care or assisting in the provision of pharmacy care are licensed/certified to practice within their concentrated area consistent with local, State and federal law., i.e. Florida's Board of Pharmacy.	• Personnel records • Program monitoring/site visit • Professional License/Certification
III. Program Staff	
Standard	**Measure**
A. Providers shall maintain records of quarterly quality improvement meetings including pharmacy staff as required by FAC 64B16-27.300, Standards of Pharmacy Practice.	• Program monitoring/site visit • Meeting Records
IV. Client Rights and Responsibilities	
Standard	**Measure**
A. Each agency must maintain their own client rights and responsibilities protocols and documentation in accordance with Rule 64D-4, F.A.C.	• Policy and procedures manual • Client record • Program monitoring/site visit

Client rights and responsibilities must be posted publicly in visible location.	
V. Client Eligibility	
Standard	**Measure**
A. Each provider will maintain their own eligibility requirements, but at a minimum, will include standards of Ryan White program Recipient eligibility per Rule 64D-4, F.A.C.	• Client record • Program monitoring/site visit
B. Notice of eligibility every 12 months must be maintained by clients, notify applicable certifying entity of any life changes.	• Client record • As entered in program electronic database • Program monitoring/site visit
VI. Treatment Adherence	
Standard	**Measure**
A. Providers shall follow nationally accepted treatment guidelines, i.e., Centers for Disease Control (CDC), Infectious Disease Society of America (IDSA), or Department of Health and Human Services (DHHS)	• Policy and procedures manual • Program monitoring/site visit
B. Patient counseling will be provided by qualified staff as needed. Counseling shall include but not be limited to, administration, drug-drug interaction, side effects, dosage, adherence education and food-drug interactions. Counseling may be offered verbally or written to the patient.	• Policy and procedures manual • Program monitoring/site visit

VII. Client Transition & Discharges	
Standard	**Measure**
A. Transition and discharge of services should include a written linkage plan maintained by each agency and must include a list of providers available within a client's county of residence. Clients must be provided with their proof of status, most recent proof of Ryan White eligibility, and their most recent labs. Pediatric client files will be kept open for three (3) months and will be considered a successful transition if seen twice by a provider following transition of services. They must be provided with their current prescriptions, all provider notes, and case manager contact information.	• Policy and procedures manual • Program monitoring/site visit
VIII. Case Closure	
Standard	**Measure**
A. Adult client cases will only be closed upon death of a permanent discharge from the clinic. Pediatric client cases will be closed after one (1) year without successful client contact or upon successful transition to adult care. Providers must also maintain agency-specific guidelines and must include the date and reasons for case closure utilizing the OAHS Case Closure Summary Form for all closed cases. *Form attached as Appendix 1.	• Policy and procedures manual • Client record • Program monitoring/site visit

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis

5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:
Adopted: 07/11/01
Revised: 12/03/03
Revised: 11/07/07
Revised: 6/17/14
Revised: 7/02/14
Revised: 12/5/18
Revised: 09/02/20

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-3

POLICY TITLE: HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS

POLICY STATEMENT

The contractor/provider will be responsible for paying private insurance premiums to client's insurance carriers, employer, or representative; and paying deductibles to the client's insurance carrier and/or health care contractor/provider. Payment of private insurance premiums with Ryan White funds will allow for the continuation of privately supported medical coverage for individuals who would otherwise spend down to Medicaid levels.

DEFINITION AND UNIT OF SERVICE DESCRIPTION

The EMA Health Insurance program provides financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health insurance program, including risk pools. In the fall of 2001, HRSA approved the use of Ryan White funding to assist eligible individuals living with HIV to maintain continuity of health insurance or to receive medical benefits under a health insurance program. In the Care Council service area, contractors/providers are allocated funding to provide assistance to qualified individuals who have been diagnosed with HIV or AIDS and are unable to support the payment of health insurance premiums, deductibles, office visits, and prescription drug co-payment fees. Since the qualified PLWH/A (Person Living with HIV/AIDS) does not access services directly from the health insurance services contractor/provider, but through a case manager, minimum standards have been developed to reflect this unique fiscal relationship. The case management relationship ensures PLWH/A confidentiality and grievance procedures.

A unit of service is defined as one insurance premium paid on behalf of one client, one co-payment paid on behalf of one client, and/or one deductible paid on behalf of one client.

PROCEDURE

1. Agency must have on file a current copy of the client's Notice of Eligibility Determination covering the service period.
2. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
3. Geographic Restriction Policy Applies.

4. Health Insurance Services P&P Addendum explaining service billing and documentation procedures are on page 209. **Health Insurance Services Definitions, CAPS, & Service Entry Process**

CAPS/LIMITS

Enrolled clients receive up to $500 per month for co-pays and up to $700 per month for COBRA, group and individual insurance premium payments, including dental insurance.

The Part A Recipient has the authority to grant special exceptions and increase caps when necessary to ensure all Part A funds are utilized for the grant period. No special exceptions shall be granted for Part B funds. Payments or reimbursements made directly to clients for a credit card payment are prohibited, except *Care Credit, as RW funds are payer of last resort.

*If the client gets services covered under a Care Credit account, the recipient can make a payment or the monthly payments on behalf of the client. Interest cannot be reimbursed. A detailed bill for the charges placed on the Care Credit in the client's name and the corresponding Care Credit bill monthly will need to be submitted as back up documentation and uploaded into e2H electronic file.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential office space for seeing clients (e.g. no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential locked location for a period stipulated by law. • Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information policies as stated by the state of Florida.	• Policy and procedures manual • Program monitoring/site visit
B. Agency must have policies and procedures in place that address client grievance procedures and eligibility	• Grievance procedure posted in visible location • Policy and procedures manual

requirements per federal and state law and local regulations. If a grievance is not satisfactorily resolved, at the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office. The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator level, then the client will be provided information on further grievance escalation at that time. • Clients are informed of the client confidentiality policy and grievance policy at first face-to-face contact.	• Program monitoring/site visit
C. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender, socioeconomic status, cultural background, disability, and religion.	• Policy and procedures manual • Program monitoring/site visit • Training records
II. Client Rights and Responsibilities	
Standard	**Measure**
A. Each agency must maintain their own client rights and responsibilities protocols and documentation.	• Policy and procedures manual • Client record • Program monitoring/site visit
III. Active File Maintenance & Case Closure	
Standard	**Measure**
A. Upon receipt of the request for payment, the service provider will notify the case manager within three working days of the outcome of the request.	• Program monitoring/site visit • Client record

B. The provider will issue payments for approved requests within 30 working days of receipt of an invoice for payment.	• Program monitoring/site visit • Client record • Dated payment receipts
C. The provider will identify error-prone case management agencies and offer individualized on-site training to up to two (2) agencies annually, upon request. The provider will also provide written updates on changes in eligibility or service benefits, procedural changes and other related information to case management agencies on a timely and regular basis.	• Program monitoring/site visit • Training records
D. The provider will establish and maintain a mechanism to assure that upon the PLWH's disenrollment, any unused portion of issued premium payments is reimbursed to the program.	• Policy and procedures manual • Program monitoring/site visit • Reimbursement record

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification
7. Copy of Premium, Co-Pay, Deductible or COBRA Bill

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:

Adopted: 03/05/03
Revised: 12/03/03
Revised: 11/7/07
Revised: 6/17/14
Revised: 7/2/14
Revised: 12/5/18
Revised: 09/02/20
Revised 08/02023
Revised: 04/03/24

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-4

POLICY TITLE: ORAL HEALTH CARE

POLICY STATEMENT

Persons Living with HIV (PLWH/A) often require dental services in order to adhere to their treatment and medical regimens. It is a crucial aspect of maintaining general health. Reasons why oral health is important to individuals living with HIV:

1. Problems in the mouth not only may be the first symptom of HIV infection, but also can signify clinical progression.
2. Proper dental care can reduce the presence of bacteria, which reduces strain on the immune system.
3. Open sores and exposed tissue are a potential entrance for infections into the body.
4. Regular dental visits allow for early identification of conditions and infections. This allows for early treatment of these issues before they develop into serious problems.

DEFINITION AND UNIT OF SERVICE DESCRIPTION

HRSA defines Oral Health/Dental Care as diagnostic, prophylactic and therapeutic services rendered by a dentist, dental hygienist, and similar professional practitioners.

A unit of **Oral Health/Dental Service** is defined as each dental service performed. For the purpose of reporting the contractor/provider must also report the number of visits.

PROCEDURE

1. Annual Proof of Primary Care.
2. Agency must have on file a current copy of the client's Notice of Eligibility Determination.
3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.

CAPS/LIMITS

5. A total of $4000 is allowable.
6. Covered services are limited to: exams, x-rays, fillings, extractions, cleanings (prophylaxis, scaling and root planning, gross debridement), dentures (partial or full) and oral health instruction. Recipient/Lead Agency will consider exceptions on a case-by-case basis only if medically necessary and HIV related.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential office space for seeing clients (e.g. no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential locked location for a period stipulated by law. • Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information policies as stated by the state of Florida.	• Policy and procedures manual • Program monitoring/site visit

B. Agency must have policies and procedures in place that address client grievance procedures and eligibility requirements per federal and state law and local regulations. If a grievance is not satisfactorily resolved, at the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office. The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator level, then the client will be provided information on further grievance escalation at that time. • Clients are informed of the client confidentiality policy and grievance policy at first face-to-face contact.	• Grievance procedure posted in visible location • Policy and procedures manual • Program monitoring/site visit
C. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender, socioeconomic status, cultural background, disability, and religion.	• Policy and procedures manual • Program monitoring/site visit • Training records
D. Provider shall have a policy in place to address dental emergencies.	• Written documentation on file
II. Personnel Qualifications	
Standard	**Measure**
A. Agency will ensure that all staff, inclusive of but not limited to, general dental practitioners, dental specialists, dental hygienists, and auxiliaries, providing dental care are	• Personnel records • Program monitoring/site visit • Professional License/Certification

licensed/certified to practice within their concentrated area consistent with State and local law.	
II. Client Rights and Responsibilities	
Standard	**Measure**
A. Each agency must maintain their own client rights and responsibilities protocols and documentation.	• Policy and procedures manual • Client record • Program monitoring/site visit
III. Eligibility and Intake	
Standard	**Measure**
A. Provider confirms client eligibility for services. Client eligibility will be reassessed every 12 months. The process to determine client eligibility must be completed in a time frame so that screening is not delayed. Eligibility assessment must meet the regulations of 64D-4 and must be consistent with funding requirements.	• Client record • Program monitoring/site visit • Client record and client satisfaction survey.
B. Oral health providers must provide the client a choice of service providers if available.	• Client record signed by client • Program monitoring/site visit
IV. Assessment &Treatment	
Standard	**Measure**
A. Providers shall follow nationally accepted treatment guidelines, i.e., American Dental Association, Centers for Disease Control (CDC), Infectious Disease Society of America (IDSA), or Department of Health and Human Services (DHHS).	• Written documentation on file as examined by the Recipient/Lead Agency.
B. Dental care shall have the primary focus of alleviating discomfort, keeping teeth and gums healthy, preventing infection, and maintaining the ability to eat nutritional foods with the goal of optimizing overall health. Procedures that are for cosmetic purposes only will not be covered.	• Written documentation on file as examined by the Recipient/Lead Agency.

Treatment must be completed within a reasonable and customary time frame.	
C. A treatment plan shall, at a minimum, include a thorough dental examination, x-rays and cleaning, and follow-up. Follow-up services shall include cleaning services, education, preventative home care instructions, and any additional services necessary to maintain dental health.	• Written documentation on file as examined by the Recipient/Lead Agency.

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:

Adopted: 05/01/02
Revised: 12/03/03
Revised: 11/07/07
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Revised: 08/2023; 04/2024 CAP LIMITS

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-5

POLICY TITLE: MENTAL HEALTH SERVICES

POLICY STATEMENT

PLWH/A with a mental health disorder, should receive at a minimum: 1) Assessment and Diagnosis – history, mental health examination, and establishing achievable treatment goals; 2) Pharmacological Treatment, if appropriate; 3) Mental Health Counseling – individual, group, family; and 4) Grief and Bereavement Counseling. Contractors/providers servicing the Part A PLWH/A with mental health co-morbidity, should have an extensive demonstrated working knowledge of PLWH/A.

DEFINITION AND UNIT OF SERVICE DESCRIPTION

Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by mental health professionals licensed by the State of Florida to practice within the boundaries and scope of their respective profession. This includes Psychiatrists, Psychologists, Psychiatric Nurse Practitioners, Masters prepared Psychiatric Registered Nurses, and Licensed Clinical Social Workers. All mental health services must be provided in accordance with the Care Council's Mental Health Standards of Care.

A unit of **Mental Health Service** for billing purposes is defined as one-hour for individual or group counseling or any portion thereof. If the session is longer than an hour, the unit should be rounded to the nearest quarter hour. (For example, if an individual session lasts 1 hour and 41 minutes, the session should be billed as 1.75 units). If it is a group session, the provider cannot charge one unit for each person attending the session, maximum amount billable is based on the length of the session.

PROCEDURE

1. Annual Proof of Primary Care.
2. Agency must have on file a current copy of the client's Notice of Eligibility Determination.
3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.

CAPS/LIMITS

No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

Mental health care for persons with HIV disease should reflect competence and experience in evaluation, formulation, and diagnosis as well as in evidence-based therapeutics, using contemporary practice guidelines where available.

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential office space for seeing clients (e.g. no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential locked location for a period stipulated by law. • Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information	• Policy and procedures manual • Program monitoring/site visit

policies as stated by the state of Florida.	
B. Agency must have policies and procedures in place that address client grievance procedures and eligibility requirements per federal and state law and local regulations. If a grievance is not satisfactorily resolved, at the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office. The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator level, then the client will be provided information on further grievance escalation at that time. • Clients are informed of the client confidentiality policy and grievance policy at first face-to-face contact.	• Grievance procedure posted in visible location • Policy and procedures manual • Program monitoring/site visit
C. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender, socioeconomic status, cultural background, disability, and religion.	• Policy and procedures manual • Program monitoring/site visit • Training records
II. Personnel Qualifications	
Standard	**Measure**
A. Agency will ensure that all staff, inclusive of but not limited to, psychiatrists, psychologists, and licensed clinical social workers,	• Personnel records • Program monitoring/site visit • Professional License/Certification

providing treatment and counseling services individually or in a group setting are licensed/certified to practice within their concentrated area consistent with, local, State and federal law.	
III. Program Staff	
Standard	**Measure**
A. License-eligible staff delivering mental health services will receive direct, professional supervision by a licensed mental health provider of the type of care they are providing to individual patients/clients.	• Personnel Records
B. Services can be provided by both a licensed mental health provider as well as a licensed-eligible registered intern.	• Personnel Records
II. Client Rights and Responsibilities	
Standard	**Measure**
A. Each agency must maintain their own client rights and responsibilities protocols and documentation.	• Policy and procedures manual • Client record • Program monitoring/site visit
III. Eligibility and Intake	
Standard	**Measure**
A. Upon initial contact with client, agency will determine if clients meet criteria for emergency needs, as detailed in the required annual comprehensive assessment and acuity assessment.	• Client record • Program monitoring/site visit
B. Provider confirms client eligibility for services. Client eligibility will be reassessed every 12 months. The	• Client record • Program monitoring/site visit

process to determine client eligibility must be completed in a time frame so that screening is not delayed. Eligibility assessment must meet the regulations of 64D-4 and must be consistent with funding requirements.	• Client record and client satisfaction survey.
C. Mental health providers must provide the client a choice of service providers if available.	• Client record signed by client • Program monitoring/site visit
IV. Assessment &Treatment	
Standard	Measure
A. The provider must provide mechanisms for urgent care evaluation and triage.	• Policies and procedures manual
B. The provider will develop and maintain client specific collaboration with primary medical care service providers.	• Client record
C. The provider will maintain an initial mental health assessment of each participating client that consists of presenting problem(s), psychosocial history, mental status examination, differential diagnoses, treatment recommendations and signature of the licensed or license-eligible professional conducting the assessment.	• Client record
D. At minimum, provider will complete an annual psycho-social assessment with the patient, either in-person or by way of telehealth.	• Client record
V. Service Coordination/Referral	
Standard	**Measure**
A. The provider will establish procedures for continuity of mental	• Policy and procedures manual • Client record

health/psychiatric care to their patients/clients in all settings in which they may need care.	• Program monitoring/site visit
B. The provider will provide referrals for continuity of substance abuse care to their patients/clients as needed.	• Client record

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:

Adopted: 06/07/00
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Revised: 09/02/20

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PROGRAM SERVICE (PS) POLICY #: PS-6

POLICY TITLE: MEDICAL CASE MANAGEMENT SERVICES

POLICY STATEMENT

HIV/AIDS medical case management systems must start where the client is in their stage of health and health care service utilization. The services must develop a supportive relationship, enable clients to make the best choices for their well-being, and facilitate access to and use of available resources. Case management contractors/providers must be able to integrate clinical and administrative supervision to address anything directly related to client care. Administrative supervision should address issues related to staffing, policy, client documentation, reimbursement, scheduling, trainings, quality enhancement activities, and overall running of the program and/or agency. If clinical supervision is not provided on-site, the contractor/provider agency must make provisions to provide clinical supervision for case managers on a routine basis.

DEFINITIONS AND UNIT OF SERVICE DESCRIPTION

Medical case management provides a range of client-centered services that link PLWH/A with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health care, support services, and continuity of care through ongoing assessments of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: 1) Initial assessment of service needs; 2) Development of a comprehensive, individualized service plan; 3) Coordination of services required to implement the plan; 4) Client monitoring to assess the efficacy of the plan; and 5) Periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. Client contact includes all types of communication including face-to-face, phone contact, leaving a message, mailing, and any other forms of communication. All case management services must meet Part A case management standards.

A unit of **Case Management** service is defined as one client contact, specifying in-person or other. In addition to counting the number of encounters, report number of 15-minute units, and any portion thereof.

Case management should be calculated and billed as follows:

All time spent doing reimbursable case management for a specific client on the same date of service must be totaled, reflecting actual length of time. Prior to billing, this block of time must be converted to 15 minute units. The total reimbursable case management activities for a date of service that is only a portion of 15 minutes can be billed as a 15 minute unit. Consider the following example:

DATE OF SERVICE	ACTIVITY	MINUTES
03/07/18	Phone call from emotionally distraught client dealing with a family crisis.	10 minutes
03/07/18	Phone call to Education & Support provider to discuss client referral.	5 minutes
03/07/18	Education and Support added to client's Plan of Care.	5 minutes
03/07/18	Service Authorization Form completed and faxed to provider.	6 minutes

A total of 26 minutes was spent doing management. Thus, the maximum billable amount of case management for 3/07/18 would be two (2) 15-minute units.

For each entry in the case narrative, there should be a corresponding note in the margin for the length of time spent. This will simplify billing procedures and achieve consistency in the documentation recorded in every case.

PROCEDURE

1. Annual Proof of Primary Care.
2. Agency must have on file a current copy of the client's Notice of Eligibility Determination.
3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.

CAPS/LIMITS

No cap/limit established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential office space for	• Policy and procedures manual • Program monitoring/site visit

seeing clients (e.g. no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential locked location for a period stipulated by law. • Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information policies as stated by the state of Florida.	
B. Agency must have policies and procedures in place that address client grievance procedures and eligibility requirements per federal and state law and local regulations. If a grievance is not satisfactorily resolved, at the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office. The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator	• Grievance procedure posted in visible location • Policy and procedures manual • Program monitoring/site visit

level, then the client will be provided information on further grievance escalation at that time. • Clients are informed of the client confidentiality policy and grievance policy at first face-to-face contact.	
C. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender, socioeconomic status, cultural background, disability, and religion.	• Policy and procedures manual • Program monitoring/site visit • Training records
II. Personnel Qualifications	
Standard	**Measure**
A. Medical Case Managers (MCM) must have appropriate skills and relevant experience prior to hire to provide medical case management services.	• Personnel records • Program monitoring/site visit • Training records • Professional License/Certification
B. MCM must meet staff qualifications as defined by the latest version of the Florida Dept of Health's HIV Case Management Guidelines (FDOH HCMG).	• Personnel records • Program monitoring/site visit • Training records • Professional License/Certification
C. MCM must complete the case management series from the Florida AIDS Education &Training Center and obtain certification within 90 days of hire and maintain certification by completing the required CEU's as defined by the FDOH HCMG.	• Personnel records • Program monitoring/site visit • Training records • Professional License/Certification
D. Case managers and direct supervisors must attend training sessions as required by the Recipient, Health Resources and Services Administration, and/or the Florida Department of Health. Additional training must be coordinated and/or provided by supervisory staff.	• Personnel records • Program monitoring/site visit • Training records • Professional License/Certification

II. Client Rights and Responsibilities	
Standard	**Measure**
A. Each agency must maintain their own client rights and responsibilities protocols and documentation.	• Policy and procedures manual • Client record • Program monitoring/site visit
III. Eligibility and Intake	
Standard	**Measure**
A. Upon initial contact with client, agency will determine if clients meet criteria for emergency needs, as detailed in the required annual comprehensive assessment and acuity assessment.	• Client record • Program monitoring/site visit
A. Provider determines client eligibility for services. Client eligibility will be reassessed every 12 months. The process to determine client eligibility must be completed in a time frame so that screening is not delayed. Eligibility assessment must meet the regulations of 64D-4 and must be consistent with funding requirements.	• Client record • Proof of income • Program monitoring/site visit • Client record and client satisfaction survey.
B. Case managers must provide the client a choice of service providers if available.	• Client record signed by client • Program monitoring/site visit
IV. Active File Maintenance & Case Closure	
Standard	**Measure**
A. Case managers must contact clients as needed (based on client need) unless a specific program requirement is set by a program. Case Manager contact requirements are subject to any additional requirements set forth by Rule 64D-4, the Florida Department of Health, and the Health Resources and Services Administration. Contact is defined as phone, face-to-face, leaving a message or a mailing.	• Client record

B. Active files must have individualized service plan reviewed by client and case manager semi-annually.	• Client record • Program monitoring/site visit
C. Active files must reflect a face-to-face visit conducted on a semi-annual basis.	• Client record • Program monitoring/site visit
D. Clients will have access to a case manager during normal business hours for the agency.	• Policy and procedures manual • Client record • Program monitoring/site visit
E. Case managers must maintain up to date documentation on all activities with, or on behalf of clients.	• Client record • Program monitoring/site visit
F. Case managers must ensure that a copy of a client's record in its entirety is sent to the receiving agency within 10 business days from receipt of original signed release.	• Client record • Program monitoring/site visit • As entered in program electronic database
G. Notice of eligibility every 12 months must be maintained by clients, notify applicable certifying entity of any life changes.	• Client record • As entered in program electronic database • Program monitoring/site visit
H. Adult client cases will only be closed upon death of a permanent discharge from the clinic. Pediatric client cases will be closed after one (1) year without successful client contact or upon successful transition to adult care.	• Policy and procedures manual • Program monitoring/site visit
I. Providers must also maintain agency-specific guidelines and must include the date and reasons for case closure.	• Policy and procedures manual • Program monitoring/site visit
V. Treatment Adherence	
Standard	**Measure**
A. Case managers will work collaboratively with client and	• Policy and procedures manual • Client record • Program monitoring/site visit

medical/psychosocial providers to promote adherence to treatment.	
VI. Client Transition & Case Closure	
Standard	**Measure**
A. Client transition of services are completed at the request of the client and when incarcerated. Case closures are completed: at the request of the client if client declined service; or when client is ineligible for services. Client case is discharged if client's behavior is violent and/or abusive and upon death of client. Pediatric client cases will be closed after one (1) year without successful client contact or upon successful transition to adult care. Providers must document client transition of care, and case closure/discharge on the Case Closure Summary Form in addition to the case notes. The Case Closure Summary Form must be reviewed and signed off by case manager supervisor.	• Policy and procedures manual • Program monitoring/site visit • Client record

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:

Adopted: 06/07/00

Revised: 12/03/03
Revised: 11/07/07
Revised: 06/17/14
Revised: 07/02/14
Revised: 12/05/18
Revised: 09/02/20
Revised: 08/2023; 04/2024 CAP LIMITS

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-7

POLICY TITLE: SUBSTANCE ABUSE OUTPATIENT CARE SERVICES

POLICY STATEMENT

Programs must integrate both internal and external referrals for substance abuse residential treatment, mental health and other supportive services for those consumers requiring and willing to participate. The EMA is committed to a client-driven approach to care and services, as well as, supporting a service delivery system that is non-judgmental, courteous, and that provides an empathetic service environment.

DEFINITION AND UNIT OF SERVICE DESCRIPTION

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

A unit of **Substance Abuse Service** for billing purposes is defined as one hour for individual or group counseling or any portion thereof. If the session is longer than an hour, the unit should be rounded to the nearest quarter hour. (For example, if an individual session lasts 1 hour and 41 minutes, the session should be billed as 1.75 units.) If it is a group session PROVIDER cannot charge one unit for each person attending the session, maximum amount billable is based on the length of the session.

PROCEDURE
Once consumer needs are identified, a substance abuse treatment plan must be established to offer the most appropriate care. All client assessments are re-evaluated to ensure monitoring of client progress, identification of emerging needs, health education, and development of alternate strategies to support client efficacy in addressing substance abuse issues. Care plans must include a consumer driven treatment plan, health education, relapse prevention and after care strategies, supervised therapy to support medical adherence and recovery, client empowerment, and supportive services. Client documentation must include:

1. Annual Proof of Primary Care.
2. Agency must have on file a current copy of the client's Notice of Eligibility Determination.
3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential office space for seeing clients (e.g. no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential locked location for a period stipulated by law. • Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information policies as stated by the state of Florida.	• Policy and procedures manual • Program monitoring/site visit

B. Agency must have policies and procedures in place that address client grievance procedures and eligibility requirements per federal and state law and local regulations. If a grievance is not satisfactorily resolved, at the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office. The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator level, then the client will be provided information on further grievance escalation at that time. Clients are informed of the client confidentiality policy and grievance policy at first face-to-face contact.	• Grievance procedure posted in visible location • Policy and procedures manual • Program monitoring/site visit
C. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender, socioeconomic status, cultural background, disability, and religion.	• Policy and procedures manual • Program monitoring/site visit • Training records
II. Personnel Qualifications	
Standard	**Measure**
A. Agency will ensure that all physicians, or those under the supervision of physician or other qualified personnel providing substance abuse treatment services are licensed/certified to practice within their concentrated area consistent State and local law.	• Personnel records • Program monitoring/site visit • Professional License/Certification

B. Qualified professionals who possess current professional licensure or who are authorized by the state and/or their agency will participate in the care and treatment of clients as required by law.	• Training records • Program monitoring/site visit
III. Client Rights and Responsibilities	
Standard	**Measure**
A. Each agency must maintain their own client rights and responsibilities protocols and documentation.	• Policy and procedures manual • Client record • Program monitoring/site visit
IV. Eligibility and Intake	
Standard	**Measure**
A. Upon initial contact with client, agency will determine if clients meet criteria for emergency needs, as detailed in the required annual comprehensive assessment and acuity assessment.	• Client record • Program monitoring/site visit
B. Provider confirms client eligibility for services. Client eligibility will be reassessed every 12 months. The process to determine client eligibility must be completed in a time frame so that screening is not delayed. Eligibility assessment must meet the regulations of 64D-4 and must be consistent with funding requirements.	• Client record • Program monitoring/site visit • Client record and client satisfaction survey.
C. Substance abuse providers must provide the client a choice of service providers if available.	• Client record signed by client • Program monitoring/site visit
V. Assessment &Treatment	
Standard	**Measure**
A. Treatment incorporates an initial assessment of client that consists of medical history and a psychosocial history with treatment recommendations.	• Policy and procedure manual • Client record
B. Outpatient treatment incorporates continuum of care strategies to provide a safe environment for a client to return to after detox or other initial intervention.	• Policy and procedure manual • Client record

C. The need for mental health treatment can not preclude a client from receiving substance abuse counseling/treatment.	• Policy and procedure manual • Client record
VI. Service Coordination/Referral	
Standard	**Measure**
A. The provider will provide referrals for continuity of mental health, and/or psychiatric care to their patients/clients as needed.	• Policy and procedures manual • Client record • Program monitoring/site visit

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:

Adopted: 06/07/00
Revised: 12/03/03
Revised: 11/7/07
Revised: 6/17/14
Revised: 7/2/14
Revised: 12/5/18
Revised: 09/02/20

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PROGRAM SERVICE (PS) POLICY #: PS-8

POLICY TITLE: EMERGENCY FINANCIAL ASSISTANCE

POLICY STATEMENT

Emergency Financial Assistance offers an alternative method of assisting clients with emergency expenses related to critical services for the Tampa EMA for medication. These short-term payments must be carefully monitored to assure limited amounts, limited use, and for limited periods of time.

DEFINITION

Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients is not permitted.

CAPS/LIMITS

No caps/limits established for this category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential	• Policy and procedures manual • Program monitoring/site visit

office space for seeing clients (e.g. no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential locked location for a period stipulated by law. • Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information policies as stated by the state of Florida.	
B. Agency must have policies and procedures in place that address client grievance procedures and eligibility requirements per federal and state law and local regulations. If a grievance is not satisfactorily resolved, at	• Grievance procedure posted in visible location • Policy and procedures manual • Program monitoring/site visit • Client grievance form signed by client

the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office. The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator level, then the client will be provided information on further grievance escalation at that time. • Clients are informed of the client confidentiality policy and grievance policy at first face-to-face contact.	
C. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender, socioeconomic status, cultural background, disability, and religion.	• Policy and procedures manual • Program monitoring/site visit • Training records
II. Personnel Qualifications	
Standard	**Measure**
A. Agency will ensure that all staff, inclusive of but not limited to, pharmacists, pharmacy technicians; and medical assistants providing	• Personnel records • Program monitoring/site visit • Professional License/Certification

pharmacy care or assisting in the provision of pharmacy care are licensed/certified to practice within their concentrated area consistent with local, State and federal law., i.e. Florida's Board of Pharmacy.	
III. Program Staff	
Standard	**Measure**
A. Providers shall maintain records of quarterly quality improvement meetings including pharmacy staff as required by FAC 64B16-27.300, Standards of Pharmacy Practice.	• Program monitoring/site visit • Meeting Records
IV. Client Rights and Responsibilities	
Standard	**Measure**
A. Each agency must maintain their own client rights and responsibilities protocols and documentation in accordance with Rule 64D-4, F.A.C. Client rights and responsibilities must be posted publicly in visible location.	• Policy and procedures manual • Client record • Program monitoring/site visit
V. Client Eligibility	
Standard	**Measure**
A. Each provider will maintain their own eligibility requirements, but at a minimum, will include standards of Ryan White program Recipient eligibility per Rule 64D-4, F.A.C.	• Client record • Program monitoring/site visit

B. Notice of eligibility every 12 months must be maintained by clients, notify applicable certifying entity of any life changes.	• Client record • As entered in program electronic database • Program monitoring/site visit
VI. Treatment Adherence	
Standard	**Measure**
A. Providers shall follow nationally accepted treatment guidelines, i.e., Centers for Disease Control (CDC), Infectious Disease Society of America (IDSA), or Department of Health and Human Services (DHHS)	• Policy and procedures manual • Program monitoring/site visit
B. Patient counseling will be provided by qualified staff as needed. Counseling shall include but not be limited to, administration, drug-drug interaction, side effects, dosage, adherence education and food-drug interactions. Counseling may be offered verbally or written to the patient.	• Policy and procedures manual • Program monitoring/site visit
I. Client Transition & Discharges	
Standard	**Measure**
A. Transition and discharge of services should include a written linkage plan maintained by each agency and must include a list of providers available within a client's county of residence. Clients must be provided with their proof of status, most recent proof of Ryan White eligibility, and their most recent labs. Pediatric client files will be kept open for three (3) months and will be	• Policy and procedures manual • Program monitoring/site visit

considered a successful transition if seen twice by a provider following transition of services. They must be provided with their current prescriptions, all provider notes, and case manager contact information.	
VIII. Case Closure	
Standard	**Measure**
Adult cases will be closed upon death or permanent discharge from the clinic. Pediatric client cases will be closed after one (1) year without successful client contact or upon successful transition to adult care. Providers must also maintain agency-specific guidelines and must include the date and reasons for case closure utilizing the OAHS Case Closure Summary Form for all closed cases. *Form attached as Appendix 1.	• Policy and procedures manual • Client record • Program monitoring/site visit

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 “Initiation of Services” Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification
7. The provider must maintain and submit a summary sheet containing the following information:
    a. Gift card/voucher number.
    b. Client's number or identifier.
    c. Dollar value of gift card/voucher.
    d. Date issued.
    e. Date of register receipt.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: October 2008
Revised: 5/12/14
Revised: 12/5/18
Revised: 09/02/20

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-9

POLICY TITLE: HEALTH EDUCATION/ RISK REDUCTION

POLICY STATEMENT

In order to best serve the PLHW/A population, it is imperative to provide support services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. The principles of self-help have become integral to the field of health education. Patient education has been particularly effective in teaching self-help strategies for managing acute and chronic diseases. As a result, many individuals have adopted new health behaviors that directly enhance the quality of their lives, while bringing the added benefit of reducing the rising costs of health care. Within the spectrum of HIV and AIDS care, health education and risk reduction programs emphasizing self-help have been introduced.

Health education and risk reduction programs focusing on self-help approaches can assist individuals with self-management techniques resulting in healthy attitudes and behavior changes. Attitudinal and behavioral changes will become increasingly important as more people live longer with an HIV seropositive and/or an AIDS diagnosis.

DEFINITIONS AND UNIT OF SERVICE DESCRIPTION

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Services cannot be delivered anonymously. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education*

*For clarification: Pursuant to HIV/AIDS Bureau Policy 16-02, Treatment Adherence services during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provide during a Medical Case Management visit should be reported in the Medical Case management service category.

A unit of **Health Education/Risk Reduction** is per quarter hour. The PROVIDER must keep track of time spent with each client and the number of encounters with each client. Notes must be unique to client interaction and must be signed by employee performing the service.

PROCEDURE

1. Annual Proof of Primary Care.
2. Agency must have on file a copy of the client's Notice of Eligibility Determination.
3. 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.

CAPS/LIMITS

No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential office space for seeing clients (e.g. no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential	• Policy and procedures manual • Program monitoring/site visit

locked location for a period stipulated by law. • Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information policies as stated by the state of Florida.	
C. Health Education/Risk Reduction Curriculum: Agency will have a written curriculum to inform clients about: • Reducing HIV transmission risks including partner testing • Preventing STIs • The benefits of treatment and information on how to access and retain care • Available resources to help with HIV treatment and prevention • PrEP education • Understanding lab values and medication regimen • Personal HIV disclosure HRSA-approved curriculum may be adopted for HERR in place of the Agency developing their own curriculum	• Policy and procedures manual • Program monitoring/site visit
D. Agency must have policies and procedures in place that address client grievance procedures and eligibility requirements per federal and state law and local regulations.	• Grievance procedure posted in visible location • Policy and procedures manual • Program monitoring/site visit

If a grievance is not satisfactorily resolved, at the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office. The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator level, then the client will be provided information on further grievance escalation at that time. • Clients are informed of the client confidentiality policy and grievance policy at first face-to-face contact.	
E. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender, socioeconomic status, cultural background, disability, and religion.	• Policy and procedures manual • Program monitoring/site visit • Training records
F. Group and individual level evaluation of clients' needs or topics: • HERR activities will be driven by an evaluation of participants' interests and needs • Evaluation may be conducted during group discussion or individually with clients	• Policy and procedures manual • Program monitoring/site visit
II. Personnel Qualifications	
Standard	**Measure**
A. Health Educators must have appropriate skills, education, and	• Personnel records • Program monitoring/site visit

relevant experience prior to hire to provide HERR services.	
B. Health Educators and direct supervisors must attend training sessions as required by the Recipient, Health Resources and Services Administration, and/or the Florida Department of Health. Additional training must be coordinated and/or provided by supervisory staff.	• Training records • Program monitoring/site visit
II. Client Rights and Responsibilities	
Standard	**Measure**
A. Each agency must maintain their own client rights and responsibilities protocols and documentation.	• Policy and procedures manual • Client record • Program monitoring/site visit
III. Eligibility and Intake	
Standard	**Measure**
A. Upon initial contact with client, agency will determine if clients meet criteria for emergency needs, as detailed in the required annual comprehensive assessment and acuity assessment.	• Client record • Program monitoring/site visit
B. Provider determines client eligibility for services. Client eligibility will be reassessed every 12 months. The process to determine client eligibility must be completed in a time frame so that screening is not delayed. Eligibility assessment must meet the regulations of 64D-4 and must be consistent with funding requirements.	• Client record • Proof of income • Program monitoring/site visit • Client record and client satisfaction survey.
C. Health Educators must provide the client a choice of service providers if available.	• Client record signed by client • Program monitoring/site visit

IV. Active File Maintenance & Case Closure	
Standard	**Measure**
A. Health Educators must contact clients as needed (based on client need) unless a specific program requirement is set by a program. Health Educators contact requirements are subject to any additional requirements set forth by Rule 64D-4, the Florida Department of Health, and the Health Resources and Services Administration. Contact is defined as phone, face-to-face, leaving a message or a mailing.	• Client record
B. Active files must have individualized service plan reviewed by client and case manager semi-annually.	• Client record • Program monitoring/site visit
C. Active files must reflect a face-to-face visit conducted on a semi-annual basis.	• Client record • Program monitoring/site visit
D. Clients will have access to a case manager during normal business hours for the agency.	• Policy and procedures manual • Client record • Program monitoring/site visit
E. Case managers must maintain up to date documentation on all activities with, or on behalf of clients.	• Client record • Program monitoring/site visit
F. Case managers must ensure that a copy of a client's record in its entirety is sent to the receiving agency within 10 business days from receipt of original signed release.	• Client record • Program monitoring/site visit • As entered in program electronic database
G. Notice of eligibility every 12 months must be maintained by clients, notify applicable certifying entity of any life changes.	• Client record • As entered in program electronic database • Program monitoring/site visit
H. Adult client cases will only be closed upon death of a permanent discharge from the clinic.	• Policy and procedures manual • Program monitoring/site visit

Providers must also maintain agency-specific guidelines and must include the date and reasons for case closure.	
V. Treatment Adherence	
Standard	**Measure**
A. Case managers will work collaboratively with client and medical/psychosocial providers to promote adherence to treatment.	• Policy and procedures manual • Client record • Program monitoring/site visit

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification
7. MAI Referral

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE

Adopted: 05/07/03
Revised: 12/5/18
Revised: 09/02/20

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-10

POLICY TITLE: HOUSING ASSISTANCE SERVICES

POLICY STATEMENT

The major cause of homelessness in Florida and throughout the Nation is poverty. Those who are poor often find it difficult to obtain housing that is both suitable and affordable. Those who do must frequently spend more than 50 percent of their limited incomes for housing, making it difficult to pay for other life essentials, e.g., medical, pharmaceuticals, etc. Those at most risk of homelessness are people living in poverty, single parents, the unemployed or under-employed, the physically and mentally disabled, substance abusers, victims of domestic violence, runaway children and throwaway youth, veterans, and those without family support networks. Homelessness often occurs in conjunction with substance abuse, chronic mental illness, and unsafe sexual behavior. All these factors increase homeless people's risks of contracting HIV. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

Housing Assistance Services: Housing provides 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. Activities within the Housing category 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 activities 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 activities. Program Guidance: HRSA RWHAP recipients and subrecipients 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. HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing. Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

B. UNIT OF SERVICE:

A unit of housing assistance is defined as one **monthly** payment of housing for rent, or utilities or any portion thereof. This contract will be reimbursed on a line-item basis.

Housing Assistance must be paid utilizing the following policies adopted by Recipients Office for Part A and Ending the HIV Epidemic (EHE). However, exceptions can be made through requests addressed to the Ryan White Program Manager:

1. Rent Payments: will be reimbursed at the PROVIDER's acquisition cost. Three times per *program* year. Each payment is one-month (30 days) rent. Exceptions may be granted by Recipient with ****extenuating circumstances***.

2. Utility Payments: will be reimbursed at the PROVIDER's acquisition cost. Three times per *program* year. Each payment is for one month (30 days) of utilities service. Exceptions may be granted by Recipient with ****extenuating circumstances***.

3. **Utility Reconnect:** will be reimbursed at the PROVIDER's acquisition cost. Each payment is for reconnection of utility services one time only (electric, gas, or water) exceptions may be granted by Recipient with ****extenuating circumstances.***

4. Late Fees: will be reimbursed at the PROVIDER's acquisition cost. Each payment is for late fees one time only per service type (rent, electric, gas, or water) exceptions may be granted by Recipient with ****extenuating circumstances***.

5. **Application Fees**: will be reimbursed at the PROVIDER's acquisition cost. Each payment is for the cost of a rent application fee. (One time only) exceptions may be granted by Recipient with ****extenuating circumstances***.

6. Documentation: Case managers are required to maintain documentation of:

A. Medical necessity related to HIV.
B. Plan of self sufficiency
C. Proof of last pay dollars and list all other sources contacted with reasons for denials.
D. Receipts if needed as back-up.

PROCEDURE

1. Annual Proof of Primary Care.
2. Agency must have on file a copy of the client's Notice of Eligibility Determination. (Part A)
3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.

****Extenuating circumstance: Services are necessary to prevent homelessness or utility shut off.***

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential office space for seeing clients (e.g., no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential locked location for a period stipulated by law. • Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information policies as stated by the state of Florida.	• Policy and procedures manual • Program monitoring/site visit
B. Agency must have policies and procedures in place that address client grievance procedures and eligibility requirements per federal and state law and local regulations.	• Grievance procedure posted in visible location. • Policy and procedures manual • Program monitoring/site visit

If a grievance is not satisfactorily resolved, at the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office. The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator level, then the client will be provided information on further grievance escalation at that time. • Clients are informed of the client confidentiality policy and grievance policy at first face-to-face contact.	
C. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender, socioeconomic status, cultural background, disability, and religion.	• Policy and procedures manual • Program monitoring/site visit • Training records
II. Client Rights and Responsibilities	
Standard	**Measure**
A. Each agency must maintain their own client rights and responsibilities protocols and documentation.	• Policy and procedures manual • Client record • Program monitoring/site visit
III. Housing Services	
Standard	**Measure**
A. Providers of this service have specific experience in caring for HIV infected clients or receive appropriate training.	• Written procedures and/or documentation on file as examined by the Recipient/Lead Agency.
B. Clients must present a need for services as related to their HIV health status.	• Documentation on file as examined by the Recipient/Lead Agency.

C. Payments made for services must be appropriate for the area and household size.	• Written procedures and/or reasonable rent charts documented on file as examined by the Recipient/Lead Agency.
D. Assistance can only be provided to HIV positive individuals within a household.	• Documentation as to household size, income and expenses as documented on file as examined by the Recipient/Lead Agency.
E. There must be a plan to move the client off assistance toward self-sufficiency as documented by the referring entity and provided to the provider of this service.	• Documentation on file as examined by the Recipient/Lead Agency.
F. All clients receiving assistance must be offered the opportunity for referral to a budget management service or financial counseling.	• Documentation on file as examined by the Recipient/Lead Agency.
G. The lease or utility bill service address must be for the same address as the client.	• Documentation on file as examined by the Recipient/Lead Agency.
H. In the absence of a lease, an approved rental verification form must be used.	• Documentation on file as examined by the Recipient/Lead Agency.
I. Full current copies of the utility bills must be provided for services showing total amounts due for the service address.	• Documentation on file as examined by the Recipient/Lead Agency.

DOCUMENTATION

1. Notice of Eligibility Determination (Part A)
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification
7. Medical Necessity Related to HIV
8. Plan of Self- Sufficiency
9. Proof of Last Pay and List of all Other Sources Contacted with Reasons for Denials

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:

Adopted: 06/06/01
Revised: 12/03/03
Revised: 5/13/14
Revised: 03/19/18

Revised: 03/03/23

RYAN WHITE PART A and EHE HOUSING ASSISTANCE SERVICES

STORAGE OF DOCUMENTS, BILLING SUBMISSION, & DATES

Storage of Documentation
Housing services documentation must be accessible in e2H and be uploaded to the E2H Non-Eligibility Document Tracker, (document tracker), under the Documents tab. The option under Referral -Housing must be used for each packet of information, and stored under the specific service, i.e., Utilities, Motel, or Rent.

The following must be stored in e2H as back up for verification of housing services billed:

- Financial Assistance Check Request with client information
- Copy of Utility bill(s), rent due, or motel stay receipt(s) for each month of service billed.
- Notes in billing submission stating:
    - Client needs for date of services billed.
    - Last Pay Dollars Used
    - If utility, invoice number and dates of service covered.
- If service exceeds cap limits (3 payments per program year), then verification of exception request and approval must be included in e2H.
- Check number or verification of electronic payment submitted to Payee and verification of cleared check or electronic payment.

E2Hillsborough Date of Service

Note: There should be single service entries for each service category. No combination of rent, utility in one service entry with a single amount for the total. They are required to be reported individually.

Utility Bills
The *invoice* **(see exceptions below) *** date on the utility bill is to be used as the billing date in e2H when entering and submitting billing; and in the notes field reference the span of time that is being covered for that specific utility bill.

Utility bills in arrears (i.e., multiple months of service) ***within the grant period*** need to be separated by each month and billed separately, with clear documentation including the utility bill invoice date and span of time that is being covered for that specific utility bill.

A copy of the utility bill for that service entry must be uploaded and saved to the document tracker and labeled with the invoice number and span of time that is being covered for that specific utility bill. All other applicable documents as stated above must also be uploaded and saved to the document tracker.

Exceptions for the end of grant periods
When a utility bill is presented that crosses over the ***prior/old grant period (End of February)*** then instead of using the invoice date, use the first date of service covered on the bill, as the billing date in e2H. Procedures for uploading in to e2H remain the same.

For example, a February utility bill dated and brought in March needs to be billed in system with the first date of service for the month such as Feb 10. And must be billed in the prior/old grant period, ***as long as claims are still being accepted for the grant period***. A February bill dated and brought into the office in March/April cannot be billed to the new grant year.
In addition, if multiple months are presented such as January and February, one with January first date of service and February first date of service billed as two separate line items.

Motel Stay Bills
Motel stays **(see exceptions below) *** must be billed by month and with clear documentation on the period that is being covered for that specific motel stay. Motel stays must use of the ***first day*** the client stayed in the motel as the billing date. If the client stay crossed over 2 or more months, then the second month's bill date would be 1st of month two, and the 1st of month three.

For example, if a client stayed from April 16 through May 14, the first billing submission date would be April 16 and the second billing date would be May 1. Both submissions need to have documentation on the progress note stating the span of time covered, in addition to any other verification requirements noted above.

A copy of the motel stay receipt for that service entry must be uploaded and saved to the document tracker and labeled with the submission date and span of time that is being covered for that specific motel stay bill. All other applicable documents as stated above must also be uploaded and saved to the document tracker.

Exceptions for the end of grant periods
Motel stays occurring in February must be billed to the ***prior/old grant period (End of February)***

For example, a February motel stay receipt brought into provider in March needs to be billed in system with the ***first day*** the client stayed in the motel, such as Feb 10. And must be billed in the prior/old grant period, ***as long as claims are still being accepted for the grant period***. A February motel bill dated and brought into the office in March/April cannot be billed to the new grant year.

In addition, if multiple months of motel stays are presented such as January and February, one with the ***first day*** the client stayed in the motel in January; then February would be billed separately as February 1st, under the ***prior/old grant period.*** All other applicable documents as stated above must also be uploaded and saved to the document tracker.

Rent Payments
The first day of that month being paid is to be used as the billing date in e2H when entering and submitting billing; and in the notes field reference the span of time that is being covered for that specific rent payment. **(See exceptions below) ***
For example, when submitting August rent, the date used for billing would be August 1st.

Rent payments must be separated by each month of rent service being billed, with clear documentation on the period that is being covered for that specific rent bill. The copy of the rent bill for that service entry must be uploaded and saved to the document tracker and labeled with the billing date and span of time that is being covered for that specific rent period. All other applicable documents as stated above must also be uploaded and saved to the document tracker.

Exceptions for the end of grant periods
Rent payments submitted for February must be billed to the ***prior/old grant period (End of February).***

For example, a February rent bill brought into provider in March needs to be billed in system with February 1st and must be billed in the prior/old grant period, ***as long as claims are still being accepted for the grant period***.

In addition, if multiple rent bills (in arrears) are presented such as January and February, each would be billed separately and dated using the 1st of the month and billed under the ***prior/old grant period.*** All other applicable documents as stated above must also be uploaded and saved to the document tracker.

Invoices/bills for services generated in one grant budget year, must be paid for with funds from the same grant budget year. Billing services from the previous grant cycle may be subject to rejection. If a payment does not clear and funds are reimbursed to subrecipient, those funds are to be reported as program income. Program income report submission includes the excel format and entry into e2H for the service entry that absorbs the funds.

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-11

POLICY TITLE: EARLY INTERVENTION SERVICES (EIS)

POLICY STATEMENT

EIS activities include targeted HIV testing (to help the unaware learn of their HIV status); monitored referrals to case management and treatment services at key points of entry for those found to be HIV-infected; linkage services designed to facilitate access to HIV care and treatment services such as Outpatient and Ambulatory Health Services, Medical Case Management, and Substance Abuse Treatment Services; and health education and literacy training that enable clients to navigate the HIV system of care and reduce future transmission of disease.

Special Note: EIS is often confused with Outreach Services. To clarify, EIS activities are designed to identify HIV-positive persons who are unaware of their status and to facilitate their entry into care. The service has four distinct components: testing, referral, linkage, and health education. Conversely, Outreach Services are activities other than counseling and testing designed to identify known HIV-positive persons and link them to medical and support services. These persons are commonly referred to as "out-of-care" or "lost-to-care." This service shares with EIS only the referral and linkage components and has an entirely different target population.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

Includes counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures) ; referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Services shall be provided at specific points of entry. Coordination with HIV prevention efforts and programs as well as prevention providers is required. Referrals to care and treatment must be monitored. Grantee may modify targeted areas to include additional key points of entry.

PROCEDURE

1. 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
2. Ryan White Consent Authorization Form
3. Geographic Restriction Policy applies.

CAPS/LIMITS

No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

I. Policies and Procedures	
Standard	**Measure**
A. Agency must have policies and procedures in place that address confidentiality (HIPAA) and release of protected health information including: • Agency policy must be in place for protocol violations and breaches as per 384.29 Florida legislature. • Agency must provide private, confidential office space for seeing clients (e.g., no half-walls or cubicles, all rooms must have doors). • Utilization of telehealth technology will be based on client need and will be maintained at the same standard as a client's face-to-face visit. • Agency will have all inactivated client records in a confidential locked location for a period stipulated by law.	• Policy and procedures manual • Program monitoring/site visit

• Agency will have all activated client records behind two locked doors. • All electronic client data will be encrypted in transit and at rest. • Must include all regulations and policies according to HIPAA and super confidential information policies as stated by the state of Florida.	
B. Agency must have policies and procedures in place that address client grievance procedures and eligibility requirements per federal and state law and local regulations. If a grievance is not satisfactorily resolved, at the agency level, the client has a right to file a written grievance, within 30 days to the Lead Agency or Recipient office. The client will be contacted within 10 business days of receipt of written grievance to discuss resolution. If resolution is unable to be resolved satisfactorily at the administrator level, then the client will be provided information on further grievance escalation at that time. • Clients are informed of the client confidentiality policy and grievance policy at first visit.	• Grievance procedure posted in visible location. • Policy and procedures manual • Program monitoring/site visit
C. Agency must have a policy and staff training in place that supports cultural and linguistic competency by providing services in a way that is respectful to race, ethnicity, sexual orientation, gender,	• Policy and procedures manual • Program monitoring/site visit • Training records

socioeconomic status, cultural background, disability, and religion.	
II. Client Rights and Responsibilities	
Standard	Measure
A. Each agency must maintain their own client rights and responsibilities protocols and documentation.	• Policy and procedures manual • Client record • Program monitoring/site visit
III. Early Intervention Services	
Standard	Measure
A Staff providing Early Intervention services (EIS) will attend appropriate training: EIS staff will have completed a training plan; which includes, at a minimum, HIV 501 training. Agency will have a written training plan for EIS staff.	• Written procedures and/or documentation on file as examined by the Recipient/Lead Agency. • Training records • Program monitoring/site visit
B. Agencies will provide HIV testing and targeted counseling, when contracted to do so. Provision of HIV testing is used only where existing federal, state, and local funds are not adequate; used as necessary to supplement not supplant existing funds for HIV testing.	• Documentation on file as examined by the Recipient/Lead Agency.
C. Clients will be referred to care: Agency has referral arrangements with local key points of entry (including case management and medical providers) to ensure diverse needs of clients are met.	• Documentation of arrangements • Client record of referrals • Program monitoring/site visit

Clients are referred to available services, when applicable.	
D. Clients will be linked to care: Client charts will have documentation of the agency effort to link the client to an initial medical appointment, within 30days. {This should be verified through either direct communication with the service provider (medical provider, case manager, etc.) or self report from the client is acceptable when reasonable attempts have been made and cannot be achieved.} Of those clients who attended their initial medical appointment: client charts will have 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: Client charts will have 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.	• Client record • Program monitoring/site visit
E. Clients will receive health education that enables clients to navigate the HIV system of care. Clients will receive health education designed to help individuals navigate and understand the local HIV system of care.	• Client record • Program monitoring/site visit

DOCUMENTATION

10. Notice of Eligibility Determination (Part A)
11. Yearly Primary Care Visit/Consultation
12. DH 3204 "Initiation of Services" Form
13. HIV+ Diagnosis
14. Signed Consent to Fax (if appropriate)
15. Copy of Client Identification
16. Medical Necessity Related to HIV
17. Plan of Self- Sufficiency
18. Proof of Last Pay and List of all Other Sources Contacted with Reasons for Denials

AUTHORITY/OVERSIGHT

3. Ryan White Program Part A Recipient
4. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:

Adopted: 06/06/01
Revised: 12/03/03
Revised: 5/13/14
Revised: 03/19/18
Revised: 03/03/23
Revised 06/07/23

HILLSBOROUGH COUNTY HEALTH CARE SERVICES
RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-12

POLICY TITLE: CLIENT CERTIFICATION/ELIGIBILITY

POLICY STATEMENT

E2 Hillsborough is designed to streamline and simplify eligibility determinations for PLWH/A served through the Ryan White Program.

DEFINITION

Any contracted agency can serve any HIV+ client, who is deemed eligible according to E2 Hillsborough. All clients still need to obtain proof of primary care annually.

PROCEDURE

1. Annual Proof of Primary Care.
2. Agency must have on file a copy of the client's Notice of Eligibility Determination.
3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.
5. The contractor/provider must use the most recent primary care verification submitted by the client to ensure their eligibility does not expire one year from the date of eligibility verification.
6. Any information collected by the contractor/provider must be noted with a E2 Hillsborough generated unique client identifier number.
7. Please reference Florida's Administrative – Eligibility Rule 64D-4 Florida Administrative Code (FAC) for further details on eligibility requirements: http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/_documents/eligibility-information/RULE-TEXT.pdf

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification
7. Yearly Verification of Primary Care, can include any of the following:

a. Dated statement from the primary care visit, on letterhead, signed by a site representative, with identifying information to link the document to the client.
b. A dated prescription with identifying information to link the document to the client, scripts from a dentist, oral surgeon, or psychiatrist or psychologist are not acceptable.
c. Dated lab with identifying information to link the document back to the client.
d. A documented conversation with the Primary Care contractor/provider, identifying primary care attendance.
e. Utilization of the Primary Care Attendance Form.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: October 2008
Revised: 5/12/14
Revised: 1/1/2018

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Ryan White
Primary Care Attendance
Verification Form

Client Name: _____

Date of Birth: _____

Social Security Number: _____

Date of last Primary Care Appointment that the above stated client attended:

Authorized Signature **Date**

_____ _____

Primary Care Office (Please Print):

_____
Name of Clinic

_____

_____
Address of Clinic

_____
City

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-13

POLICY TITLE: GEOGRAPHIC RESTRICTIONS

POLICY STATEMENT

Clients should be encouraged to receive services in their area of residence and within the designated geographic areas per funding category.

DEFINITION

The Ryan White Program Part A funds are designated for clients that live in the EMA (Hillsborough, Pasco, Pinellas and Hernando Counties) EHE funds are designated for clients that live in the EMA (Hillsborough and Pinellas Counties)

PROCEDURE
Encourage clients to access the appropriate service in their county of residence or in the closest county where the service is available.

DOCUMENTATION
Proof of residence.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: October 2008
Revised: 5/13/14
Revised: 03/20/18

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PROGRAM SERVICE (PS) POLICY #: PS-14

POLICY TITLE: MAIL DELIVERED MEDICATIONS

POLICY STATEMENT

Whenever a cost saving in prescriptions or for the convenience of clients, particularly when transportation is an issue, mail order prescriptions will be made available.

DEFINITION

Mail delivered medications are prescriptions dispensed and sent to the client via the mail.

PROCEDURE
To access this service the case manager will:

1. Fax the provider pharmacy the intake form together with the prescription.
2. Later, the case manager must mail the original prescription to the provider pharmacy or must destroy it.
3. If the client needs the medication refilled beyond the number of refills on the original prescription, a new prescription must be issued.
4. Once a prescription expires it must not be used again.

If for some valid reason the client is in need of AIDS Drug Assistance Program (ADAP) medications, but ADAP cannot be accessed immediately, these medications can be provided by the local pharmacy program on a temporary basis. The case manager will complete the A.R.T. Exception Form, attached at the end of this chapter, and fax it to the Ryan White program management staff for approval. The program management staff will sign and fax to the case manager the approval if the reason for the request is warranted.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: October 2008
Revised: 5/13/14
Revised: 03/20/18

EXCEPTION REQUEST FOR RYAN WHITE A.R.T. MEDICATIONS

CLIENT NAME: _____ e2H ID#: _____ DATE: _____

DOB: _____ SSN: _____-_____-_____ FPL: _____%

*** * *Complete and ☑ check off <u>all</u> areas that pertain to this client and their current situation.* * ***

☐ **Pending Medicaid:** Date of Application _____ (No more than 60 days)
☐ Medicaid Application Confirmation page attached

☐ **ADAP has been applied for and is:**
☐ ADAP Requested refill too late or has no current RX's ☐ Client missed ADAP –re-enrollment. See below for new ADAP appt.
☐ Client has been scheduled for an appointment with ADAP to be enrolled. The appointment is scheduled for
Date: _____ @ Where: _____

☐ **Client has Medicare Part D and is pending:**
☐ Part D Benefit to Begin on _____ ☐ ADAP ☐ Subsidy Assistance

☐ **Client has Private Insurance with effective date of_____, Reason for RW service_____(premium lapse/COBRA?).**

☐ **Client was recently released on A.R.T. medications from:**
☐ Hospital; Release Date: _____
☐ Incarceration; Release Date:_____Contact Name_____ _____
☐ _____; Release Date: _____
(other, please specify)

☐ **Compassionate Care Assistance has been applied for regarding the requested A.R.T. medications:**
☐ Client is pending an answer
☐ Client was denied and a copy of denial attached

<u>I have confirmed</u> and documented in the client record that the client has had less than a 30-day break in A.R.T. therapy by:

☐ Telephone contact with _____ (staff name at ADAP office & which County)

☐ Telephone contact with the client's pharmacy_____ (name of Pharmacy & phone number)

☐ Telephone contact with the client's Provider _____

☐ Records provided by ☐ Client or ☐ Other_____(please specify), and we have a copy in the client's file.

REQUEST #1

□ It has been confirmed that this request is not to **<u>START</u>** the client on A.R.T. medications and their last A.R.T. pick up occurred: _____ **<u>OR</u>** □ This is new "Test and Treat" client.

Case Manager (Name & Signature)**:** _____ **Phone #:** _____

C M Agency Supervisor Approval: _____ **Date:** _____

REQUEST #2

□ Client's <u>current status has been **UPDATED**</u> on this form. (CM comment, initials/date <u>required</u>).

Last A.R.T. pick up occurred _____.

Case Manager (Name & Signature)**:** _____ **Phone #:** _____

C M Agency Supervisor Approval: _____ **Date:** _____

REQUEST #3

□ It has been confirmed that the client has successfully secured other means for continued therapy.

<u>UPDATE</u> **Form above.** (CM comment, initials/date <u>required</u>). Last A.R.T. pick up occurred _____

Case Manager (Name & Signature)**:** _____ **Phone #:** _____

C M Agency Supervisor Approval: _____ **Date:** _____

Ryan White Office Authorization: _____ **Date:** _____

INSTRUCTIONS FOR PROVIDERS

This form is an exception form to be completed by CASE MANAGERS for clients who are currently taking antiretroviral (A.R.T.) medications and experiencing a situation that will prevent them from continuing this therapy.

A single exception form will be utilized for all three requests.

VERY IMPORTANT: Incomplete forms and/or forms improperly or inaccurately completed will be rejected and returned to the case manager or case management agency. Subsequently medications will not be filled and may result in a delay of medications being filled and provided to the client. It is the responsibility of the agency completing the form to ensure it is accurate, complete and signed by the appropriate authorities.

1. **REQUEST #1**: The CASE MANAGER is required to complete the form and **answer all questions that pertain to this client** and their current situation. It also requires appropriate authorizations:
    a. CASE MANAGER'S name, signature and phone number.
    b. CM AGENCY SUPERVISOR APPROVAL name, signature and date of approval.
    c. Give the form to client to take to pharmacy or fax the form to pharmacy.
    d. Pharmacy Staff is responsible to review prior to dispensing A.R.T. medications, sign, date and scan the form into the pharmacy software system for future reference. If pharmacy staff has questions or concerns, they will contact the case manager and/or supervisor. No Antiretroviral medications will be dispensed (prescriptions filled) without the exception form correctly completed with the appropriate authorizations. It will be the responsibility of the Case Manager to ensure that this process is completed correctly, so medications can be dispensed to the patient.

2. **REQUEST #2:** The CASE MANAGER will pull request #1; update all questions that pertain to this client and their current situation and complete Request #2 section with appropriate authorizations:
    a. CASE MANAGER'S name, signature and phone number. ***Updates are required. The CM will comment, initial & date***.
    b. CM AGENCY SUPERVISOR APPROVAL name, signature and date of approval.
    c. Give the form to client to take to pharmacy or fax the form to pharmacy.
    d. Pharmacy Staff is responsible to review prior to dispensing A.R.T. medications, sign, date and scan the form into the pharmacy software system for future reference. If pharmacy staff has questions or concerns, they will contact the case manager and/or supervisor. No Antiretroviral medications will be dispensed (prescriptions filled) without the exception form correctly completed with the appropriate authorizations. It will be the responsibility of the Case Manager to ensure that this process is completed correctly, so medications can be dispensed to the patient.

3. **REQUEST #3:** The CASE MANAGER will pull request #2 and update all questions that pertain to this client and their current situation and complete Request #3 section with appropriate authorizations:
    a. CASE MANAGER'S name, signature and phone number. ***Updates are required. The CM will comment, initial & date***
    b. CM AGENCY SUPERVISOR APPROVAL name, signature and date of approval.
    c. The CM will obtain the Ryan White Office Authorization, name, signature and date of approval.
    d. Give the form to client to take to pharmacy or fax the form to pharmacy.
    e. Pharmacy Staff is responsible to review prior to dispensing A.R.T. medications, sign, date and scan the form into the pharmacy software system for future reference. If pharmacy staff has questions or concerns, they will contact the case manager and/or supervisor. No Antiretroviral medications will be dispensed (prescriptions filled) without

the exception form correctly completed with the appropriate authorizations. It will be the responsibility of the Case Manager to ensure that this process is completed correctly, so medications can be dispensed to the patient.

If at any time there are issues or concerns about this process please contact Aubrey Arnold, Ryan White Program Manager, at 813-272-6935.

Revised January 2020, replaces previous versions

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES PROGRAM

SERVICE (PS) POLICY #: PS-15

POLICY: PLANNING COUNCIL SUPPORT

POLICY STATEMENT

Planning Council Support is a legislatively mandated function.

DEFINITION

Ryan White funds may be used to support the Planning Council (PC) and services that support its activities (e.g., transportation for PLWH/A to attend network meetings), which can include in some instances, training of providers intended to improve medical outcomes, and consumer education and training that is intended to improve medical outcomes. The terms "Planning Council" and "Care Council" (CC) are interchangeable and refer to the same entity.

PROCEDURE

Responsibilities include:

1. Development of the needs assessment and integrated/comprehensive plan
2. Staff committees and Planning Council meetings
3. Support the Planning Council in implementing legislated tasks
4. Provide expert advice on Ryan White legislative requirements and HRSA/HAB regulations and expectations, and explain and interpret the Planning Council's Bylaws
5. Oversee a training program for members
6. Encourage member involvement and retention, with a special focus on consumers
7. Serve as a liaison with the recipient, community, and the Chief Elected Official (CEO)

CAPS/LIMITS

Allowable costs may include:

1. Costs incurred by Planning Council (PC) members, i.e., reasonable out of pocket costs like transportation, meals, etc.
2. Costs for the development of the comprehensive plan, assessment of the administrative mechanism, Statewide Coordinated Statement of Need (SCSN), and assistance in the coordination and writing of the annual grant application.
3. Development/implementation of the Planning Council Grievance Procedures and Marketing activities associated with PC activities and increased community participation.

4. Costs associated with conducting needs assessment and other methods for obtaining input on community needs and priorities, such as public meetings, focus groups, and ad hoc panels for the purpose of assisting the Planning Council in setting service priorities.
5. Staff support (clerical and professional expenses) required by the Planning Council for performance of required Care Council activities, including routine administrative activities.
6. Costs associated with providing meals or refreshments at Planning Council meetings.
   Guidance for meal allowances is included below.

Based on Ryan White Part A legislation and guidance, including the Ryan White Part A Manual and Policy Clarification Notice (PCN) 15-01, the provision of lunch during PC meetings may be an allowable expense under these conditions:

1. Reasonable and Necessary: The cost supports PC operations by addressing barriers to participation and aiding recruitment and retention efforts, particularly for unaffiliated Ryan White Part A clients.
2. Budgeted Expense: It is included in the PCS budget under the 10% administrative cap with justification. Each grant cycle, the Care Council Chair must request in writing an approval for an annual meal allowance, not to exceed $150.00 per month, and it must be presented during the Annual Negotiations Meeting.
3. Documented: Receipts and records must be maintained, and meeting minutes will reflect the purpose of the expense. With each meal allowance reimbursement request, three items must be submitted:
    1. The monthly meal allowance approved by the Ryan White Recipient Office.
    2. Receipts for the food and beverages
    3. Meeting minutes including attendance log
4. Monitored: During the Annual Negotiations Meeting the Care Council delegate will present the impact of offering meals from the previous year's allowance to ensure the costs support recruitment and retention efforts. The new year's annual allowance request must be based on the impact report from the last year and reflect appropriate spending amounts. All documentation must be available upon request to the Recipient for fiscal monitoring.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: October 2008
Revised: 5/13/14, 2/24/25

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-16

POLICY: PUBLIC POSTING OF CHARGES

POLICY STATEMENT

Ensure provider 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. This expectation applies to Recipients that also serve as direct service providers.

PROCEDURE
The Recipient and provider will do the following to remain in compliance:

1. The Recipient will review the provider's policy for a schedule of charges. The client eligibility determination procedures for imposition of charges will be based on the description of the accounting system used for tracking patient charges, payments, and adjustments.
2. The provider shall establish, document, and have available for review:
   a. A policy for a schedule of charges.
   b. Current schedule of charges.
   c. Client eligibility determination in client records.
   d. Fees charged by the provider and the payments made to that provider by clients.
   e. Process for obtaining and documenting client charges and payments through an accounting system, manual or electronic.
3. Provider policies and procedures will be reviewed to determine:
   a. Existence of a provider policy for a schedule of charges. A publicly posted schedule of charges based on current Federal Poverty Level (FPL) including the cap on charges.
   b. Client eligibility for imposition of charges based on the schedule.
   c. Track client charges made and payments received.
   d. How accounting systems are used for tracking charges, payments, and adjustments.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015,
Revised: 4/23/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-17

POLICY: FEDERAL POVERTY LEVEL BELOW 100% AND CLIENT CHARGES

POLICY STATEMENT

No charges are to be imposed on clients with income below 100% of the Federal Poverty Level (FPL).

PROCEDURE
Both the Recipient/Lead Agency and provider will do the following to review a client's income for eligibility:

1. The Recipient/Lead Agency shall review provider eligibility determination policy and procedures and ensure that clients with incomes below 100% of the FPL are not charged for services. The Recipient/Lead Agency shall also review client records and documentation of actual charges and payments to ensure the policy is being correctly and consistently enforced and clients below 100% of FPL are not being charged for services.
2. The provider will document their policy for the schedule of charges does not allow clients below 100% of FPL to be charged for services and personnel are aware of and consistently following the policy for schedule of charges. The policy for schedule of charges must be publicly posted.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-18

POLICY: FEDERAL POVERTY LEVEL ABOVE 100% AND CLIENT CHARGES

POLICY STATEMENT

Charges to clients with incomes greater than 100% of Federal Poverty Level (FPL) are determined by the schedule of charges. Annual limitation on the amounts of charge (i.e. caps on charges) for Ryan White services are based on the percent of the client's annual income, as follows:

1. 5% for clients with incomes between 100% and 200% of FPL.
2. 7% for clients with incomes between 200% and 300% of FPL.
3. 10% for clients with incomes greater than 300% of FPL.

PROCEDURE
The following procedures will be established to ensure clients with income greater than 100% FPL are properly determined for the appropriate services:

1. The Recipient/Lead Agency shall review the provider policy for the schedule of charges and cap on charges to ensure they meet legislative requirements. In addition, the Recipient/Lead Agency will review the accounting system and records of charges and payments to ensure compliance with caps on charges and review client records for eligibility determination application to ensure consistency with policies and federal requirements.
2. The provider will establish and maintain a schedule of charges and a policy that includes a cap on charges with the following:
   a. Responsibility for client eligibility determination to establish individual fees and caps.
   b. Tracking of Part A charges or medical expenses inclusive of enrollment fees, deductibles, co-payments, etc.
   c. A process for alerting the billing system when the client has reached the cap and should not be further charged for the remainder of the year.
   d. Personnel are aware of and consistently following the policy for schedule of charges and the cap on charges.
3. The Recipient/Lead Agency shall review the policy for schedule of charges and the cap on charges by:
   a. Review of the accounting system for tracking patient charges and payments.
   b. Review of the charges and payments to ensure that charges are discontinued once the client has reached his/her annual cap.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015

Revised: 4/13/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: PS-19

POLICY: ACCESS TO E2 HILLSBOROUGH FORMS

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Ryan White Programs
Computer Management Information System Authorization

I_____/_____ on behalf of _____am
Client/Guardian *SS#* *minor, if applicable*
aware that _____(AGENCY) is part of a health network of care who provide one or more HIV services (Ryan White Part A, the Minority AIDS Initiative, and Ending the HIV Epidemic) within counties of Hillsborough, Pinellas, Pasco and Hernando. I do hereby consent to and authorize Hillsborough County to disclose to ALL the below listed providers for which I am a client to input and/or access the following electronic information: Demographic, Social Security Number, Contact, Financial/Employment, Insurance, assigned client identification code, HIV/AIDS status, clinical-medical data, and socioeconomic data. I acknowledge by signing this form that other agencies which are Ryan White contracted providers will need my exact name and date of birth, or my exact social security number in order to access my information, to initiate services. I hereby hold Hillsborough County harmless for disclosure and/or release of my Protected Health Information to any Ryan White contracted provider or the Health Resources and Services Administration (Funding Source) in connection with the Ryan White Program. I understand that my name, address and other controlled identifiers are placed into the system, and that I have a right to request relevant health information that is tracked in the system.

The management of information is through a program called, eCOMPAS (or e2) which stands for Electronic Comprehensive Outcomes Measurement Program for Accountability & Success. I understand that this information is necessary to appropriately coordinate care. Access to the information above is available to the Funding Source, Hillsborough County, Health Care Services Department the Ryan White Recipient, their program and administrative staff or consultants, and RDE Systems, who provide the software and technical support for the e2 system. I am aware that the Funding Source and select providers are evaluating the effectiveness of health information through the Networks of Care initiative. This Authorization also includes sharing data with the State of Florida, Department of Health and other contracted providers listed on the Hillsborough County website at https://www.hillsboroughcounty.org/en/residents/social-services/health-care-plan/ryan-white-rfa as well as posted in the lobby or other conspicuous place such as a lab area or other common area of the clinic/offices that the client would have access to for the purposes of locating, initiating contact and offering assistance with linkage/re-engagement to HIV care and treatment.

This Authorization will remain valid for 10 years or until revoked by me. If I revoke this Authorization form, I understand that I must do so in writing and that I must present my written revocation to this Agency and to Hillsborough County's Ryan White Program Manager. I understand that the revocation will not apply to Health Information that has been released prior to the revocation. A written revocation will be effective five (5) days after is it received by the Ryan White Program Manager. Services rendered after the date of revocation will not be paid for by the Ryan White programs.

If the signer is a guardian, legal documentation of the representative's identity and authority to act on the individual's behalf must be attached. For a minor, the parent must attach a copy of the birth certificate to this form.

I further expressly consent to give Hillsborough County and the Funding Source access to any and all records stored in the system and any other records held by any Ryan White contracted agency for the purpose of monitoring, reporting, operating, payment and administration. A list of service providers will be updated annually (if any new agency is contracted and will be posted in each providers' lobby or other conspicuous place such as lab area or other common area of clinic/offices that the client would have access to along with the Notices of Privacy Practices. I stipulate reproduction of this signed Authorization are authentic as original.

_____ _____
Client/Representative signature Self or Representative's Relation to Client

_____ _____

Witness Date

Revised 5/16/2022

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Programas Ryan White
Autorización para el sistema de información de gestión informática

Yo,_____/_____ en nombre y representación de
Cliente/Tutor *No. de Seguro Social*
_____ tengo conocimiento de que_____(AGENCIA)
Menor, si corresponde
es parte de una red de atención médica que brinda uno o más servicios de VIH (Ryan White Parte A, the Minority AIDS Initiative y Ending the HIV Epidemic) dentro de los condados de Hillsborough, Pinellas, Pasco y Hernando. Por la presente, doy mi consentimiento y autorizo al Condado de Hillsborough a divulgar a TODOS los proveedores enumerados a continuación de los cuales soy cliente, a ingresar y/o acceder a la siguiente información electrónica: información demográfica, número de seguro social, datos de contacto, información financiera/de empleo, seguro, código de identificación asignado al cliente, estado de VIH/SIDA, datos clínico-médicos y datos socioeconómicos. Reconozco al firmar este formulario que otras agencias que son proveedores contratados por Ryan White necesitarán mi nombre exacto y fecha de nacimiento, o mi número de seguro social exacto para acceder a mi información, con el fin de iniciar los servicios. Por la presente eximo de responsabilidad al condado de Hillsborough por la divulgación y/o comunicación de mi información médica protegida a cualquier proveedor contratado por Ryan White o a la Administración de Recursos y Servicios de Salud (Fuente de financiación) en relación con el Programa Ryan White. Entiendo que mi nombre, dirección y otros datos identificadores controlados se ingresan en el sistema y que tengo derecho a solicitar información de salud relevante que se rastrea en el sistema.

La gestión de la información se realiza a través de un programa denominado eCOMPAS (o e2), lo que significa en inglés Electronic Comprehensive Outcomes Measurement Program for Accountability & Success (Programa electrónico integral de medición de resultados para la rendición de cuentas y su éxito). Entiendo que esta información es necesaria para coordinar adecuadamente los servicios de atención. El acceso a la información anteriormente mencionada está disponible para la Fuente de Financiación, el condado de Hillsborough, el Departamento de Servicios de Atención Médica, el beneficiario de Ryan White, su programa y personal administrativo o consultores, y RDE Systems, quienes proporcionan el software y el soporte técnico para el sistema e2. Tengo conocimiento de que la Fuente de Financiación y los proveedores seleccionados están evaluando la efectividad de la información de salud a través de la iniciativa Networks of Care. La presente Autorización también autoriza a compartir datos con el Estado de Florida, el Departamento de Salud y otros proveedores contratados que figuran en el sitio web del Condado de Hillsborough en https://www.hillsboroughcounty.org/en/residents/social-services/health-care-plan/ryan-white-rfa, así como lo publicado en la sala de espera u otro lugar visible, como un área de laboratorio u otra área común de la clínica/oficinas a las que el cliente tendría acceso con el fin de localizar, iniciar contacto y ofrecer asistencia con la vinculación/volver a iniciar la atención y el tratamiento del VIH.

La presente Autorización continuará siendo válida durante 10 años o hasta el momento que yo la revoque. Si revoco el presente Formulario de Autorización, entiendo que debo hacerlo por escrito y que debo presentar mi revocación por escrito a esta Agencia y al Gerente del Programa Ryan White del Condado de Hillsborough. Entiendo que la revocación no se aplicará a la información médica que se haya divulgado previo a la revocación. Una revocación por escrito entrará en vigor cinco (5) días después de que la reciba el Gerente del Programa Ryan White. Los programas Ryan White no pagarán los servicios prestados luego de la fecha de revocación.

Si el firmante es un tutor, se deberá adjuntar la documentación legal pertinente a la identidad del representante y la autoridad para actuar en nombre y representación de la persona. En el caso de un menor, el/la padre/madre deberá adjuntar una copia del acta de nacimiento a este formulario.

Además, doy mi consentimiento expreso para dar acceso al Condado de Hillsborough y a la Fuente de Financiación a todos y cada uno de los registros almacenados en el sistema y cualquier otro registro en poder de cualquier agencia contratada por Ryan White con el propósito de monitorear, informar, gestionar, pagar y administrar. Una lista de proveedores de servicios se actualizará anualmente (si se contrata una nueva agencia, se publicará en la sala de espera de cada proveedor u otro lugar visible, como el área de laboratorio u otra área común de la clínica/oficinas a las que el cliente tendría acceso junto con los Avisos de Prácticas de Privacidad. Considero la reproducción de esta Autorización firmada como auténtica y original.

_____	_____
Firma del cliente/representante	*En nombre y representación propia o relación con respecto al cliente*
_____	_____
Testigo	*Fecha*

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III. FISCAL MANAGEMENT

A. OVERVIEW

Each year the Hillsborough Board of County Commissioners, through the Health Care Services Department distributes millions of dollars in state and federal funding for HIV/AIDS programs and services to community-based organizations, hospitals, health centers, treatment facilities, etc. that directly serve the public. This process begins with recognition of the need for specific services, followed by planning and priority allocation of funds by the West Central Florida Ryan White Care Council to meet the needs of the HIV/AIDS community, followed by Hillsborough County facilitating a Request For Applications (RFA), and then selection of the provider agencies to be funded. Programs can be funded using various types and combinations of resources, so administering and managing these resources requires a collaborative relationship between the Hillsborough County's Ryan White Part A Office (Recipient) and the funded contractor/provider. Ongoing communication between the Recipient and the contractor/provider must be fostered to ensure the success in managing the Ryan White Program funds.

B. FISCAL MANAGEMENT POLICIES AND PROCEDURES

The guidance and polices set forth in this document apply to all contracted and sub-contracted agencies. It is the responsibility of the contractor/provider to ensure this information is available to all sub-contractors. The policies are in place to ensure the proper use of Ryan White Part A Program and EHE Program funds and to guarantee the agencies using these funds are doing so with the understanding these funds represent the "payor of last resort." The following represent current Fiscal Management (FM) Policies and Procedures approved by the Ryan White Part A Program and EHE Program Recipient Office. For any questions or clarification please contact the Ryan White Part A Program and EHE Program office.

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-1

POLICY: CONDITION OF AWARD BUDGETS

POLICY STATEMENT

The Conditions of Award (COA) identifies agency line item budget of expenditures to be incurred during the contract period as required by the U.S. Department of Health and Human Services.

Hillsborough County and provider shall maintain comprehensive budgets, reports, and procedures with sufficient detail to account for Ryan White funds by service category, contractor, administrative costs, and (75/25 Rule) core medical and support services rules to delineate between multiple funding sources and show program income.

DEFINITION

When awarding federal grants, the U.S. Department of Health and Human Services establishes conditions that must be met in order to be in compliance with the grant award, these conditions are referred to as COAs.

PROCEDURE

1. The Recipient shall review the sufficiency of all accounting policies and procedures, budgets, and accounting systems and reports to account for Part A funds in order to meet Ryan White fiscal requirements.
2. The provider will ensure the adequacy of agency fiscal systems to generate needed budgets and expenditure reports, including:
   a. Accounting policies and procedures.
   b. Budgets.
   c. Accounting system and reports.

3. The provider agency must complete a brief description (using the Condition of Award budget template provided) of the purpose of the contract and estimate the number of units of service that will be provided. The units of service to be provided multiplied by the fee for service shall equal the total amount of the contract. The budget narrative is provided both in the Request for Applications (RFA) process as well as 30 days prior to a new contract being awarded and 30 days prior to a contract renewal.

4. Complete a budget narrative, to include:
   a. **Personnel/Staff Salaries –** This schedule must include each employee's name, title, salary amount, and percentage dedicated to the grant. Any amendments to this salary amount must be submitted to the appropriate accountant and approved prior to a request for

reimbursement. Notify the fiscal section in writing of staff changes before sending any request for reimbursement.

b. **Fringe Benefits –** Reimbursement of fringe benefits may include: FICA 7.65% of gross salary, employee health insurance plans, worker's compensation insurance, pension plans, and any severance. Benefits should be charged in proportion to the salaries dedicated to the program. The Hillsborough County Ryan White program (Recipient) shall approve any changes to the reimbursement of fringe benefits

c. **Travel –** Travel expenditures must be directly related to the grant and justified as a direct benefit to the grant. Contractor/provider must identify the employee traveling, where travel is taking place, and costs associated with the travel. Include a separate local or out of area travel amount.

d. **Equipment –** Please reference Purchase of Equipment Policy, FM-31 page 115.

e. **Supplies –** Provide a brief description of expendable supplies such as office or educational. Supplies for clients must be listed under "Other."

f. **Other Expenditures –** Any other cost item that does not fit in one of the above mentioned categories, must be included in "Other." These items may include rent, consultant fees, printing, postage, telephone, utility costs, insurance, etc.

g. **Federally approved Indirect Cost –** A rate established by contractor/providers with the Federal Government must be included with the Categorical Budget if the contractor/provider intends to charge this rate to the contract. Indirect costs cannot exceed ten (10) percent.

5. Administrative Costs: The Ryan White legislation imposes a cap on contractor administration. Legislative intent is to keep administrative costs to an absolute minimum. Contractors must keep administrative costs to no more than ten (10) percent of the total budget. Hillsborough County recognizes that some administrative resources are needed by contractors to support direct service programs, and it is Ryan White Program policy to provide those resources within reason. However, it is important to note that Ryan White Part A funds are meant to support direct services rather than administration. Hillsborough County staff will review budgets to determine the amount of funds supporting administration. If it is excessive, the County staff will work with the provider in revising budgets and work plans if necessary to reduce administrative costs. Administrative costs include the following:

a. **Management and oversight of specific programs funded by Ryan White Part A:** This includes staff who have agency management responsibility but no direct involvement in the program or the provision of services. This does not include the direct supervision of program/clinical staff. However, management and oversight of a specific aspect of the Ryan White Part A Program and EHE Program could be a portion of an individual's responsibilities. For example, a program director or project coordinator might have responsibility for indirect management and oversight of the program along with responsibility for the direct provision of services, supervising day-to-day program operations, or direct supervision of staff involved in the provision of services. In such a case, the former would be considered administrative, while the latter would be considered direct program. Positions that might involve management and oversight duties may include: Executive Director, Deputy Executive Director, Program Manager, Program Coordinator, Clinic Manager, etc.

b. **Other types of program support, such as quality assurance, quality control and related activities:** This includes staff whose duties relate to agency-wide quality assurance (e.g., developing agency quality assurance protocols, reviewing a sample of charts to determine the quality of services agency-wide, or participating on an agency's/facility's quality committee).

c. **Routine contract administration:** This includes proposal, work plan and budget development, receipt and disbursal of contract funds, and preparation of programmatic and financial reports as required by the Ryan White Program.

d. **Audit:** All funds included in the budget's audit line. Please note that under revised federal audit requirements, Recipients who expend $500,000 or more in federal funds must have a single A-133 audit. Federal Recipients who spend less than $500,000 in federal funds annually are prohibited from charging federal funds for single audits. Therefore, only those contractors receiving federal funds of $500,000 or more may request approval of reimbursement for single audit expenses through their Ryan White contract. However, Ryan White Part A funds may be used to support limited financial review with prior approval from Hillsborough County.

e. **Other administrative activities:** This includes fiscal activities, such as accounting, bookkeeping, payroll, etc., and operations responsibilities, such as security, maintenance, etc. Positions that may involve such duties include: Comptroller, Accounting Manager, Director of Operations, Bookkeeper, Accountant, Payroll Specialist, Finance Coordinator, Maintenance Worker, Security Officer, etc. Some types of insurance are considered program costs (e.g., medical malpractice insurance, insurance for a vehicle used as part of a transportation program), while some are considered administrative (general liability, board insurance).

f. **Indirect:** Includes usual and recognized overhead, including established indirect cost rates. Examples of such costs are rent, utilities, etc. Indirect costs are those shown in the budget's "administrative costs" line.

With regard to items "a" through "e" above, providers must submit detailed duty descriptions. If staff spends a portion of the time supported by the contract on administrative activities, contractor/provider must identify the percentage of time devoted to those activities so the Recipient is able to identify the amount of the budget that supports administration. The percentage of staff time devoted to administration must also be applied to the fringe amount. Therefore, if five percent of all personnel services are identified as administrative, five percent of the fringe amount is also considered administrative.

6. Contractor/providers are required to complete a new Conditions of Award Budget for any renewed contract year following the procedures outlined above within 30 days of the contract period. In addition, anytime a contract amount is modified a revised COA is due within 30 days of the amount being revised.
7. Contract modifications are required when the grant total or funded service category are modified/changed.

DOCUMENTATION

1. Condition of Award Budget (see following pages).
2. Please reference the Service Specific Policies and Procedures for a breakdown of the Unit Cost for each funded service.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: October 2008
Revised: 5/13/14
Revised: 4/12/2018

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CONDITION OF AWARD

HILLSBOROUGH COUNTY
HEALTH CARE SERVICES DEPARTMENT

Ryan White Program

Provider Instructions: All providers MUST complete a separate electronic Condition of Award (COA) for each contracted service. Effective immediately only the electronic, emailed COA will be accepted. All fields highlighted green REQUIRE provider review and input where applicable. If expenses include employee salaries a budget narrative MUST be completed. When completed, SAVE the form and EMAIL it as an attachment to the appropriate Accountant at one of the following email addresses:

Onelia Pineda (813-274-6988) at: pinedao@hillsboroughcounty.org

Drop-down lists are available for your convenience.

STATUS:	(Specify Modification # or describe action)	SUBMITTAL DATE	TOTAL SERVICE AMOUNT

CONTRACTED SERVICE:	ORIGINAL CONTRACT #

FUNDING SOURCE:	PROGRAM YEAR:	COUNTIES SERVED:	
Part A: (March 1st - February 28th)			HERNANDO
PROVIDER NAME:			HILLSBOROUGH
			PASCO
PREPARED BY (Name & Title):			PINELLAS

TELEPHONE NUMBER & EXT.	EMAIL ADDRESS

AGENCY QUESTIONS: ***MUST answer EACH question***

1. Are 51% of the Board of Directors racial/ethnic minority?	
2. Are 51% of the Professional Staff racial/ethnic minority?	
3. Faith Based Organization?	
4. Community Based or Minority AIDS Organization?	

THIS SECTION RESERVED FOR USE BY THE GRANTEE

REVIEWED BY:		
DATE APPROVED:		
DATE DENIED:		State reason for denial below:

CONDITION OF AWARD
CATEGORICAL BUDGET
Ryan White Program

Use delete key or right click and clear contents to clear cells; use tab, enter or arrow keys to navigate from cell to cell.

TYPES OF EXPENSE								SERVICE $	ADMIN $	TOTAL $
Gross Annual Salaries PAID: *A budget narrative is REQUIRED*							breakdown			$ -
Fringe Benefits:										
The chart below will automatically calculate based on your detailed entry below.										
	TOTAL	Amount or Percent			TOTAL	Amount or Percent				
F.I.C.A. Medicare:	0.00			Medical Insurance:	0.00					
Disability:	0.00			Life Insurance:	0.00					
Cafeteria Benefits:	0.00			Worker's Comp.:	0.00					
Retirement:	0.00			Deferred Comp.:	0.00					
Other (describe):					0.00					
Fringe Benefits Subtotal :					$ -		breakdown			$ -
Percent of Fringe Benefits in relation to Salaries :										
GRAND TOTAL (SALARIES + FRINGE):								$ -	$ -	$ -
Office Supplies: *Office supplies include pens, paper, file folders etc.*							breakdown			$ -
OTHER EXPENSES TO BE PAID BY THIS GRANT:										
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
Other Subtotal :					$ -		breakdown			$ -
TRAVEL:										
Out Of Town Travel (A *travel form is REQUIRED*)										
	$-Amount	or	# of Miles							
Local Travel @ $.445		0.00		$ -						
Other:										
Travel Subtotal :					$ -		breakdown			$ -
EQUIPMENT: *(List the type of equipment and cost)*										
1. Equipment:										
2. Equipment:										
Equipment Subtotal :					$ -		breakdown			$ -
CONSULTANT/SUBCONTRACTOR: *(A copy of the contract is REQUIRED)*										
1.										
2.										
Consultant/Subcontractor Subtotal :					$ -		breakdown			$ -
INDIRECT COSTS: *(Federal approved rate)*							breakdown			$ -
TOTALS FOR PROGRAM & ADMIN COLUMNS :								$ -	$ -	$ -
TOTAL ADMIN MUST BE 10% or LESS :										
TOTAL CONTRACTED SERVICE AMOUNT (sum of TOTAL column) :										$ -
TOTAL SERVICE AMOUNT (Listed on Page 1) :										$ -

VERY IMPORTANT: Use WHOLE NUMBERS when completing the Categorical Budget. Totals are formatted to ROUND to the nearest whole dollar; you may find that you need to adjust your budgets by $1 here or there to balance at the bottom of page 2.

CONDITION OF AWARD

BUDGET NARRATIVE

Ryan White Program

Use delete key or right click and clear contents to clear cells; use tab, enter or arrow keys to navigate from cell to cell.

Personnel: If the position is vacant, indicate such and provide estimated date when the position will be filled. Identify which positions will be paid by this contract. Identify (1) position title; (2) employee name; (3) gross annual salary received by this employee; (4) percentage of time/effort charged to this contract; (5) portion of salary paid by this contract; (6) brief job description and other funding sources for this position if it is partially funded by this contract.

VERY IMPORTANT !

1) If you copy data from other spreadsheets, **ALWAYS copy, select Paste Special and then select Values** (there may be formulas within the data your pasting) those formulas will corrupt the built-in formulas contained in this document and will create error messages for users;

2) **DO NOT cut** and paste data within this document, **ALWAYS copy and paste** (cut will corrupt built-in formatting) this also creates problems for users;

3) DO NOT type on the row below when you run out of space; cells within this document are formatted to wrap text **(each row is meant to reflect an individual record)**, this allows other users to **maximize its use** as a spreadsheet;

4) **ALWAYS enter a very brief job description**, the cell is formatted to wrap text. However you may, in addition to entering a very brief job description, attach copies of the job descriptions to your email as a PDF or Word file.

Position Title	Employee Name	Gross Annual Salary	ENTER $-Amount or Percent CHARGED		INDICATES Portion of Gross Annual Salary and Percent PAID	Job Description & other funding sources
			Amount	or Percent		
					$ -	
					$ -	
					$ -	
					$ -	
					$ -	
					$ -	
					$ -	
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					$ -	
					$ -	
					$ -	
					$ -	
Total number of employees charged to contract:	0	$ -	$ -		$ -	Total Gross Annual Salaries PAID by this contract.

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-2

POLICY TITLE: PAYOR OF LAST RESORT

POLICY STATEMENT

Language under the federal statutes regulating the HIV Health Care Services Program includes provisions relating to Medicaid and other third-party revenues. Section 300ff-27(b)(7)(F) of Title 42 under the United States Code requires assurances from the State that Ryan White funding will not be "utilized to make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made . . ." by programs and sources other than Ryan White. Additionally, § 300ff-15(a)(1)(A) states that all funds received under the grant are awarded "to supplement not supplant State funds" to provide HIV related services; Section 300ff-15(a)(1)(B) requires political subdivisions within the eligible area to maintain the level of expenditures for HIV-related services at a level equal to the level of expenditures for the preceding year; and finally, § 300ff-15(a)(1)(C) requires political subdivisions within the eligible area not to use funds received under the grant as part of maintaining their level of the preceding year's expenditures.

DEFINITION

Federal law requires that any eligible services to a Medicaid eligible PLWH/A must be billed to Medicaid rather than Ryan White. Likewise, all services an eligible PLWH/A receives that is covered by their existing insurance coverage, benefits/assistance program must be billed to that other payor. These requirements reflect the condition that Ryan White funding will be the last resource used to pay for HIV related services, making the funding the payor of last resort. The service contractor/provider assumes the financial risk for providing services for which other sources of funding could reasonably have been anticipated or determined.

PROCEDURE

The guidance and policies set forth apply to all contracted and subcontracted agencies/contractor/providers. It is the contractor/providers responsibility to ensure that Ryan White funds are payor of last resort. To do so, the contractor/provider must:

1. Screen clients for eligibility to receive services through other programs (e.g., Medicaid, Medicare, VA benefits, private health insurance).
2. Periodically reassess client eligibility for Ryan White services.
3. Document client eligibility.
4. Have policies and procedures in place addressing these screening requirements. Hillsborough County Ryan White staff will review these policies and procedures as well as documentation of screening activities and client eligibility during contract monitoring.

All HIV service contractor/providers entering into contracts with the County must agree to the following requirement contained in Attachment B, Paragraph 8, of their contracts, as amended from time to time:

"The contractor agrees to maximize third-party reimbursement available for HIV counseling, testing, medical care, case management and other funded services, including Medicaid reimbursement for HIV primary care available through participation in the HIV Primary Care Medicaid Program, and reimbursement for services for the uninsured and underinsured through ADAP."

If providing a Medicaid compensable service, the Provider must obtain a Medicaid number and must maintain documentation of Medicaid certification. The provider further certifies that any and all revenue recovered as a result of Ryan White services provided will be reported to Hillsborough County as Program Income (utilizing the Program Income Expenditure Report) and any Program Income funds recovered through Medicaid or other payor sources will be used within the agency to expand HIV services. The Contractor shall request approval in writing of its proposed use of these Program Income funds. No such revenue shall be allocated without the written endorsement Ryan White Part A Program and EHE Program Manager.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: October 2008
Revised: 5/13/14
Revised: 4/12/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-3

POLICY TITLE: FISCAL REPORTING OF THIRD PARTY FUNDS/PROGRAM INCOME

POLICY STATEMENT

As a component of fiscal reporting, providers are required to track third party reimbursement funds and expenditures.

PROCEDURE
Providers are to do the following:

1. Providers will complete and submit an electronic Program Income/Expenditure Report (PIER) on a quarterly basis by calendar year.
2. All fields highlighted green REQUIRE provider review and input where applicable.
3. When completed, SAVE and name the file: PIER 1st qtr; PIER 2nd qtr; PIER 3rd qtr: PIER 4th qtr (as applicable).
4. Upload the document to MOVEit.
5. Open MOVEit: select Folders / then Distribution / then Reports / then Parent Folder / then Program Income Expenditure Report/ then appropriate Calendar Year/ then launch the Upload Wizard and attach your file.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/12/2018

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PROGRAM INCOME/EXPENDITURE REPORT

HILLSBOROUGH COUNTY
Health Care Services Department

Ryan White Program

Provider Instructions: The purpose of this report is to track third-party reimbursement funds and how they are spent. Providers **MUST** complete and submit an electronic Program Income/Expenditure Report (PIER) on a quarterly basis by calendar year. All fields highlighted green REQUIRE provider review and input where applicable. When completed, ***SAVE and name the file: PIER 1st qtr; PIER 2nd qtr; PIER 3rd qtr: PIER 4th qtr (as applicable)*** . Upload the document to MOVEit. Open MOVEit: select ***Folders /*** then ***Distribution /*** then ***Reports /*** then ***Parent Folder /*** then ***Program Income Expenditure Report/*** then appropriate ***Calendar Year/*** then launch the Upload Wizard and attach your file. Calendar years 2010 through 2015 have been created for each provider, please file your reports accordingly. If you have questions, please contact the Accountants below:

Onelia Pineda ph: 813.274.6988 email: pinedao@hillsboroughcounty.org

SUBMITTAL DATE	YEAR REPORTED

PREPARED BY (Name & Title):	
TELEPHONE NUMBER & EXT.	**EMAIL ADDRESS**

PROVIDER NAME:

PROGRAM INCOME

	SOURCE OF INCOME	Aggregate Totals for Calendar Year $-1st Qtr Due 4/15	$-2nd Qtr Due 7/15	$-3rd Qtr Due 11/15	$-4th Qtr Due 1/15
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
	TOTAL INCOME:	$ -	$ -	$ -	$ -

PROGRAM EXPENDITURES

	TYPE OF EXPENDITURE	Calendar Year $-1st Qtr Due 4/15	$-2nd Qtr Due 7/15	$-3rd Qtr Due 11/15	$-4th Qtr Due 1/15
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
	TOTAL EXPENDITURE:	$ -	$ -	$ -	$ -

TOTAL PROGRAM INCOME Y-T-D: $ -

TOTAL PROGRAM INCOME EXPENDED Y-T-D: $ -

BALANCE: $ -

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-4

POLICY TITLE: PROMPT PAYMENT

POLICY STATEMENT

Hillsborough County as the Ryan White Recipient is to make payment to providers within 45 calendar days after receipt of a billing, unless the billing is improperly presented or lacks documentation.

PROCEDURE
In order to adhere to the 45 calendar day payment procedure in place ("Florida's Prompt Payment Act"), the Recipient and the provider will do the following:

1. The Recipient shall establish and implement policies and procedures that allow for partial payments of invoices. Reimbursement to providers will be reviewed to determine whether it routinely occurs within 45 calendar days of receipt of the invoice, document delays due to incomplete documentation and take action to improve reimbursement rates if review shows payment period of more than 45 calendar days.
2. In order to facilitate this process, the provider shall submit invoices on time monthly with complete documentation. The provider will also maintain data documenting the reimbursement period including monthly bank reconciliation reports and receivables aging report.
3. This will be measured by:
   a. Reviewing Recipient payable records
   b. Reviewing provider invoices, submission dates, and bank deposits of Part A payments
   c. Reviewing Recipient policies on how to avoid payment delays of more than 45 calendar days to providers

***Disclosure: We are currently in the process of identifying necessary updates to our fiscal policies and procedures in response to findings issued during a recent HRSA site visit. At this stage, we are actively gathering the supporting documentation, operational data, and internal records required to inform these revisions. This includes coordinating with relevant BOCC departments and the Treasurer's Office to ensure that all information is verified and aligned with federal compliance requirements.

Planned policy updates will include clear verbiage around our standard payment turnaround times, the availability and criteria for an expedited payment option, and guidance on selecting the appropriate payment method—whether cost reimbursement or advance pay. Once this review is complete, formal policy changes will be drafted, reviewed, and implemented accordingly. We will provide updates and training on any approved changes as the process moves forward.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/12/2018, April 2025

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-5

POLICY TITLE: LIMITATIONS OF PART A FUNDING – REASONABLENESS OF COSTS

POLICY STATEMENT

The written procedures for determining the reasonableness of costs, the process for allocations, and the policies for allowable costs shall be 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. Only those costs deemed reasonable will be reimbursed.

PROCEDURE
The Recipient and provider, working in conjunction, will determine allowable and reasonable costs through the following activities:

1. The Recipient shall have in place policies to be used in determining allowable costs and test to determine whether provider costs for services as charged to the program are reasonable and allowable.
2. In turn, the provider shall have in place policies and procedures to determine allowable and reasonable costs. The provider will also have in place reasonable methodologies for allocating costs among different funding sources and Ryan White categories. Finally, they will make available policies, procedures, and calculations to the Recipient upon request.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 04/12/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-6

POLICY TITLE: LIMITATIONS OF PART A FUNDING – ADMINISTRATIVE COSTS

POLICY STATEMENT

Up to ten (10) percent of federal funds may be spent on administrative costs in any given grant year for Recipients with or without a fiduciary intermediary or administrative agent. Administrative costs for providers cannot exceed 10 percent in the aggregate.

PROCEDURE
The Recipient will identify and appropriately categorize administration expenses and ensure they do not exceed ten (10) percent of the total grant amount. It will also provide HRSA/HAB with current operating budgets with sufficient detail to determine and review administrative expenses. The Recipient office shall identify and describe all expenses within the Recipient budget that are categorized as administrative costs and document that administrative expenses do not exceed ten (10) percent of the awarded Ryan White grant.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/13/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-7

POLICY TITLE: LIMITATIONS OF PART A FUNDING – ALLOWABLE EXPENDITURES

POLICY STATEMENT

The use of Recipient administrative funds only allowable expenditures.

PROCEDURE
Hillsborough County (Recipient) will make available current operating budgets and allocation expense reports with sufficient detail for HRSA to review administrative expenses. It will be based on the following list of allowable administrative activities:

1. Routine grant administrative and monitoring activities, including the development of applications and the receipt and disbursal of program funds.
2. Development and establishment of reimbursement and accounting systems.
3. Preparation of routine programmatic and financial reports.
4. Compliance with grant conditions and audit requirements.
5. All activities associated with the Recipient's contract award procedures, including the activities carried out by the HIV Health Services Care Council.
6. Development of request for proposals, provider and contract proposal review activities, negotiation and awarding of contracts.
7. Monitoring activities including telephone consultation, written documentation, and onsite visits.
8. Reporting on contracts, and funding reallocation activities.
9. Indirect costs.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/13/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-8

POLICY TITLE: CALCULATING UNIT COSTS

POLICY STATEMENT

Unit costs calculated by Recipients and providers will be 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.

DEFINITION

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 ten (10) percent) and dividing by the number of units of service to be delivered.

PROCEDURE
The Recipient shall include in provider agreements a provision that requires submission of reports that detail performance and allow review of the provider's budget, cost of services, and unit cost methodology. The provider will have in place systems that can provide expenses and client utilization data in sufficient detail to determine reasonableness of unit costs. The Recipient office will review unit cost methodology for provider and provider services and review budgets to calculate allowable administrative and program costs for each service.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/13/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-9

POLICY TITLE: LIMITATIONS OF PART A FUNDING – PROVIDER ADMINISTRATIVE EXPENSES

POLICY STATEMENT

Aggregated provider administrative expenses may not total more than ten (10) percent of Part A services dollars.

PROCEDURE
The Recipient office will maintain file documentation on all providers including their current operating budgets and expense/allocation reports, with sufficient detail to identify and calculate administrative expenses. The provider will prepare a project budget and track expenses with sufficient detail to allow identification of administrative expenses. The Recipient shall review provider budgets to ensure proper designation and categorization of administrative costs, calculate the administrative costs for each provider, and calculate the total amount of administrative expenses across all providers to ensure that the aggregate administrative costs do not exceed ten (10) percent.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/13/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-10

POLICY TITLE: LIMITATIONS OF PART A FUNDING – ASSIGNMENT OF PROVIDER ADMINISTRATIVE EXPENSES

POLICY STATEMENT
Appropriate provider assignment of Ryan White Part A administrative expenses, with administrative costs, includes operational activities, such as rent, utilities and facility costs, costs of management, oversight of specific programs funded, which might include program coordination, clerical, financial, and management staff not directly related to patient care, program evaluation, liability insurance, audits, and computer hardware/software not directly related to patient care.

PROCEDURE
Both the Recipient and provider will perform the following activities to remain in compliance with provider administrative expenses:

1. The Recipient shall obtain and keep on file current provider operating budgets with sufficient detail to review program and administrative expenses and ensure appropriate categorization of costs. The Recipient will also review expense reports to ensure that all administrative costs are allowable.
2. The provider shall prepare a project budget that meets administrative cost guidelines. In addition, providers shall prepare expense reports tracking administrative expenses with sufficient detail to permit review of administrative cost elements.
3. Pursuant to PCN 15-01, the administrative CAP is limited to 10% for each specific allocation.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/16/2018, 3/25/2025

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES
RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-11

POLICY TITLE: LIMITATIONS OF PART A FUNDING – INDIRECT COSTS RATE

POLICY STATEMENT

The inclusion of indirect costs (capped at 10%) will be implemented only where the Recipient has a certified HHS-negotiated indirect costs rate using the Certification of Cost Allocation Plan or Certificate of Indirect Costs, which has been reviewed by the HRSA/HAB Project Officer.

PROCEDURE

1. The Recipient shall file with HRSA/HAB a current approved HHS-negotiated indirect rate for the Recipient, indicating where a provider plans to use Ryan White funds for the indirect costs and maintain on file the documented HRSA-approved provider indirect costs rate. The Recipient shall also review provider budgets and expense reports to determine the use of the indirect cost rate and adherence to the ten (10) percent administrative cap as well as review provider budgets to ensure no duplication of costs covered in indirect rate and other line item expenses.
2. If a provider is using indirect cost as part or all of its ten (10) administration costs, they shall obtain and keep on file a federally approved HHS-negotiated Certificate of Cost Allocation Plan or Certificate of Indirect Costs. In addition, the provider will submit a current copy of the Certificate to the Recipient.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/18/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-12

POLICY TITLE: LIMITATIONS OF PART A FUNDING – ADHERENCE TO PLANNING COUNCIL ALLOCATIONS AND PRIORITIES

POLICY STATEMENT

The expenditure of Ryan White Part A Program and EHE Program service funds must be consistent with the service priorities and fund allocations to specific service categories (both core medical and support services) established by the Planning Council, and the Council must approve any reallocations of funds except during the final three months of the respective fiscal year, when Recipient-approved sweeps are authorized by the Planning Council.

PROCEDURE
The Recipient will adhere to the following instructions to ensure they comply with the Planning Council's yearly allocations and priorities:

1. The Recipient must ensure the Part A program services budget submitted to HRSA/HAB includes the fund allocations to service categories established by the Planning Council. The Recipient shall also ensure that total sub-grant amounts by service category reflect the Planning Council allocations and also ensure that any reallocation of funds across service categories reflect compliance with Planning Council reallocation policies and procedures.
2. The Recipient shall compare the Planning Council list of service priorities and funding allocations with:
   a. Recipient budgeted amounts for each service category.
   b. Actual contract amounts by service category.

The Recipient shall review the Part A Program's policies for reallocation across service categories, as established by the comparison of actual expenditures by service categories with Planning Council allocations and reallocations consistent with Planning Council policies.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/17/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-13

POLICY TITLE: PAYMENT COST STANDARDS

POLICY STATEMENT

Payments made to providers for services must 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.

PROCEDURE

1. The Recipient shall ensure that expenses conform to federal cost principles for cost-reimbursable grants. This includes Recipient and provider staff being familiar with OMB Circular A - Code of Federal Regulations (CFR). Budgets and expenditures are to conform to OMB and CFR requirements. An inclusion will be made in sub-grant agreements with a provision requiring compliance with OMB cost principles.
2. Providers are to ensure that budgets and expenses conform to federal cost principles.
3. The Recipient office shall review all budgets and expenditure reports to determine whether use of funds is consistent with OMB and CFR cost principles.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/17/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-14

POLICY TITLE: LIMITATIONS OF PART A FUNDING – CLINICAL QUALITY MANAGEMENT COSTS

POLICY STATEMENT

Total clinical quality management costs for the Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA) may not exceed five (5) percent of the annual Ryan White Part A grant or $3 million, whichever is less.

PROCEDURE
The grant shall provide a budget to HRSA that separately identifies all clinical quality management costs and separately track costs associated with clinical quality management.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/18/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-15

POLICY TITLE: LIMITATIONS OF PART A FUNDING – CORE MEDICAL SERVICES SPENDING

POLICY STATEMENT

No less than 75 percent of service dollars must be expended on core medical services unless a waiver has been obtained from HRSA.

DEFINITION

Service dollars are those grant funds remaining after removal of administrative and clinical quality management funds.

PROCEDURE

1. The Recipient shall monitor program allocations, sub-grant agreements, actual expenditures, and reallocations throughout the year to ensure 75 percent of program funds are expended for HRSA- defined core medical services. Provider monitoring and financial reporting are required that document expenditures by program service category. The Recipient will maintain budgets and funding allocations, provider award information, and expenditure data with sufficient detail to allow for the tracking of core medical services expenses. Recipient may request a core services waiver.
2. The provider shall report to the Recipient expenses by service.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/17/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-16

POLICY TITLE: LIMITATIONS OF PART A FUNDING – SUPPORT SERVICES SPENDING

POLICY STATEMENT

Total expenditures for support services are limited to no more that 25 percent of service dollars.

DEFINITION

Support services are those services subject to approval by the Secretary of Health and Human Services that are needed for individuals with HIV/AIDS to achieve their medical outcomes.

PROCEDURE

1. The Recipient shall document and assess the use of support service funds to demonstrate they contribute to positive medical outcomes for clients. Recipient shall monitor program allocations, subgrant agreements, actual expenditures, and reallocations throughout the year to ensure no more than 25 percent of program funds are expended for HHS-approved support services. The Recipient will conduct provider monitoring and financial reporting that documents expenditures by program service category. Finally, Recipient will maintain budgets and funding allocations, provider award information, and expenditure data with sufficient detail to allow for the tracking of support service expenses.
2. Providers are to report to the Recipient expenses by service category and document to support that service funds are contributing to positive medical outcomes for clients.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/18/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-17

POLICY TITLE: UNALLOWABLE COSTS - GENERAL

POLICY STATEMENT

The Recipient shall provide to all Part A providers definitions of unallowable costs. Federal Grant funds should be treated with the same conservatism one would use with personal funds. Providers should be conscientious in the use of grant funds to maximize the benefit to the client without providing extravagant expenditures to enhance the service contractor/provider agency. The purpose of the Ryan White Program is to assist HIV affected communities in the provision of public health services through a continuum of care to the greatest number of HIV individuals.

PROCEDURE

1. The Recipient will document receipt of the Notice of Award and maintain a file of signed assurances in addition to the following:
   a. Have signed certifications and disclosure forms for any provider receiving more than $100,000 in direct funding.
   b. Include definitions of unallowable costs in all provider requests for proposals, subrecipient agreements, purchase orders, and requirements or assurances.
   c. Include in financial monitoring a review of provider expenses to identify any unallowable costs.
   d. Require provider budgets and expense reports with sufficient budget justification and expense detail to document they do not include unallowable costs.
2. In turn the provider is responsible for maintaining a file with signed subrecipient agreement, assurances, and/or certification that specify unallowable costs, ensuring budgets do not include unallowable costs. The provider will also submit budgets and financial expense reports to the Recipient with sufficient detail to document they do not include unallowable costs.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: May 2015
Revised: 4/18/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-18

POLICY TITLE: UNALLOWABLE COSTS – FACILITIES/LAND

POLICY STATEMENT

No use of Part A funds may be used to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility (other than minor remodeling).

PROCEDURE
To remain compliant, the Recipient and provider shall perform the following activities:

1. The Recipient shall document receipt of the Notice of Award and maintain a file of signed assurances. The Recipient will have signed certifications and disclosure forms for any provider receiving more than $100,000 in direct funding. In addition, the Recipient shall:
   a. Include definitions of unallowable costs in all provider request for proposals, subrecipient agreements, purchase orders, and requirements or assurances.
   b. Include in financial monitoring a review of provider expenses to identify and unallowable costs.
   c. Require provider budgets and expense reports with sufficient budget justification and expense detail to document that they do not include unallowable costs.
2. The provider shall maintain a file with signed subrecipient agreement, assurances, and/or certification that specify unallowable costs. The provider shall also:
   a. Ensure that budgets do not include unallowable costs.
   b. Ensure that expenditures do not include unallowable costs.
   c. Provide budgets and financial expense reportsto the Recipient with sufficient detail to document that they do not include unallowable costs.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-19

POLICY TITLE: UNALLOWABLE COSTS – CASH PAYMENTS

POLICY STATEMENT

No cash payments are permitted to service recipients.

DEFINITION

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.

PROCEDURE
The Recipient shall ensure that policies and procedures for service categories involving payments made on behalf of clients prohibit cash payments to service recipients. The provider shall maintain documentation of policies that prohibit use of Ryan White funds for cash payments to service recipients.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-20

POLICY TITLE: UNALLOWABLE COSTS – USE OF FUNDS FOR DRUG USE OR SEXUAL ACTIVITY

POLICY STATEMENT

No use of Part A funds shall be used to develop materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual.

PROCEDURE
The Recipient shall ensure that policies and procedures outline the prohibition of the use of funds for intravenous drug use or sexual activity. The provider shall maintain documentation of policies that prohibit use of Ryan White funds for those purposes.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-21

POLICY TITLE: UNALLOWABLE COSTS – VEHICLE PURCHASING

POLICY STATEMENT

No use of Part A funds may be used for the purchase of vehicles without written approval from HRSA/Grants Management Office (GMO) approval.

PROCEDURE

1. If any vehicles were purchased, the Recipient shall maintain file documentation of permission of GMO to purchase a vehicle.
2. If vehicle purchase is needed, the provider shall seek Recipient assistance in obtaining written GMO approval and maintain document in file

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-22

POLICY TITLE: UNALLOWABLE COSTS – MARKETING

POLICY STATEMENT

Funds are prohibited from being used 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.) or broad-scope awareness activities about HIV services that target the general public.

PROCEDURE

1. The Recipient shall review program plans and budget narratives for any marketing or advertising activities to ensure they do not include unallowable costs. The Recipient will review 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.
2. The provider shall prepare a detailed plan and budget narrative that describe planned use of any advertising or marketing activities.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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Revised: 3/31/2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-23

POLICY TITLE: UNALLOWABLE COSTS – HIV PREVENTION EDUCATION

POLICY STATEMENT

Part A funds may not be used for outreach activities having HIV prevention education as their exclusive purpose.

PROCEDURE
The Recipient will require providers to submit a detailed narrative program plan of outreach activities to ensure their purpose goes beyond HIV prevention education to include testing and early entry into care.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-24

POLICY TITLE: UNALLOWABLE COSTS – LOBBYING

POLICY STATEMENT

Part A funds may not be used for influencing or attempting to influence members of Congress, or other federal, state, or local officials.

PROCEDURE
The Recipient and provider will perform the following actions to maintain proper documentation regarding the prohibition of the use of funds for lobbying purposes:

1. The Recipient shall file a signed "Certification Regarding Lobbying," and as appropriate, a "Disclosure of Lobbying Activities." In addition, Recipient will ensure that provider staff are familiar and in compliance with prohibitions on lobbying with federal funds.
2. The provider will include information in their personnel manual and employee orientation on regulations forbidding lobbying with federal funds.

Note: Forms can be obtained from the CFR website

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-25

POLICY TITLE: UNALLOWABLE COSTS – FOREIGN TRAVEL

POLICY STATEMENT

Part A funds are not permitted to pay for foreign travel.

PROCEDURE

1. The Recipient shall request a detailed narrative from providers on budgeted travel and review to determine if any funds are budgeted for foreign travel.
2. The provider shall maintain a file documenting all travel expenses paid by Part A funds.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-26

POLICY TITLE: UNALLOWABLE COSTS – MISCELLANEOUS

POLICY STATEMENT

Part A funds are prohibited for the services defined below.

DEFINITION

Examples of services that are unallowable expenses include:

1. Employment, vocational rehabilitation, or employment-readiness services.
2. Art, drama, music, dance, or photography therapy.
3. Social, recreational, or entertainment activities. Ryan White funds cannot be used to support amusement, diversion, social activities, or any costs related to such activities, such as tickets to shows, movies or sports events, meals, lodging, transportation, and gratuities. Movie tickets or other tickets cannot be used as incentives. Ryan White funds cannot support parties, picnics, structured socialization, athletics, etc.
4. Services for incarcerated persons, except transitional case management.
5. Costs associated with operating clinical trials.
6. Funeral, burial, cremation or related expenses.
7. Direct maintenance expense, loan payments, insurance, or license and registration fees associated with a privately owned vehicle.
8. Local or State personal property taxes.
9. Criminal defense or class action suits unrelated to access to services.
10. Inpatient services.
11. Clothing.
12. Installation of permanent systems for filtration of all water entering a private residence.
13. Professional licensure or to meet program licensure requirements.
14. Gift certificates.
15. Federal funds cannot be used for organized fundraising, including financial campaigns, solicitation of gifts and bequests, expenses related to raising capital or contributions, or the costs of meetings or other events related to fund raising or other organizational activities, such as the costs of displays, demonstrations, and exhibits, the cost of meeting rooms, and other special facilities used in conjunction with shows or other special events, and costs of promotional items and memorabilia, including gifts and souvenirs. These costs are unallowable regardless of the purpose for which the funds, gifts or contributions will be used.
16. Transportation for any purpose other than acquiring medical services or acquiring support services that are

linked to medical outcomes associated with HIV clinical status. Transportation for personal errands, such as grocery shopping, other shopping, banking, social/recreational events, restaurants, or family gatherings is not allowed.

17. Pediatric developmental assessment and early intervention services, defined as the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children.
18. Permanency planning, defined as the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
19. Voter registration activities.
20. Costs associated with incorporation.
21. Reiki, Qi Gong, Tai chi and related activities.
22. Relaxation audio/video tapes.
23. Yoga, yoga instruction, yoga audio/video tapes, yoga/exercise mats.

Contract work plans and job descriptions for staff supported by Ryan White funds will be reviewed to ensure they include only those activities fundable under the Ryan White Program.

PROCEDURE

The Recipient shall review provider budgets and invoices to ensure unallowable expenses are not incurred.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM- 27

POLICY TITLE: INVOICE SUBMISSION AND REIMBURSEMENT REQUESTS

POLICY STATEMENT

The Recipient must ensure the appropriate disbursement of Ryan White Program funds in compliance with Federal, State, and County grant management policies and procedures. Additionally, Recipient is responsible to oversee contractor/provider expenditures to confirm consistency with their approved Conditions of Award.

PROCEDURES

1. Providers will submit claims for reimbursement as often as they choose, but at a minimum they must submit claims monthly, using E2 Hillsborough. Multiple month reimbursements may be returned to the contractor/provider. Contractually, failure to invoice in a timely manner may result in the contractor/provider forfeiting reimbursement for those services. This includes lab fees, specialty fees, and diagnostic fees as well. We will hold reimbursements if these ancillary services are not billed timely.
2. The Recipient will notify an agency in writing if a request for reimbursement has been adjusted. Notice of any adjustment will contain the amount, reason for the adjustment, and any supporting documentation that was submitted.

Once the selected services are submitted in E2Hillsborough using the "Easy Submit Queue", they are picked up electronically every Monday evening for processing. The claims file is subsequently processed typically on Thursdays and should be available for retrieval in the Data Warehouse.

LINE ITEM BUDGET PROCEDURES

Each line item must have a separate cover sheet that includes the title of the budget line item, total amount of expenditures, amount being requested (percentage, if applicable) and a calculator tape listing all expenditures belonging to each line item.

1. Include copies of all receipts necessary to support the request for reimbursement. Any charges that are not accompanied by a copy of the payment check or a signed receipt will be deleted from the request for reimbursement.
2. Monthly requests for reimbursement must contain the Monthly Administrative Report (MAR) of services. Do not submit any back up documentation in PDF - this is not acceptable.
3. Amounts over the quarterly cap should be shaded in gray. Subsequent reimbursement requests/billing can be submitted by the contractor/provider for any unpaid portion.
4. Do not use staples in the monthly request for reimbursement.
5. Submit an original and a copy of the request for reimbursement. The original Request for Ryan White Reimbursement Form should have an original signature on the authorized signature line.

6. If the amount requested for reimbursement is less than the actual amount spent, please state on the cover sheet "Amount Requested from Ryan White Program "$0.0" and the percentage (%) this amount represents. For example: Case Manager's Monthly Salary = $2,500 representing 100% of total allocated monthly salary.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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Revised: May 2015, May 2018

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-28

POLICY TITLE: REALLOCATION OF FUNDS

POLICY STATEMENT

All funds must be expensed within the contract/funding year in accordance with their service contract. Unexpended funds will be reallocated to contractors/providers who can utilize them.

DEFINITION
Reallocation is an action taken by the West Central Florida Care Council to redistribute any unexpended funds to contractors/providers who can utilize those funds within the contract/funding year.

PROCEDURE
The Recipient will evaluate the contractors/provider's contract performance status of expenditures and services provided. Expenditures are projected based on the rate of expenditures shown during the first six months of the contract.

1. E-mails or phone calls are sent to all contractors/providers requesting them to inform the Recipient whether they plan to expend all funds by the end of the contract and if they will need additional funds.
2. Contractors/providers who are under expended are requested to demonstrate how they will expend all their funds by the end of the contract.
3. The contractors/providers who are over expended and need additional funds will indicate to the Recipient the amount of funds they need.
4. After the contractors/providers' responses are received, the Recipient will evaluate the requests and prepare reallocations.
5. The reallocation plan is provided to the financial committee, formally known as the Reallocations Resource Prioritization and Allocations Recommendations Committee (RPARC) for review and their final recommendation is submitted to the Care Council for final reallocation approval.
6. The Care Council reviews the reallocation plan and approves it as presented or makes changes according to their criteria.
7. When the Care Council makes its decision, Recipient will call or e-mail the contractors/providers whose contracts are affected.
8. A new COA is to be submitted to the Recipient by the provider agency that is affected by the reallocation/amendment, which must be accompanied by the signed modification.
9. Amendments under $100,000 can be approved by the Health Care Services Department Director and

forwarded for the Board of County Commissioners (BOCC) records.

10. At the beginning of the grant year and/or when existing contracts are amended, the payments to contractor/providers are delayed.
    a. New contracts and modified contracts above $100,000 per service have to be approved by the BOCC, which regularly meets twice a month.
    b. After the approval, the documents have to be signed and recorded by BOCC records. This process takes about two weeks after the new contract or an amended contract is signed.
    c. Change orders have to be prepared on all contract modifications, which increase or decrease a contract amount. Change orders have to be approved by other County Departments.
11. When the Recipient receives the copy of the contract or modified contract, they issue a purchase order for the new contract or a change order to amend the amount of a contract.
12. The new contract or the amended contract is forwarded to the Procurement Department, so that the purchase order can be reviewed and approved in a timely manner.
13. When the approved purchase order or change order is received by the Department (Recipient), the fiscal staff issue a receiver in the Oracle system (the official Financial Accounting System for Hillsborough County), and initiate payment for approval and disbursement by the Clerk's Office.
14. The Clerk's Office reviews the documentation in the Oracle system and once approved, they issue the checks or an EFT (Electronic Funds Transfer) to the provider.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

PUBLISHED DATE: October 2008
Revised: May 2014, May 2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-29

POLICY TITLE: PURCHASE OF EQUIPMENT

POLICY STATEMENT

The Recipient does not allow the purchase of any equipment such as computers, software, etc. under the Ryan White Program funding. Other allowable line item budgets for equipment and furniture must be limited to items necessary for providing services to benefit the client and only with prior approval by Recipient. Prior approval of equipment items ensures only necessary items are purchased. Where appropriate, an analysis of lease option/purchase alternatives must be made and submitted to the Recipient for prior approval.

DEFINITION

Equipment is non-expendable tangible property having a useful life of more than one year and having an acquisition cost of $750 or more per unit.

PROCEDURE
The following steps have been put into place to ensure that equipment is properly secured:

1. The purchase or lease of equipment/furniture from Ryan White program funds must be pre-approved by the Recipient. Use form RW Equipment Form. Complete the first section, sign and date the form. Provide three (3) written quotes from vendors. Submit RW Equipment Form and the three (3) written quotes to the Recipient for approval.
2. Upon approval, the Recipient will select the vendor, sign the form and return it to the contractor/provider.
3. The contractor/provider will purchase the equipment from the selected vendor and complete the bottom section of the form.
4. When submitting the request for reimbursement, the contractor/provider must include a completed RW Equipment Form and a copy of the paid invoice. Include the proof of payment (copy of payment check or credit card receipt).
5. Equipment purchased with Ryan White Program funding is the property of Hillsborough County and will be labeled by the County as such. In addition, these items may have to be returned to the County when the contract expires or is terminated, and are subject to inventory during the annual monitoring visits.

DOCUMENTATION
1. Completed and duly signed RW Equipment Form
2. Three written quotes

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-30

POLICY TITLE: TRACKING AND REPORTING ON PROPERTY

POLICY STATEMENT

The Recipient and provider must track and report tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part A funds and having:

1. A useful life of more than one year, and;
2. An acquisition cost of $5,000 or more per unit (Lower limits may be established, consistent with recipient policies).

PROCEDURE

The Recipient and providers shall each develop and maintain a current, complete, and accurate asset inventory list and depreciation schedule. The Recipient shall ensure each provider maintains a current, complete, and accurate asset inventory list and depreciation schedule, and that they identify assets purchased with Ryan White funds.

The provider will make the list and schedule available to the Recipient upon request.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM - 31

POLICY TITLE: SAFEGUARDING OF ASSETS

POLICY STATEMENT

Implementation of adequate safeguards for all capital assets must be in place to assure they are used solely for authorized purposes.

PROCEDURE
The Recipient shall exercise effective control over capital assets. The Recipient shall review its own and provider inventory lists of assets purchased with Ryan White funds. During fiscal and program monitoring, the Recipient shall ensure assets are available and appropriately registered as well as review, for completeness and accuracy, the depreciation schedule for all capital assets.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM - 32

POLICY TITLE: RESIDUAL INVENTORY/PROPERTY

POLICY STATEMENT

The title to supplies will be vested to 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:

1. Retain the supplies for use on non-federally sponsored activities or sell them.
2. Compensate the federal government for its share contributed to purchase of supplies.

PROCEDURE

1. The Recipient shall develop and maintain a current, complete, and accurate supply and medication inventory list and ensure providers develop and maintain similar lists and make them available to the Recipient on request.
2. Provider will develop and maintain a current, complete, and accurate supply and medication inventory list and make the list available to Recipient upon request.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM - 33

POLICY TITLE: TIME AND EFFORT REPORTING SYSTEM

POLICY STATEMENT

The requirement for each agency to have a time and effort reporting system is in the Ryan White Part A Program and EHE Program contract. These circulars are applicable to both State and Federally funded programs. A time and effort reporting system is a requirement of ***all*** contracts with the Hillsborough County Health Care Services Department Ryan White Program, including Part A and Minority AIDS Initiative.

DEFINITION

"Time and Effort Reporting" framework offers agencies a mechanism to document an employee's work time and allocation to specific funding sources. It is the basis for agency payroll and billing to appropriate funding sources for personnel expenditures. This framework is most often implemented using employee timesheets that, once approved, are used for preparing the agency's payroll. The Time and Effort framework must be documented in the agency's policies and procedures.

PROCEDURE

1. Contractors/providers must have a system in place to document time and effort of direct program staff supported by all federal funds. New federal contractors must submit their written policies related to time and effort to the Ryan White Program Recipient Office for approval.
2. Most often, such systems take the form of a time sheet entry. These time and effort reporting procedures must clearly identify the percentage of time each staff person devotes to contract activities in accordance with the approved budget. The percent of effort devoted to the project may vary from month-to-month. The employee's time sheet must indicate the percent of effort the employee devotes to each particular project for a given time period. The effort recorded on the time sheet must reflect the employee's funding sources, and the percent of effort recorded for Ryan White funds must match the percentage being claimed on the Ryan White voucher for the same time period. In addition, 100 percent of the employee's time must be documented. In cases where the percentage of effort of contract staff changes during the contract period, contractors must submit a budget modification request to the Ryan White Program Recipient Office.
3. Upon monitoring, contractors will be expected to produce time and effort documentation. Only indirect staff are not subject to time and effort reporting requirements. Such staff **must** be included in the administrative costs line, rather than in Program Services. Every funded Ryan White Program contractor/provider:
   a. Must establish and utilize a time and effort reporting system.
   b. Must have this system documented in the agency's policies and procedures.
   c. Must understand the burden of proof to substantiate Personnel Services charges to the contract.

d. Is subject to be monitored for compliance of their time and effort reporting system; failure to have a system in place will result in a monitoring exception and possible disallowance for the salaries of funded staff.

4. Timesheets or Personnel Activity Reports must document employee time worked and the distribution of activities to funding sources. If day sheets are being used to track daily activities for billing purposes (e.g. Part A or MAI), these day sheets should be part of the time and effort reporting system.

AUTHORITY/OVERSIGHT

This Policy is issued under the authority of the Budget and Accounting Act of 1921, as amended; the Budget and Accounting Procedures Act of 1950, as amended; the Chief Financial Officers Act of 1990; Reorganization Plan No. 2 of 1970; and Executive Order No. 11541 ("Prescribing the Duties of the Office of Management and Budget and the Domestic Policy Council in the Executive Office of the President"). OMB circulars described, and monitored by the RWP Recipient Office Contract Monitoring staff.

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-34

POLICY TITLE: LOCAL AND NATIONAL TRAVEL

POLICY STATEMENT

Out of Area: Out of area travel is generally prohibited. However, in some cases it may be justifiable within the grantor guidelines. The grant will only reimburse pre-approved out of area travel to attend conferences, workshops, training sessions, etc. related to HIV/AIDS.

Local: Travel must be directly beneficial to the grant and specified in the agency's approved "Condition of Award Budget."

DEFINITION

Reimbursable local and national travel includes payment for travel conducted either to provide direct services (local travel) or pre-approved out-of-area travel for approved business purposes.

PROCEDURE

Out-of-Area Travel Procedures

1. Travel is only approved in special circumstances.
2. A travel request form ("Request and Authorization of Travel") must be completed and pre-approved by Hillsborough County fiscal staff.
3. In order to be pre-approved, the contractor/provider must submit "Request and Authorization of Travel," and attach a brochure or other descriptive literature describing the meeting the traveler wants to attend. The traveler must complete the information contained in Section I, except for the approval section, and send it to the Recipient for approval.
4. To be reimbursed for travel expenses, the traveler must submit an authorized Travel Form, completed and signed, a completed registration form, the brochure related to the meeting, and receipts, copies of checks or credit card receipts that substantiate the total amount requested for reimbursement. Allowable travel expenditures include airfare, bus or train fare, mileage, lodging, and a total of $38.00 per diem meal allowances ($8 breakfast, $8 for lunch, and $22 for dinner), and ground transportation, which includes travel to and from an airport to the hotel/meeting place and return.

Local Travel Procedures

1. Local travel expenditure must be included in the agency's approved Condition of Award Budget.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-35

POLICY TITLE: COST-SHARING AND MATCH

POLICY STATEMENT

Recipients are required to report to HRSA/HAB information regarding the portion of program costs that are not borne by the federal government.

Recipients are expected to ensure that non-federal contributions:

1. Are verifiable in Recipient records.
2. Are not used as matching for another federal program.
3. Are necessary for program objectives and outcomes.
4. Are allowable.
5. Are not part of another federal award contribution, unless authorized.
6. Are part of the approved budget.
7. Are part of unrecovered indirect cost, if applicable.
8. Are apportioned in accordance with appropriate federal cost principles.
9. Include volunteer services, if used, which are an integral and necessary part of the program, with volunteer time allocated value similar to amounts paid for similar work in the Recipient organization.
10. Value services of contractors at the employees' regular rate of payplus reasonable, allowable and allocable fringe benefits.
11. Assign value to donated supplies that are reasonable and do not exceed the fair market value.
12. Value donated equipment, buildings, and land differently according to the purpose of the award.
13. Value donated property in accordance with the usual accounting policies of the recipient (not to exceed fair market value).

PROCEDURE

1. The Recipient shall report to HRSA/HAB on the non-federal funds or in-kind resources the EMA/TGA is allocating to the program, ensuring the non-federal contribution meets all the requirements stated in the Standard in Column 1 of the federal standard form.
2. Provider shall follow the same verification process as the Recipient.
3. A review of the Recipient annual comprehensive budget by:
   a. Reviewing all Recipient in-kind and other contributions to the Ryan White Program.
   b. Reviewing Recipient documentation of other contributed services or expenses.

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-36

POLICY TITLE: MAINTENANCE OF EFFORT

POLICY STATEMENT

Part A Recipients are required to meet maintenance of effort (MOE) requirements: as a Condition of Award, EMA/TGA political subdivision expenditures for HIV-related core medical services and support services to be maintained at a level equal to their level during the one-year period preceding the fiscal year (FY) for which the Recipient is applying to receive a Part A grant. Part A funds are used to supplement, not supplant, State funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease.

PROCEDURE

1. The Recipient shall submit the following MOE information to HRSA/HAB annually:
   a. A list of core medical and support services budget elements to be used to document MOE in subsequent grant applications.
   b. A description of the tracking system to be used to document these elements.
   c. Budget for EMA/TGA contributions.
   d. Tracking/accounting documentation of actual contributions.

The Recipient shall review core medical services and support service budget elements that document the contributions of the EMA/TGA and will do so by reviewing tracking/accounting system data that documents the EMA/TGA contribution to core medical services and supportive services, reviewing the Recipient budget for EMA/TGA contributions, and reviewing actual tracking/accounting documentation of contributions.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-37

POLICY TITLE: EXPENDITURE OUTSIDE OF THE GRANT PERIOD

POLICY STATEMENT

The purpose of the Ryan White Treatment Modernization Act is to assist HIV affected communities in the provision of public health services through a continuum of care to the greatest number of HIV individuals. Recipients and sub-Recipients must be good stewards of grant funds to maximize the benefit to the client without providing extravagant expenditures to enhance the service contractor/provider agency.

Expenditures for items outside of the grant period (e.g., a subscription starts in March, but is paid for by the agency in February. The subscription cannot be charged to the grant ending in February.) Receipt of services or items must occur during the grant period in order to be reimbursed, regardless of when the agency paid for the item.

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1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-38

POLICY TITLE: WITHHOLDING PAYMENTS

POLICY STATEMENT

HRSA/HAB is not to withhold payments for proper charges incurred by the Recipient unless the Recipient or provider has failed to comply with grant award conditions or is indebted to the United States. The Recipient is not to withhold provider payments unless the provider has failed to comply with grant award conditions.

PROCEDURE

1. The Recipient shall periodically track the accounts payable process from the date of receipt of invoices to the date the checks are deposited.
2. Providers will provide timely and properly documented invoices. Providers will comply with contract conditions.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-39

POLICY TITLE: CARRYOVER FUNDS

POLICY STATEMENT

The Eligible Metropolitan Area (EMA) must submit an estimation of carryover funds 60 days prior to the end of the grant period – by December 31 of every calendar year.

PROCEDURE
The Recipient shall be responsible for preparing accounting reports documenting unobligated balances included in the carryover request. Recipient shall also prepare and submit estimated unobligated balances and estimated carryover requests 60 days prior to end of grant year.

NOTE: No requests will be approved without this submission.

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1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-40

POLICY TITLE: UNOBLIGATED BALANCES

POLICY STATEMENT

The EMA must demonstrate its ability to expend funds efficiently by expending 95% of its formula funds in any grant year. The EMA must submit an estimation of unobligated balances 60 days prior to the end of the grant period – by December 31 of every calendar year. The EMA annual unobligated balance for formula dollars may not exceed more than 5% reported to HRSA/HAB in the Recipient's Federal Financial Report (FFR).

PROCEDURE

1. The Recipient shall prepare and submit an estimated unobligated balance and estimated carryover request. No carryover requests will be approved without submission. In addition, the Recipient will:
   a. Review the submission of both Recipient and provider budgets.
   b. Maintain accounting and financial reports that document year-to-date spending of Recipient and provider funds.
   c. Review individual provider financial reports that document unspent funds.
   d. Calculate year–to-date expenditures and budget variances monthly.
   e. Develop a reallocation methodology and implement it in coordination with the Planning Council.
2. The provider shall report monthly expenditures to date to the Recipient and inform the Recipient of variances in expenditures.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

FISCAL MANAGEMENT (FM) POLICY #: FM-41

POLICY TITLE: PLANNING FOR UNOBLIGATED BALANCES

POLICY STATEMENT

The EMA recognizes the consequences of unobligated balances and shall make evidence of plans to avoid a reduction of services, if any of the following penalties is applied:

1. Future year award is offset by the amount of the unobligated balance less any approved carry over.
2. Future year award is reduced by amount of unobligated balance less the amount of approved carry over.
3. The Recipient is not eligible for a future year supplemental award.

PROCEDURE

1. The Recipient shall design and implement a cost-saving plan to address penalties resulting from excessive unobligated balance. Recipient will also explore the possibility ofrequesting or using local dollars to offset any penalty to the program.
2. The provider will report any unspent funds to the Recipient and carry out monthly monitoring of expenses to detect and implement cost-saving strategies.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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IV. PROGRAM AND FISCAL MONITORING

A. OVERVIEW

Every Ryan White Program funded contractor/provider should work closely with a Project Manager, hereinafter called the monitoring staff, to ensure that it meets the terms of their contract, uses funding appropriately, and delivers effective services. This staff is dedicated to monitoring implementation of programs, reporting progress, and assisting in finding solutions to problems. They have responsibility for a continuum of tasks, many quite complex that help determine how programs achieve their goals. They are key players in the chain of events that leads from understanding a service need to meeting it. To help monitoring staff in one of their most critical tasks, the Recipient Office has put together this section of the Ryan White Program – Program and Fiscal Policies and Procedures section.

The overarching objectives of the Monitoring Process include:

- Share useful methods and tools gathered from various units.
- Offer support to new and seasoned program/contractor/providers.
- Define the monitoring process.
- Expedite the process for conducting contract monitoring and issuing timely reports.
- Facilitate optimal follow-up on recommendations and corrective actions.

B. PROGRAM AND FISCAL MONITORING POLICIES AND PROCEDURES

Policies and Procedures reflected in this section were determined by agreement with Fiscal and Programmatic staff and senior management of the Ryan White Program.

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

CONTRACT MONITORING (CM) POLICY #: CM-1

POLICY TITLE: MONITORING VISITS

POLICY STATEMENT

Hillsborough County (Recipient) monitoring staff will perform comprehensive and standardized monitoring visits of all contractor/providers delivering HIV health and support services funded by the Recipient. The purpose of the monitoring visit is to ensure that eligible clients receive the highest quality care possible in accordance with all applicable federal, state, and local governing bodies and current Standards of Care.

DEFINITION

Monitoring is a collaborative process between the Contract Monitoring staff and the funded contractor/provider and the responsibility of the Ryan White Program Recipient Office. The overarching goal of the Contract Monitoring function is to ensure that quality and cost-effective services are rendered to PLWH/A in the Eligible Metropolitan Area (EMA).

PROCEDURE

1. The monitor will contact the contractor/provider to coordinate and schedule a monitoring visit. The monitoring may include virtual and desk audits, in addition to on site visits.
2. A confirmation e-mail will be sent by the monitor to the contractor/provider. The e-mail will confirm the date(s), time(s), and location(s) as well as a brief description of what the visit will consist of for either program and/or fiscal monitoring. Reports for each service category will be attached to the e-mail for the contractor/provider to review and prepare staff responses prior to the visit.
3. The monitoring visit will include, but is not limited to, the following elements:
   a. Programmatic Review:
      i. All policies and procedures for the service(s) funded by Ryan White will be reviewed to ensure compliance with applicable federal, state, and local laws, rules and regulations.
      ii. Interviews will be conducted with key staff regarding the programmatic component(s) of the contractor/provider and progress towards achieving contract objectives.
      iii. Client records will be reviewed against the applicable monitoring tool, Standards of Care, and contract requirements to ensure compliance.
      iv. The monitor will conduct an environmental review in the areas where clients receive services to determine if there are any identifiable hazards as well as areas of Health Insurance Portability and Accountability Act (HIPAA) concerns. Additionally, the environmental review will involve ensuring the contractor/provider maintains all requisite licensures and certifications in accordance with city, county, state and/or federal regulations.
      v. The monitor will review personnel records for staff funded by Ryan White to determine if training and educational requirements are met.

vi. The contractor/provider is responsible for maintaining a list of all equipment purchased with Ryan White funds and provide that list to the monitor at the time of the visit. A physical inventory will be done for all items in excess of $1,000.

b. Fiscal Review:

i. Review of financial policies and procedures of the contractor/provider to ensure their financial management system addresses generally accepted accounting principles.
ii. Interviews will be conducted with key staff regarding the fiscal component(s) of the contractor/provider and progress towards achieving contract objectives.
iii. The Recipient fiscal staff will review invoicing and reports to ensure budgetary controls and contract expenditures are in compliance with contract requirements. The review will answer the following:
   A. Is the contractor/provider using the approved budget?
   B. Do monthly expenditures match the approved budget?
   C. Is back-up of documentation being kept in monthly files?
   D. Are monthly invoices submitted to the Recipient for reimbursement in a timely manner?
   E. Are fiscal reports submitted in a timely manner?

4. The monitor will have an exit conference with the Executive Director or designee, which will conclude the monitoring visit. The exit conference will address the programmatic strengths and weaknesses detected during the visit.
5. A final report consisting of an Executive Summary and corresponding reports for each service category will be finalized by the monitor. The contractor/provider should receive the final report within thirty working days following the exit conference.
6. Once the contractor/provider receives the final report, the Executive Director or designee must submit their Corrective Action Plan, if applicable, stipulating their plans to address the findings as well as timeframes for implementation to the Recipient within 30 calendar days of receipt.
7. The monitor will review the Corrective Action Plan to ensure the contractor/provider has addressed all of the monitoring findings. Subsequently, the Recipient will submit a written notification of approval to the contractor/provider.
8. The monitor will follow-up on all substantive findings within three (3) months of receipt of contractors/provider's implementation plan to assess their progress on the corrective action plan. Follow-up may be a simple telephone conversation or result in a second monitoring visit and will continue until issues are resolved.
9. First time contractor/providers (those having never been funded by Ryan White) will receive a start-up site visit within three (3) months of the commencement of services during the contract year. The contractor/provider will receive confirmation of the site visit. The monitor will review contractor/provider for compliance with the contract and monitoring tools. Upon completion the monitor will provide written recommendations for programmatic development.

DOCUMENTATION:

1. Programmatic checklists for each service.
2. Programmatic monitoring tools for each service.
3. Fiscal and Programmatic monitoring reports.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A & EHE Recipient

2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

CONTRACT MONITORING (CM) POLICY #: CM-2

POLICY TITLE: DOCUMENTATION/RECORD HANDLING DURING MONITORING VISIT

POLICY STATEMENT

All client-related documentation related to eligibility shall be maintained in the approved RW electronic database. All other required documentation per service category may be maintained electronically, in the approved RW electronic database, and is the preferred method of client file storage, excluding mental health case notes, pharmacy, and primary care case notes. If hard copy client files are still used by provider than files shall be in a legible, consistent, and legally acceptable format.
Prior to the monitoring visit, the monitor will prepare a list of randomly selected client IDs from monthly billing reports submitted and will provide that list upon arrival for the visit, with the exception for Health Departments, to whom the list will be transmitted via secure messaging the day prior to the visit.

DEFINITION

Process to describe the Recipient office monitoring of client confidential documentation and health related information in provider agency service files.

PROCEDURE

1. A separate chart will be kept for each client.
2. All client-related documentation produced and/or signed by contractor/provider staff will be accurate and complete to the best knowledge of the individual producing and/or signing the document.
3. All documentation produced by contractor/provider staff will be legible.
4. Blue or black ink should be used in the client record on documents produced and/or signed by contractor/provider staff.
5. All service documentation will be dated and signed with the name and title (or acronym) of the individual providing the service.
6. When an error is corrected a single straight line will be drawn through the error, then the correction, the initials of the individual making the correction and the date of the correction will be written above the lined-through error.
7. Backup documentation is required for all services billed. Acceptable backup documentation includes, but is not limited to the following:
    a. Appropriate HIV proof, such as:
        i. Confirmed positive HIV antibody test result {e.g. Elisa (EIA) & Western Blot} by blood or OraSure.
        ii. A positive HIV direct viral test such as PCR or P24 antigen.
        iii. A positive HIV viral culture result.
        iv. A detectable HIV viral load or viral resistance test.

v. A Physician's (PAC Waiver) Referral form, only if it includes a viral load test result and the physician's signature.

b. Evidence of annual medical care visits by clients, such as:
   i. A dated statement from the medical care site, on letterhead, signed by a site representative, with identifying information to link the document to the client.

ii. A dated prescription with identifying information to link the document to the client.
iii. Dated lab slip with identifying information to link the document to the client.
iv. A documented conversation with the medical care contractor/provider, verifying the client's most recent medical care visit.
v. Utilization of the Primary Care Attendance Verification Form, attached.
vii. Consent signed by all clients authorizing Hillsborough County staff access to client charts.

8. Client charts that are transported from one contractor/provider's site to another should be transported in a locked case.
9. Client charts pulled for review that the monitor did not review that day, should be locked up overnight.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

CONTRACT MONITORING (CM) POLICY #: CM-3

POLICY TITLE: EMPLOYEE RECORDS

POLICY STATEMENT

Employees of all contractor/provider agencies must be properly qualified and trained to perform required job duties and all employee records must contain complete and up-to-date information.

DEFINITION

Employee records are defined as file documents tied to an employee. For example, the file should include the employee's resume, credentials such as licensing or certifications, personnel related memos, or confidential materials, such as health information, evaluations, etc.

PROCEDURE

A separate file, or employee record, will be maintained for each employee who is paid, in whole or in part, by funds administered by the Ryan White Program. Each employee record shall contain:

1. A job description for any position for which the employee has billed services to the Ryan White Program.
2. Documentation of any and all degrees, certifications, licensure, and/or documented experience working with the HIV/AIDS population required by the contract with Hillsborough County or the Standards of Care.
3. A confidentiality statement must be signed and dated by each employee or volunteer. The statement must be signed prior to an employee or volunteer providing any services to clients or has access to any confidential information.
4. Documentation of all training required by the contract or Standards of Care.
5. Contractors/providers of medical care must have experience in caring for HIV infected persons or receive appropriate training.
6. Medical Case Managers must preferably possess a bachelor's degree in a social science area or be an RN with one (1) year of case management experience, or Medicaid must grandfather them in.
7. Medical Case Managers may substitute their master's degree for 1 year of case management experience.
8. Medical Case Managers who possesses a bachelor's degree not in a social science may substitute at least 12 months in direct case management experience.
9. Medical Case Managers may substitute applicable experience (either within HIV or other social service disciplines) on a year-to-year basis for the required education.
10. Medical Case Managers and Intake and Eligibility Staff must provide a certificate of attendance for case management training which is provided routinely by the Florida Department of Health, Bureau of HIV/AIDS Community Programs Unit. The training includes both web based training modules as well as live training sessions.

11. Intake and Eligibility Case Managers and Supervisors must complete the Department Of Health "Determining Eligibility Training" and have a Certificate of Attendance on file. This training is offered routinely by the Florida Department of Health, Bureau of HIV/AIDS (HAB).
12. MAI contractor/providers funded in whole or in part by Part A should have specific experience in caring for HIV infected clients or receive training including AIDS 104 w/in the first 90 days of hire or as soon as available, not to exceed 12 months, this training is provided through the Florida Department of Health on a routine schedule.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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CONTRACT MONITORING (CM) POLICY #: CM-4

POLICY TITLE: EQUIPMENT MANAGEMENT - INVENTORY

POLICY STATEMENT

Any item purchased by a subcontracted provider with Ryan White Program funds must be maintained, inventoried, and controlled in accordance with the equipment management requirements established by Hillsborough County. The provider shall not dispose of nonexpendable property purchased under with these grant funds, except with prior written approval from the County. (See Fiscal Management Policy # FM-31, 32, 33, and 34)

PROCEDURE

1. Any item purchased by a provider or subcontractor with funds that exceeds $250.00 in cost must be inventoried by the provider annually.
2. This inventory must be maintained for review during contract monitoring by Hillsborough County staff. Items of equipment that cost in excess of $1,000.00 will also be physically tagged with County property control numbers by Hillsborough County staff during the monitoring visits or through a scheduled visit for this sole purpose by Hillsborough County.
3. Title to equipment acquired by the provider shall vest with Hillsborough County and/or the United States Federal Government upon acquisition. Hillsborough County will notify the provider if the property is donated to the provider at some point in time.
4. The provider must ensure that all equipment purchased is adequately insured to cover any loss, destruction or damage.
5. The provider must report to Hillsborough County in writing of any lost, stolen or damaged items. If any item is stolen, a copy of the police report must also be submitted to the Recipient.
6. All items of equipment acquired must be maintained, inventoried, and controlled in accordance with the equipment management requirements established by the County and in accordance with the Federal Public Health Service Grants Policy Statement. In accordance with the FY 1995 Appropriations Act (P.L.103-333) and advice from the Health Resource and Services Administration (HRSA), all equipment and products purchased with grant funds should be American-made.
7. The provider must obtain approval from Hillsborough County Ryan White fiscal staff prior to purchase of equipment, in accordance with Fiscal Management Policy # FM-31, Purchase of Equipment.
8. The provider shall not dispose of nonexpendable property purchased with these grant funds, except with prior written approval from Hillsborough County.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
POLICIES AND PROCEDURES

CONTRACT MONITORING (CM) POLICY #: CM-5

POLICY TITLE: KEY POINTS OF ENTRY

POLICY STATEMENT

Hillsborough County as a Ryan White Recipient requires that all providers maintain active relationships with entities in the Eligible Metropolitan Area (EMA) that constitute key points of access to the health care system for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their HIV status but who are not in care. These key points of access include emergency rooms, substance abuse treatment programs, detoxification programs, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV disease counseling and testing sites, mental health programs, and homeless shelters. Providers must discuss the key points of entry that are covered by their collaborative agreements with Hillsborough County in the context of their applications when proposing to deliver services in the Request for Applications (RFA) process.

PROCEDURE

1. The provider must have Memorandum of Agreement (MOA) with all key points of entry within the appropriate area of the provider.
2. The purpose of the MOA is to bring newly diagnosed clients into care or bring clients who have not been seen in the last year, back into care.
3. The provider must notify the Recipient of any changes to existing MOAs with key points of entry.
4. Ambulatory/Outpatient Health Services providers and Case Management providers must have MOA's with the following key points of entry:
   a. Emergency rooms.
   b. Substance abuse agencies.
   c. Adult and juvenile detention facilities.
   d. STD clinics, and local health departments.
   e. HIV counseling and testing sites.
   f. Mental health agencies.
   g. Homeless shelters.
   h. Federally Qualified Health Center (if one is located in the provider's county).
5. All providers of services, other than ambulatory/outpatient health services and case management, must have MOA's with agencies providing services under sections b, c, d, e, f, g, and h listed in section 4 above.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

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V. DEFINITIONS/GLOSSARY OF TERMS *

Acquired Immunodeficiency Syndrome (AIDS): A disease caused by the human immunodeficiency virus.

AIDS Drug Assistance Program (ADAP): A State-administered program authorized under Part A of the CARE Act that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

Administrative or Fiscal Agent: An organization, agent, or other entity (e.g., public health department, community-based organization), which assists a Recipient in carrying out administrative activities (e.g., disbursing program funds, developing reimbursement and accounting systems, developing Requests For Applications [RFA], monitoring contracts). Not all Recipients use a separate administrative or fiscal agent.

AIDS Insurance Continuation Program (AICP)

AIDS Pharmaceutical Assistance (APA): A local pharmacy assistance program implemented by a Part A EMA or State. The Part A Recipient, consortium, or Part A Planning Council contracts with one or more organizations to provide medications to clients. These organizations may or may not provide other services (e.g., primary care, case management) to persons living with HIV they serve through a Ryan White Treatment Modernization (or other funding source) contract with their Recipient.

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

American Indian or Alaska Native: A person having origins in any of the original people of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Annual Data Report (ADR): The annual data report is a form completed by Ryan White Program Recipients and contractor/providers. This report provides aggregate contractor/provider, client, and services data for all Ryan White programs. The ADR is completed and submitted to HAB Office of Science and Epidemiology (OSE).

Antiretroviral: A substance that fights against a retrovirus, such as HIV. (See Retrovirus)

Area Health Education Center (AHEC): Centers that exist to enhance access to quality health care by improving the supply and distribution of health care professionals in underserved areas by facilitating community and academic partnerships.

Asian: A person having origins in any of the original people of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Assessment of the Administrative Mechanism (AAM) – Care Council assessment to determine the EMA grant management and effective and timely disbursement of the Ryan White Program funds into the community.

Black or African American: A person having origins in any of the black racial groups of Africa.

Board of County Commissioners (BOCC): There are seven (7) members of the Board of County Commissioners for Hillsborough County. Four (4) are elected from single-member districts, and three (3) are elected for county-wide seats.

Care Council: A planning body appointed or established by the Chief Elected Official (CEO) of an EMA. The primary responsibilities of a planning council are to establish a delivery plan for HIV care services in the EMA and set priorities for the use of Part A CARE Act funds. Our local Care Council is a combined Part A Planning Council and Part B consortium. There are several committees that report directly to the Care Council.

Community Advisory
HSAC (Health Services Advisory Committee)
Membership, Nominations, Recruitment & Training
P & E (Planning and Evaluation Committee)
RPARC (Resource Prioritization and Allocation Recommendations Committee)
SIOC (Standards, Issues and Operations Committee)
WICY&F (Women, Infants, Children, Youth and Families Committee)

E2 Hillsborough: The management information system used by the EMA, administered by RDE Systems.

Carryover: The allowance of un-obligated funds, upon receipt of a waiver, to be expended for the one-year period beginning upon the expiration of the grant year. Any carryover funds not expended within the one-year timeframe of the carryover year will be canceled and returned to the U.S. Department of Health and Human Services (HHS) Secretary.

Centers for Disease Control and Prevention (CDC): The Federal agency within HHS that administers HIV/AIDS prevention programs, including the HIV Prevention Community Planning process, among other programs. The CDC is responsible for monitoring and reporting infectious diseases, administers HIV/AIDS surveillance grants, and publishes epidemiologic reports such as the HIV/AIDS Surveillance Report.

Centers for Medicare and Medicaid Services (CMS): Formerly the Health Care Financing Administration (HCFA), CMS is the Federal agency in HHS responsible for administering Medicaid, Medicare, and the State Children's Health Insurance Program.

Chief Elected Official (CEO): The official recipient of Ryan White Program Part A funds within the EMA, usually a city mayor, county executive, or chair of the county board of commissioners. The CEO is ultimately responsible for administering all aspects of the CARE Act in the EMA and ensuring that all legal requirements are met. In an EMA with more than one political jurisdiction, the recipient of Ryan White Program Part A funds is the CEO of the city or urban county that administers the public health agency providing outpatient and ambulatory services to the greatest number of persons with AIDS in the EMA.

Combination Therapy: Multiple drugs or treatments used together to achieve optimum results against HIV/AIDS infection. Information on treatment guidelines can be found at the following Internet address: http://www.aidsinfo.nih.gov/guidelines/.

Co-morbidity: A disease or condition indicating the coexistence of two or more unrelated disease processes (e.g., mental illness or substance abuse co-existing with HIV disease).

Community Based Organization (CBO): An organization providing services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

Compassionate Use Program: A compassionate use program is designed to make investigational drugs accessible to treat patients with diseases for which no comparable or satisfactory alternative drug therapy is available

Comprehensive Planning: The process of determining the organization and delivery of HIV services. Planning bodies use this strategy to improve decision-making about services and maintain a continuum of care for PLWH/A.

Consortium/HIV Care Consortium: A regional or statewide planning body established by Recipients under Ryan White Program Part A. This body consists of one or more public and one or more nonprofit private, healthcare and support services contractor/providers, persons with HIV/AIDS, and community-based organizations operating within areas determined by the State to be most affected by HIV/AIDS. The consortium agrees to use Part A grant funds to plan, develop, and deliver (directly or through agreement with others) comprehensive outpatient healthcare and support services for individuals with HIV/AIDS. Agencies comprising the consortium are required to have a record of services provided to individuals with HIV/AIDS.

Continuum of Care: An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWH/A.

Continuous Quality Improvement (CQI): The ongoing monitoring, evaluation, and improvement process.

Direct Client Services Fund (DCSF): Fund established by the Recipient to pay for HRSA eligible services for Ryan White clients when no contracted contractor/provider exists in the client's geographic area.

Eligibility Criteria: The standards set by a State or Territory ADAP, usually through an advisory committee, to determine who receives access to ADAP services. Financial eligibility is usually determined as a percentage of Federal Poverty Level (FPL), such as 200% FPL. Medical eligibility is most often a positive HIV diagnosis. Eligibility criteria vary among ADAP.

Eligible Metropolitan Area (EMA): The geographic area eligible to receive Ryan White Program Part A funds. The Office of Management and Budget (OMB) define metropolitan areas based on Census Bureau data. AIDS cases reported to the CDC determines eligibility. Some EMA include just one city and others are composed of several cities and/or counties. Some EMA extend over more than one State.

Emerging Community (EC): An area with a cumulative total of at least 500 AIDS cases, but fewer than 1,000 cases during the most recent 5 years.

Enzyme-Linked Immunosorbent Assay (ELISA): The most common test used to detect the presence of HIV antibodies in the blood, which are indicative of ongoing HIV infection. A positive ELISA test result must be confirmed by another test called a Western Blot test.

Epidemic: A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population, or geographic area. Epidemic diseases can be spread from person-to-person or from a contaminated source such as food or water.

Epidemiology: The branch of medical science that studies the relationship between the various factors that determine the frequency and distribution of diseases, including the incidence, distribution, and control of disease in a population.

Exposure Category: See Risk factor

Florida Community Planning Group (FCPG): All local HIV community prevention and planning groups.

Food and Drug Administration (FDA): The HHS agency 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 to safeguard the Nation's blood supply.

Full Time Equivalent (FTE): A standard measurement of full-time staff (either paid or volunteer) based on a 35-40 hour work-week. The FTE is calculated by taking the sum of hours worked by staff divided by 35-40, depending on how an organization defines full-time employment (e.g., 2 staff members who each work 20 hours per week equals 1 FTE).

Recipient: The recipient and responsible administrator of CARE Act funds. A full listing of definitions of grants management terms can be accessed at: http://www.nih.gov/grants/policy/gps/ under PHS Grants Policy Statement.

Recipient of Record: The official Ryan White Program Recipient that received Federal funding directly from the Federal government (HRSA). This agency may be the same as the contractor/provider agency, or may be the agency through which the contractor/provider agency has subcontracted.

Health Education/Risk Reduction: The provision of services to educate clients with HIV/AIDS about HIV transmission and how to reduce the risk of transmission, including information on medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Health Insurance Programs (HIP): Programs authorized and primarily funded under Part A, including the ADAP, to make premium payments, co-payments, deductibles, or risk pool payments on behalf of a client to maintain his/her health insurance coverage. This includes the Health Insurance Continuation Program (HICP).

Health Resources and Services Administration (HRSA): The HHS agency responsible for directing national health programs that improve the Nation's health by expanding equitable access to comprehensive, quality, health care for all. HRSA works to improve and extend life for persons living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA HIV/AIDS Bureau (HAB) is responsible for administering the Ryan White Program.

Highly Active Antiretroviral Therapy (HAART): An aggressive anti-HIV treatment usually including a combination of two or more drugs with activity against HIV whose purpose is to reduce the viral load to undetectable levels.

HIV/AIDS Bureau (HAB): The bureau within HRSA that is responsible for administering the Ryan White Program. Within HAB, the Division of Service Systems (DSS) administers Part A, Part B, and the AIDS Drug Assistance Program (ADAP); the Division of Community Based Programs administers Part A, Part B, and the HIV/AIDS Dental Reimbursement Program; and the Division of Training and Technical Assistance administers the AIDS Education and Training Centers Program. The Bureau's Office of Science and Epidemiology administers the Special Projects of National Significance (SPNS) Program. Other HAB Program Management Units, include:

Division of Community-Based programs (DCBP)
Division of Service Systems (DSS)

Division of Training and Technical Assistance (DTTA)
Office of the Associate Administrator for HIV/AIDS (OAA)
Office of Policy and Program Development (OPPD)
Office of Program Support (OPS)
Office of Science and Epidemiology (OSE)

HIV Counseling and Testing: The delivery of HIV counseling and testing to an individual. Counseling includes pretest and post-test counseling activities (i.e., offering the individual the HIV antibody test, as appropriate; services discussing the benefits of testing, including the medical benefits of diagnosing HIV disease in the early stages and the medical benefits of receiving early intervention primary care; reviewing the provisions of laws relating to confidentiality, including information regarding any disclosure that may be authorized under applicable law, and information regarding the availability of anonymous counseling and testing; and discussing the significance of the result, including the potential for developing HIV disease). Testing refers to an antibody test administered by health professionals to ascertain and confirm the presence of HIV infection (e.g., ELISA and Western Blot). Counseling and testing does not include tests to measure the extent of the deficiency in the immune system. These tests are considered to be fundamental components of comprehensive primary care. This service category excludes mental health counseling/therapy, substance abuse counseling/treatment, and psychosocial support services and these services are listed separately.

HIV Disease: The entire spectrum of the natural history of the human immunodeficiency virus, from post infection through the clinical definition of AIDS.

HIV/AIDS Education and Training Centers (AETC): Funded by the Ryan White Program, the AETC support training for health care contractor/providers to counsel, diagnose, treat, and manage individuals with HIV infection and to help prevent high-risk behaviors that cause infection.

HIV/AIDS Status: The outcome of the client's HIV test result, including: HIV-positive/not AIDS, the client tested positive for being diagnosed with HIV but has not advanced to AIDS; HIV-positive/AIDS status unknown, the client tested positive for HIV but it is unknown whether or not the client has advanced to AIDS; CDC-defined AIDS, the client has advanced to and has been diagnosed with AIDS; HIV-negative (affected), the client is HIV-negative and is an affected individual of an HIV-positive friend or family member; and unknown HIV/AIDS, the status of the client is unknown and not documented.

Housing Opportunities for Persons With AIDS (HOPWA): A program administered by the U.S. Department of Housing and Urban Development (HUD) which provides funding to support housing for PLWH/A and their families.

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

Incidence Rate: The number of cases of a disease per population per specified time period, often expressed per 100,000 population. AIDS rates are often expressed this way.

Infected Ryan White Client: An individual with HIV/AIDS who receives at least one Ryan White Program eligible service during the reporting period.

Lead Agency: The agency responsible for contract administration; also called a fiscal agent. An incorporated consortium sometimes serves as the lead agency.

Maintenance of Effort (MOE): The Part A and Part B requirement to maintain expenditures for HIV-related services/activities at a level equal to or exceeding that of the preceding year.

Minority AIDS Initiative (MAI): Service group for minority concerns.

More than one race: A racial category where an individual identifies with more than one race.

Native Hawaiian or Other Pacific Islander: An individual with origins from any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.

Needs Assessment: A systematic process to determine the service needs of a defined population. Defined as the extent of need, available services, and service gaps by population and geographic area.

Obligated Funds: Monies that have been committed/promised/assigned/set aside for a specific purpose and will require payment during the same or a future period.

Office of Management and Budget (OMB): The office within the executive branch of the Federal government which prepares the President's yearly budget, develops the Federal government's fiscal program, oversees administration of the budget, and reviews government regulations.

Office of Science and Epidemiology (OSE): The office within HRSA HIV/AIDS Bureau that administers the SPNS Program, HIV/AIDS evaluation studies and the Ryan White Program Performance Data Report.

Opportunistic Infection (OI): An infection or cancer that occurs in persons with weak immune systems due to AIDS, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus are all examples of opportunistic conditions. Also more loosely termed "Opportunistic Condition."

Part A: Provides emergency relief to metropolitan areas that are disproportionately affected by HIV/AIDS.

Part B: Assists States and Territories in improving the quality, availability, and organization of health care and support services for individuals and families with HIV disease, and provides access to needed pharmaceuticals through the AIDS Drug Assistance Program (ADAP).

Part B Base Funds: The amount of Part B funds not allocated to the ADAP.

Part C: Provides support for early intervention and primary care services for persons with HIV/AIDS.

Part D: Enhances access to comprehensive care for children, youth, women, and their families at-risk for HIV, and access to research of potential clinical benefit.

Part F: Under the CARE Act, Part F provides funding for the AETC, SPNS, and the HIV/AIDS Dental Reimbursement Program.

Patient Assistance Program (PAP): A program where a pharmaceutical manufacturer provides emergency therapeutics to ensure a continuum of care for individuals unable to obtain medications through anyother source (i.e., clients on waiting lists for ADAP).

Planning Council: A planning body appointed or established by the Chief Elected Official (CEO) of an EMA. The primary responsibilities of a planning council are to establish a delivery plan for HIV care services in the EMA and set priorities for the use of Ryan White Program Part A.

Person[s] Living with HIV/AIDS (PLWH/A): individuals who are living with HIV or AIDS.

Prevalence: The total number of persons living with a specific disease or condition at a given time.

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 patient who is HIV positive. Examples include medical, sub-specialty care, dental, nutrition, mental health or substance abuse treatment, and pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; counseling and testing.

Priority Setting: The process used by a planning council or consortium to rank priorities among service categories. These rankings are to ensure consistency with locally identified needs. The process should also address how best to meet each priority.

Prophylaxis: Primary prophylaxis is treatment to prevent the onset of a particular disease. Secondary prophylaxis or maintenance therapy is treatment to prevent the recurrence of symptoms in an existing infection that has been brought under control.

Protease: An enzyme that triggers the breakdown of proteins. HIV's protease enzyme breaks apart long strands of viral protein into separate proteins constituting the viral core and the enzymes it contains. HIV protease acts as new virus particles are budding off a cell membrane.

Protease Inhibitor: Protease inhibitors (PI) prevent maturation of virus protein by competitively inhibiting HIV protease, an enzyme essential for viral protein cleavage. When HIV protease is blocked, immature virus particles are produced.

Public Health Service (PHS): An administrative entity of HHS. HRSA is a PHS agency and became a HHS operating division (OPDIV) that reported directly to the Secretary in October 1995.

Quality: The degree to which a health or social service meets or exceeds established professional standards and user expectations. Evaluation of the quality of care should consider: (1) the quality of the inputs; (2) the quality of the service delivery process; and (3) the quality of outcomes, in order to continuously improve systems of care for individuals and populations.

Quality Assurance (QA): The formal and systematic process of identifying problems in service delivery, designing activities for overcoming these problems, and following up to ensure no new problems developed and corrective actions have been effective. The emphasis is on meeting minimum standards of care.

Quality Improvement (QI): An ongoing process that involves organizational members in monitoring and evaluating inputs, processes, outputs, and outcomes in order to continuously improve service delivery. In contrast to QA, which focuses on identifying and solving problems, QI seeks to prevent problems and to maximize the quality of care.

Quality Management (QM): A systematic approach to performance planning, feedback, and review directed at improving performance at all levels of an organization.

Resource Allocation: The legislatively mandated responsibility of planning councils to assign CARE Act amounts or percentages to established priorities across specific service categories, geographic areas, populations, or subpopulations.

Retrovirus: A type of virus that, when not infecting a cell, stores its genetic information on a single-strand RNA molecule instead of the more usual double-strand DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material.

Request for Application (RFA): An open and competitive process for selecting contractors/providers of services.

Risk Factor or Risk Behavior/Exposure Category: Behaviors or other factors that place a person at risk for a disease. For HIV/AIDS, these factors include male-to-male sexual contact, injection drug use, and commercial sex work.

Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act): The Federal legislation created to address the health care and service needs of persons living with HIV/AIDS (PLWH/A) disease and their families in the United States and its Territories. The CARE Act was enacted in 1990, reauthorized in 1996, 2000, 2006, and 2009.

Seroconversion: The development of detectable antibodies to HIV in the blood as a result of infection. It normally takes several weeks to several months for antibodies to the virus to develop after HIV transmission. When antibodies to HIV appear in the blood, a person will test positive to the standard ELISA test for HIV.

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

Seroprevalence Report: A report that provides information about the percent or rate of persons in specific testing groups and populations who have tested positive for HIV.

Service Gaps: A need that is not currently being addressed through existing services, either because no services are currently available or because available services are inappropriate or inaccessible to the target population.

Special Projects of National Significance (SPNS): Supports the development of innovative HIV/AIDS service delivery models that have the potential for replication in other areas, locally and nationally.

Statewide Coordinated Statement of Need (SCSN): A written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act program coordination. The SCSN process is convened by the Part A Recipient, with equal responsibility and input by all programs. Representatives must include all CARE Act titles and Part F managers, contractor/providers, PLWH/A, and public health agency(s).

Substance Abuse and Mental Health Services Administration (SAMHSA): The agency within HHS that administers programs related to alcohol abuse, substance abuse, and mental health.

Supplemental Grant (Part A): Based on "demonstrated need." Distribution based on 2/3 formula, 1/3 supplemental for both EMA and TGA. Priority in making grants is given to areas experiencing a "decline or disruption" of all Area-provided services.

Surveillance: An ongoing, systematic process of collecting, analyzing, and using data on specific health conditions and diseases (e.g., CDC and Prevention surveillance system for HIV/AIDS cases).

Surveillance Report: A report providing information on the number of reported cases of a disease such as HIV/AIDS, nationally and for specific sub-populations.

Target Population: A population identified to be reached through some action or intervention. Targeted populations may be groups with specific demographic or geographic characteristics.

Transitional Grant Area (TGA): An area with a cumulative total of at least 1,000 but fewer than 2,000 AIDS cases during the most recent 5 years.

Transmission Category: A grouping of disease exposure and infection routes. In relation to HIV/AIDS, transmission categories may include injection drug use, men who have sex with men, heterosexual contact, and perinatal transmission.

Treatment Extension Act of 2009: Congress passed this bill as a continuation of the Treatment Modernization Act in October of 2009. This bill expired in September 30, 2013.

Unduplicated Client Count: An accounting of clients in which a single individual is counted only once. For contractors/providers with multiple sites, a client is only counted once, even if he or she receives services at more than one of the contractors/provider's sites.

Unexpended Funds (Un-liquidated obligations): Obligated funds that have not been paid out.

Unique Record Number (URN): A nine-digit encrypted record number following HRSA URN specifications that distinguishes the client from all other clients and that is the same for the client across all contractor/provider settings. The URN is constructed using the first letter of the first name, the third letter of the first name (if blank, use middle initial, if no middle initial use '9'), the first letter of the last name, third letter of the last name (if blank, use '9'), month of birth, day of birth, and gender code. This string is then encrypted using a HRSA-supplied algorithm that can be incorporated into the contractors/provider's data collection system.

Un-obligated Balance: Monies that have not been committed/promised/assigned/set aside for a specific purpose by the end of the grant year.

Unmet Need: Comparing available services to identified needs reveals unmet needs and service gaps. This should include an examination of unmet needs for HIV-positive individuals who know their status but are not in care: service gaps for those who are currently in care: disparities in care; and capacity development needs of providers and the overall system of care. Analysis of unmet needs and service gaps might include not only a determination of overall needs but also identification of particular service needs for specific PLWH/A populations.

Veterans Administration Facility (VAF): A facility funded through the Department of Veterans Affairs.

Viral Load Test: In relation to HIV, a test that measures the quantity of HIV RNA per unit of blood plasma. Results are expressed as a number of copies per milliliter of blood plasma and are an indicator of virus concentration and reproduction rate. This test is used as a predictor of HIV disease progression.

Western Blot: A test for detecting the specific antibodies to HIV in a person's blood. It is commonly used to verify positive ELISA tests. A Western Blot test is more reliable than the ELISA, but it is harder and more costly to perform. All positive HIV antibody tests should be confirmed with a Western Blot test.

White: A person having origins in any of the original people of Europe, the Middle East or North Africa.

**** Source:*** *U.S. Department of Health and Human Services, Health Resources and Services Administration, the ADAP Manual Ryan White CARE Act Definitions and Acronyms*

V. Appendix of Unfunded Categories

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-1

POLICY TITLE: MEDICAL TRANSPORTATION SERVICES

POLICY STATEMENT

Transportation services may include direct transportation by transportation contractor/provider, directly, or thru taxi vouchers and public transportation (bus passes). Methods of delivery are driven by the consumers' needs and timeliness of service delivery. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITION AND UNIT OF SERVICE DESCRIPTION

Medical transportation services include those provided directly or through a voucher to a client so they may access health care services. Such services may include taxis, tokens, bus passes, vouchers or agency vehicle transportation.

A unit of **Medical Transportation** Services is negotiated per contract, and may consist of one (1) bus pass or one (1) trip, where a trip is considered one-way.

PROCEDURE

1. Annual Proof of Primary Care.
2. Agency must have on file a copy of the client's Notice of Eligibility Determination.
3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.
5. For PLWH/A accessing the Ryan White Program Sunshine Line Transportation, the case manager should complete the RWP Sunshine Line Request Form for monthly bus passes; or when the PLWH/A has Medicaid or HCHCP, the RWP Sunshine Line Request Form should be used to request an exemption from the Recipient.

CAPS/LIMITS

No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

STANDARD	MEASURE
1. Providers must have appropriate licensure and insurance coverage.	1. Written procedures and/or documentation on file as examined by the Recipient/Lead Agency.
2. Services are available to eligible residents of the service area as funding permits.	2. Documentation specifying appropriate procedure on file at agency as examined by the Recipient.

DOCUMENTATION

1. Notice of Eligibility Determination (NOE)
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed consent to fax (if appropriate)
6. Copy of Client Identification

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:

Adopted: 09/01/99
Revised: 12/03/03
Revised: 9/5/07
Revised: 5/12/14
Revised: 12/5/18

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-2

POLICY: AIDS DRUG ASSISTANCE PROGRAM (ADAP TREATMENTS)

POLICY STATEMENT

Technically a Part B funded service, although included by HRSA. Currently funded through the State of Florida.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

A State administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

Units of service determined by the State of Florida.

PROCEDURE
Determined by the State of Florida.

CAPS/LIMITS
Determined by the State of Florida.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
Determined by the State of Florida.

AUTHORITY/OVERSIGHT
3. State of Florida
4. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-3

POLICY: EIS (Early Intervention Services) refer to PS-11

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HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-4

POLICY: HOME HEALTH SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

Includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT

5. Ryan White Program Part A Recipient
6. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-5

POLICY: HOME AND COMMUNITY BASED HEALTH SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

Includes skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT
7. Ryan White Program Part A Recipient
8. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-6

POLICY: HOSPICE SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

Includes room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

To be determined at a later date.

AUTHORITY/OVERSIGHT
9. Ryan White Program Part A Recipient
10. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-7

POLICY: MEDICAL NUTRITION THERAPY

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

Provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

To be determined at a later date.

AUTHORITY/OVERSIGHT
11. Ryan White Program Part A Recipient
12. HRSA/HAB

PUBLISHED DATE: 05/31/2018
Revised Date: 12/5/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-8

POLICY: CHILD CARE SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

The provision of care for the children of clients who are HIV- positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training.

NOTE: This does not include child care while a client is at work.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT
13. Ryan White Program Part A Recipient
14. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-9

POLICY: PEDIATRIC DEVELOPMENT ASSISTANCE AND EARLY INTERVENTION SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

The provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT
15. Ryan White Program Part A Recipient
16. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-10

POLICY: LEGAL SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

The provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT
17. Ryan White Program Part A Recipient
18. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-11

POLICY: LINGUISTIC SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

The provision of interpretation and translation services.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT
19. Ryan White Program Part A Recipient
20. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-12

POLICY: OUTREACH SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

Programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT
21. Ryan White Program Part A Recipient
22. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-13

POLICY: PERMANENCY PLANNING

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

The provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT
23. Ryan White Program Part A Recipient
24. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-14

POLICY: PSYCHOSOCIAL SUPPORT SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

The provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT
25. Ryan White Program Part A Recipient
26. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-15

POLICY: REFERRAL FOR HEALTHCARE SUPPORT SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT
27. Ryan White Program Part A Recipient
28. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-16

POLICY: REHABILITATION SERVICES

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

Services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
To be determined at a later date.

AUTHORITY/OVERSIGHT
29. Ryan White Program Part A Recipient
30. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-17

POLICY: RESPITE CARE

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

The provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

To be determined at a later date.

AUTHORITY/OVERSIGHT
31. Ryan White Program Part A Recipient
32. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-18

POLICY: SUBSTANCE ABUSE SERVICES RESIDENTIAL

POLICY STATEMENT

To be written at a later date. Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNITS OF SERVICE DESCRIPTION

The provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Units of service description to be determined at a later date.

PROCEDURE
To be determined at a later date.

CAPS/LIMITS
No caps/limits established for this service category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE

To be determined at a later date.

AUTHORITY/OVERSIGHT
33. Ryan White Program Part A Recipient
34. HRSA/HAB

PUBLISHED DATE: 05/31/2018

HILLSBOROUGH COUNTY HEALTH CARE SERVICES

RYAN WHITE PROGRAM
PROGRAM SERVICE POLICIES AND PROCEDURES

PROGRAM SERVICE (PS) POLICY #: AP-19

POLICY TITLE: NON-MEDICAL CASE MANAGEMENT SERVICES

POLICY STATEMENT

PLWH/A require a rich base of diverse resources, adaptation of existing resource capabilities, long term chronic care, and the development of innovative models of care. The Case Manager should serve as the focal point in the coordination of client-centered HIV/AIDS services. Case management services should be offered through an intra-agency (multiple agencies), interdisciplinary and coordinated system of care.

Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNIT OF SERVICE DESCRIPTION

Non-medical case management services include the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed support services. These services do not involve coordination and follow-up of medical treatments. In accordance with HRSA HAB policy notice 01-01, this service does include transitional case management for incarcerated persons as they prepare to exit the correctional system as part of effective discharge planning, or those who are in the correctional system for a brief period, which would not include any type of discharge planning. All case management services must be provided in accordance with the EMA case management standards.

Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and the periodic reevaluation and revision of the plan as necessary over the life of the client. Services may include client-specific advocacy and/or review of utilization of services. Services can take place at the client's home, hospital, clinic, and/or contractor/provider office.

A unit of **Case Management** service is defined as one client contact, specifying in-person or other. In addition to counting the number of encounters, report number of 15-minute units, and any portion thereof.

Case management should be calculated and billed as follows:

All time spent doing reimbursable case management for a specific client on the same date of service must be totaled, reflecting actual length of time. Prior to billing, this block of time must be converted to 15 minute units. The total reimbursable case management activities for a date of service that is only a portion of 15 minutes can be billed as a 15 minute unit. Consider the following example:

DATE OF SERVICE	ACTIVITY	MINUTES
03/07/18	Phone call from emotionally distraught client dealing with a family crisis.	10 minutes
03/07/18	Phone call to Education & Support provider to discuss client referral.	5 minutes
03/07/18	Education and Support added to client's Plan of Care.	5 minutes
03/07/18	Service Authorization Form completed and faxed to provider.	6 minutes

A total of 26 minutes was spent doing management. Thus, the maximum billable amount of case management for 3/07/18 would be two (2) 15 minute units.

For each entry in the case narrative, there should be a corresponding note in the margin for the length of time spent. This will simplify billing procedures and achieve consistency in the documentation recorded in every case.

Eligibility determination services may be billed on a line-item reimbursement method.

PROCEDURE

1. Annual Proof of Primary Care.
2. Agency must have on file a copy of the client's Notice of Eligibility Determination.
3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Geographic Restriction Policy applies.

CAPS/LIMITS

No caps/limits established for this category.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
Case managers must follow all rules under the State Eligibility Rule.

DOCUMENTATION
1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification

AUTHORITY/OVERSIGHT
1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:
Adopted: 06/07/00
Revised: 12/03/03
Revised: 11/7/07
Revised: 6/17/14
Revised: 03/19/18

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PROGRAM SERVICE (PS) POLICY #: AP-20

POLICY TITLE: FOOD BANK/HOME-DELIVERED MEALS

POLICY STATEMENT

The exact contribution diet makes to disease is hard to estimate. However, nutritional food services are often associated with promoting health and fighting disease.

As in any population at risk for nutritional status decline, psychosocial and economic issues affect the maintenance of nutritional status. People at risk for malnutrition, based on psychosocial or economic status should be referred to social-service professionals for a more complete evaluation and intervention.

Although not funded currently this service is a HRSA defined category and could potentially have funding allocated in the future.

DEFINITIONS AND UNIT OF SERVICE DESCRIPTIONS

Food services include the provision of actual food or meals. It can include grocery store gift cards to purchase food or hygiene items. However, there must be a tracking mechanism to ensure the provider gets each receipt returned from the client. There must also be a penalty for any client who does not return their receipt. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.

Guidelines for providing nutritional supplements to eligible recipients:

1. Standard Dosage: 8 oz. three times daily. Flavor of product must be indicated on prescription. Multiple flavors need multiple prescriptions.
2. Formulary Restriction: Three month supply (one month supply with two refills). A new prescription is required every three months.
3. All nutritional supplements require a written prescription. The BMI and/or rationale (from the criteria above) for providing the nutritional supplement must be indicated on the prescription.

Unacceptable reasons to provide supplements include patient convenience or lack of finances. **Exceptions** will be considered on a case-by-case basis and are at the discretion of the Recipient/Lead Agency office. Service Requirements:

1. Yearly Proof of Primary Care.
2. Agency must have on file a copy of the client's Notice of Eligibility Determination.

Clinical Eligibility Criteria	Supportive Documentation
(At least one of the following criteria must be met to be eligible to receive nutritional supplements)	(Supportive documentation must be submitted to pharmacy at the time the prescription is filled)
Body Mass Index (BMI) < 20	BMI calculation documented on prescription form
>/= 5% weight loss in 1 month	Percentage of weight loss over one month documented on prescription form
>/= 10% weight loss in 3 months	Percentage of weight loss over three months documented on prescription form
Phase angle of < 5.0 (male) or <4.5 (female) as measured by bioelectrical impedance testing (BIA)	BIA calculation documented on prescription form
Current evidence of illness preventing adequate food intake (especially when nutritional demands are increased)	Documentation of appropriate illness on prescription form: hypoalbuminemia, thrush (oral Candidiasis), esophageal Candidiasis, CVA, surgery, chemotherapy and/or radiation associated with cancer treatment, severe dental problems, other acute illness and/or opportunistic infection

Suggestions for Prescribers:

1. Multiple flavors require multiple prescriptions as each flavor is associated with a unique NDC number for billing.
2. Evidence of clinical eligibility must be indicated on the prescription or must be attached to the prescription.
3. Formulary restriction: maximum three month supply (one month supply with two refills). A new prescription is required every three months with updated and current supportive documentation of clinical eligibility. Providers must evaluate response to therapy when issuing new prescriptions.

Unacceptable Use of Nutritional Supplements:

1. Client convenience.
2. Lack of finances (food banks, food stamps, financial assistance should be pursued first).

Miscellaneous Information:

1. Exceptions to the above guidelines will be considered on a case-by-case basis and are at the discretion ofthe Recipient/Lead Agency.
2. Questions and/or concerns should be addressed to the Recipient/Lead Agency's Office (813-272-6935 or arnolda@hillsboroughcounty.org).
3. Patients with active substance abuse issues shall be referred for additional assessment and intervention.

A unit of **Food Bank services** is defined as $5 worth of food or necessity items.

A unit of **Nutritional Supplements** is defined as one prescription not to exceed a 30-day supply of prescribed HIV-related food supplements for one eligible individual.

PROCEDURE

1. Annual Proof of Primary Care.
2. Agency must have on file a copy of the client's Notice of Eligibility Determination.
3. A 30-day grace period will be permitted for obtaining documentation of primary care for new clients. Clients who have not provided documentation within the 30-day grace period will no longer be eligible to receive Ryan White funded services.
4. Documentation of income less than 150% of poverty for food bank services.
5. Appropriate documentation to verify client meets requirements for nutritional supplements.

CAPS/LIMITS

Client must be below 150% of poverty level.

CARE COUNCIL APPROVED MINIMUM STANDARDS OF CARE
FOOD BANK

STANDARD	MEASURE
1. Individuals providing the service have specific experience in caring for HIV infected clients or receive appropriate training.	1. Written procedure and/or documentation on file as examined by the Recipient/Lead Agency.
2. Procedure in place to assess the consumers' need.	2. Written procedure on file as examined by Recipient/Lead Agency.
3. A minimum of one (1) person affiliated with the food pantry will be trained in and be responsible for the implementation of proper safe food handling procedures. This person will also provide training for food handling and safety to all persons directly involved in this service provision.	3. Certification of the responsible individual as a registered nutritionist/dietitian and documentation of the training of other staff and volunteers on file as examined by Recipient/Lead Agency.
4. Wholesome quality foods and/or basic hygiene and toiletry items are available.	4. Nutritionist will review and advise provider on site about products offered. This will be accomplished on a quarterly basis.
5. If a food voucher system is used, reimbursement procedures are followed.	5. Fiscal Monitoring.
6. Procedures in place to insure that safe food handling practices are followed.	6. Written policy on file as examined by Recipient/Lead Agency.

7. Food shall be offered for human consumption in a way that does not mislead or misinform the consumer.	7. Documentation of inspection by provider on file. Onsite inspection by Recipient/Lead Agency.
8. Food will be stored in accordance with safe food handling practices.	8. Documentation of inspection by provider on file. Onsite inspection by Recipient/Lead Agency.
9. Food items are inspected regularly. Rotten, spoiled, or contaminated items are not issued.	9. Documentation of inspection by provider on file. Onsite inspection by Recipient/Lead Agency.
10. All food items must be free of evidence of rodent, insect, and bird activity.	10. Documentation of inspection by provider on file. Onsite inspection by Recipient/Lead Agency.
11. Toxic non-food items must be stored separately.	11. Documentation of inspection by provider on file. Onsite inspection by Recipient/Lead Agency.

NUTRITIONAL SUPPLEMENTS

STANDARD	MEASURE
1. Supplements should be removed from stock no later than 60 days prior to their expiration date.	1. Documentation of inspection by provider on file. Onsite inspection by Recipient/Lead Agency.
2. Provider will utilize most cost-effective product available and will review and document each fiscal year.	2. Documentation of inspection by provider on file. Onsite inspection by Recipient/Lead Agency.

DOCUMENTATION

1. Notice of Eligibility Determination
2. Yearly Primary Care Visit/Consultation
3. DH 3204 "Initiation of Services" Form
4. HIV+ Diagnosis
5. Signed Consent to Fax (if appropriate)
6. Copy of Client Identification
7. Documentation of Income Less than 150% of Federal Poverty Level for Food Bank Services.
8. Appropriate Documentation to Verify Client Meets Requirements for Nutritional Supplements.

AUTHORITY/OVERSIGHT

1. Ryan White Program Part A Recipient
2. HRSA/HAB

STANDARD OF CARE EFFECTIVE DATE:

Adopted: 05/07/03
Revised: 12/03/03
Revised: 11/7/07
Revised: 5/12/14

VI. References

Budget and Accounting Act of 1921, https://bulk.resource.org/gao.gov/67-13/00001A37.pdf

Budget and Accounting Act of 1950, https://bulk.resource.org/gao.gov/81-784/00001FBD.pdf

Centers for Disease Control and Prevention Healthy People 2020, https://www.cdc.gov/nchs/healthy_people/hp2020.htm

Chief Financial Officers Act of 1990, http://www.gao.gov/special.pubs/af12194.pdf

Executive Order No. 11541, http://www.archives.gov/federal-register/codification/executive-order/11541.html

Florida's Prompt Payment Act, 2001. http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=Ch0218/part07.htm&StatuteYear=2001&Title=-%3E2001-%3EChapter+218-%3EPart+VII

HRSA HIV/AIDS Bureau National Monitoring Standards, http://hab.hrsa.gov/manageyourgrant/files/universalmonitoringpartab.pdf

HRSA Policy and Program Notices, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

National HIV/AIDS Strategy, https://www.hiv.gov/federal-response/national-hiv-aids-strategy/overview

Office of Management and Budget Circulars, http://www.whitehouse.gov/omb/circulars_default

Orange County Eligible Metropolitan Area Policies and Procedures Manual

Reorganization Plan No. 2, 1970, http://docs.uscode.justia.com/2010/title5/USCODE-2010-title5/pdf/USCODE-2010-title5-app-reorganiz-other-dup91.pdf

Ryan White Program, Hillsborough County Government, http://www.hillsboroughcounty.org/index.aspx?nid=2048

Ryan White Treatment Extension Act of 2009, http://hab.hrsa.gov/abouthab/legislation.html

West Central Florida Ryan White Care Council, http://www.thecarecouncil.org/committees.php

ADDENDUM Health Insurance Services Definitions, CAPS, & Service Entry Process

Definitions:

- A unit of health insurance is defined as one payment on behalf of the client for one of the following services:
    - **Co-pay/Deductible payments** billed as one unit per activity.
    - **Premiums/COBRA payments** billed as one unit per month.
- The **Date of Service** (DOS) **for all** Health Insurance Services is defined as the payment date written on the check. (ENCOUNTER DATE = CHECK DATE). *Date of service as established is the service request date or encounter date on the date the client is face to face and check issued for payments.*

CAPS

- **Co-pay/Deductible payments** are approved up to $500 per month and billed as one unit per activity. Exceptions may be granted by Recipient with extenuating circumstances.
    - For example: 1 prescription (Rx) – 1 unit, 1 office visit (OV) co-pay – 1 unit; 5 Rx in 1 payment is 5 units, the same for deductibles.
- **Premiums/COBRA payments** are approved up to $700 per month and billed as one unit per month. Exceptions may be granted by Recipient with extenuating circumstances. When a quarterly payment is billed by Insurance carrier, it can be paid in one check, but it cannot go beyond the current NOE end date or cross grant years.

Service Entry into e2Hillsborough:

Co-pay/Deductible payments for RX

- RX Service entry for co-pays is entered by the quantity or # of RX's being filled and the dollar amount of the RX. If multiple RX's, then enter the # of RX's and the ***average cost*** per RX. *(Average cost of individual RX is calculated by dividing the total cost, by the number of Rx's.)*
- A comment must be written on the **service note** line note including the following information: the number of scripts, *the invoice #, and the name of the vendor.

For example:

- If paying 1 RX for $50 enter DOS (as defined above), 1 unit and $50. A $50 payment will be auto calculated. Service line comment: 1 script, INV # XXX, Waldo's Pharmacy
- If paying for 3 RX's for a total of $150 enter the DOS, 3 units and $50 per RX and a $150 payment will be auto calculated. Service line comment: 3 scripts, INV #XXX, Walnut's Pharmacy.

Exceptions

- * If there is **not an *invoice* number** listed on the bill, then when entering the comment on the **service note,** the invoice # must be replaced by the ***account number and payment due date*** as listed on the bill, all other information must remain as noted above.

- *E**nd of grant periods.** When any bill is presented that crosses over the ***prior/old grant period (End of February)*** then instead of using the invoice date, use the first date of service covered on the bill, as the billing date in e2H. Procedures for uploading into e2H remain the same.

Co-pay/Deductible payments for office visit (OV)

- OV entry for co-pays/deductible is entered as 1 unit per office visit, using the DOS as defined above, and the payment amount. If multiple OV's are being paid on one invoice, then each service date must be entered separately 1 *service date per entry*, using the same method described above.
- A comment must be written on the **service note** line note including the following information: *the invoice #, and the name of the vendor.

For example:

- If paying an OV for $90 enter DOS (as defined above), 1 unit and $90. A $90 payment will be auto calculated. Service line comment: 1 OV, INV # XXX, Dr Smith,

Exceptions

- * If there is **not an *invoice* number** listed on the bill, then when entering the comment on the **service note,** the invoice # must be replaced by the ***account number and payment due date*** as listed on the bill, all other information must remain as noted above.

- *E**nd of grant periods.** When any bill is presented that crosses over the ***prior/old grant period (End of February)*** then instead of using the invoice date, use the first date of service covered on the bill, as the billing date in e2H. Procedures for uploading in to e2H remain the same.

Premiums/COBRA payments

Service entry for a 1-month Premium/COBRA payment is entered as 1 unit, using the DOS as defined above. Service entry for a quarterly payment is entered up to 3 units, using the DOS as defined above. The amount being paid must be equal to the amount of invoice and check. *Payment may be lesser if the clients NOE does not cover the entire quarter.

- Payment can never be higher than the invoice amount.
- A note in e2H with the name of the initial month's payment is sufficient, but it does need to have this noted.
- A comment must be written on the **service note** line including the following information: the number of month's covered, *the invoice #, and the name of the vendor.

- When the premium invoice being paid crosses grant years, (February and March); as it is an industry standard to pay premiums in advance, the case manager must document the standard service note information as stated above **and include an additional note stating that** "***the client is being paid in February to avoid interruption of coverage."***

For example:

- If paying a 1-month premium for $400 enter DOS (as defined above), 1 unit at $400/unit and a $400 payment will be auto calculated. Service line comment: May 2024, INV # XXX, Blueway Ins. Co.
- If paying for 3 months of premiums for $900 enter DOS (as defined above), 3 units at $300 *average* per unit and a $900 payment will be auto calculated. Service line comment: June, July, August 2024, INV #XXX, Cigna Ins. Co.

Exceptions

- * If there is **not an *invoice* number** listed on the bill, then when entering the comment on the **service note,** the invoice # must be replaced by the ***account number and payment due date*** as listed on the bill, all other information must remain as noted above.

- *E**nd of grant periods.** When any bill is presented that crosses over the ***prior/old grant period (End of February)*** then instead of using the invoice date, use the first date of service covered on the bill, as the billing date in e2H. Procedures for uploading in to e2H remain the same.

Below referenced is the HRSA program services Policy Clarification Notices (PCN's) and the Health insurance PCN:

- 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds (PDF - 172 KB) (Effective for awards made on or after October 1, 2016)
- 18-01 Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance (PDF - 84 KB)

Here is the link for all HRSA PCN's: Policy Notices | Ryan White HIV/AIDS Program (hrsa.gov)