

**Ryan White Program  
Service Delivery Guidelines  
Fiscal Year 2010-2011  
(Year 20)**

**Section II –  
Cost and Eligibility Summary**



*Miami-Dade County  
Office of Grants Coordination*

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***RYAN WHITE PROGRAM***  
***FY 2010-2011 (YEAR 20)***  
***COST AND ELIGIBILITY SUMMARY***



***Miami-Dade County***  
***Office of Grants Coordination***

**Effective March 1, 2010**

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**RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2010-2011 (YEAR 20)**  
**IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.**

SERVICE CATEGORY (listed in priority order)	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Outpatient Medical Care [including Minority AIDS Initiative (MAI)]	Client Medical Visit and Unduplicated # of Clients Served	<p>Multiplier applied to reimbursable procedure rate listed in the Year 2010 Florida Medicare Part B Physician Fee Schedule (Participating, Locality 04), file dated January 15, 2010, for Evaluation and Management (E&amp;M) codes for outpatient medical care and psychiatric visits only. Inpatient and emergency room services are not covered.</p> <p>Medical Procedures performed at Ambulatory Surgical Centers (ASCs) will be reimbursed at rates found in the 2010 Florida Medicare Part B ASC Fee Schedule, by HCPCS Codes and Payment Rates, revised December 31, 2009</p>	<p>Maximum Multiplier Rate of 1.50 Applied to Medicare Reimbursable Rates for Evaluation and Management codes for outpatient medical care and psychiatric visits only.</p> <p>No multiplier will be applied to the Medicare ASC Reimbursement Rates</p>	400%	I, II, III Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional	Yes

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\*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

**RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2010-2011 (YEAR 20)**  
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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Outpatient Medical Care (including MAI)  (cont'd)	(see previous page)	<p>Medical Procedures performed at Outpatient Hospital centers will be reimbursed at rates found in the approved Medicare Addendum B Outpatient Prospective Payment System (OPPS) by HCPCS Code for CY 2010 Fee Schedule</p> <p>All other non-E&amp;M procedures will be reimbursed at the 2010 Medicare rate as referenced above. No multiplier will be applied to non-E&amp;M procedures.</p> <p>Laboratory procedures will be reimbursed at rates included in the 2010 Medicare Clinical Diagnostic Laboratory Fee Schedule, for Florida (FL), revised December 29, 2009.</p>	<p>No multiplier will be applied to the Medicare OPPS Reimbursement Rates</p> <p>All other non-E&amp;M procedures will be reimbursed at the 2010 Medicare rate as referenced above. No multiplier will be applied to non-E&amp;M procedures.</p> <p>Flat rate only for labs and injectables. No multiplier may be applied.</p>	400%	I, II, III Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional	Yes

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**RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2010-2011 (YEAR 20)**  
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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Outpatient Medical Care (including MAI)  (cont'd)  Consumable Medical Supplies	Number of Clients Served, Consumable Medical Supply Distributions per Client (for Administering Prescribed Medications Only), and Dollar Amount Spent per Client	<p>Injectables will be reimbursed at rates included in the 2010 Medicare Part B Drug Average Sales Price (ASP) Drug Pricing Files, Payment Allowance Limits for Medicare Part B Drugs, dated Jan. 20, 2010.</p> <p>Allowable flat rate listed in the Medicare Durable Medical Equipment and Supplies Revised 2010 Fee Schedule, for Florida (FL), dated Dec. 10, 2009.</p> <p>If no Medicare Rate is available for DME and supplies, providers will be reimbursed at the Medicaid DME for All Medicaid Recipients fee schedule rates, most current as of March 1, 2010. In such case, providers must submit a request to the County for a Supplemental Reimbursement Rate</p>	<p>No multiplier may be applied to laboratory or injectable fees.</p> <p>Flat rate only. No multiplier may be applied.</p>	400%	I, II, III Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional	Yes

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<p align="center"><b>RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2010-2011 (YEAR 20)</b>  <b><u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></b></p>						
SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Prescription Drugs (including MAI for all components)	Individual Drugs Dispensed, # of Filled Prescriptions, \$ Spent per Drug, and Unduplicated # of Clients Served	PHS of Injectable/ Non-Injectable Medication Plus Flat Rate Dispensing Fee  AND AWP of Injectable/ Non-Injectable Medication Minus Discount Rate	PHS Price Plus Flat Rate Dispensing Fee  AND AWP Minus Applied Discount Rate of No Less Than 10%	400%	I, II, III and Physician's Referral or Prescription, with Letter of Medical Necessity or Prior Authorization Form, if Applicable	Yes
Prescription Drugs: Consumable Medical Supplies (for Administering Prescribed Medications only)	Number of Clients Served, Consumable Medical Supply Distributions per Client (for Administering Prescribed Medications Only), and Dollar Amount Spent per Client	Allowable flat rate listed in the Medicare Durable Medical Equipment and Supplies Revised 2010 Fee Schedule, for Florida (FL), dated Dec. 10, 2009. If no Medicare Rate is available for DME and supplies, providers will be reimbursed at the Medicaid DME for All Medicaid Recipients fee schedule rates, most current as of March 1, 2010. In such case, providers must submit a request to the County for a Supplemental Reimbursement Rate	Flat rate only. No multiplier may be applied.	400%	I, II, III and Physician's Referral or Prescription, with Letter of Medical Necessity, if Applicable	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Medical Case Management (including MAI)	Type of 15 Minute Client Encounter (Face-to-Face or Other) and Unduplicated # of Clients Served  OR  Type of 15 Minute Activity Performed by a Case Management Supervisor (chart review, consultation, etc.)	Cost of 15 Minute Encounter	\$14.00 / Encounter	400%	I, II, III	Yes
Medical Case Management: Peer Education and Support Network (PESN) (including MAI)	Type of 15 Minute Encounter (Face-to-Face or Other) and Unduplicated # of Clients Served	Cost of 15 Minute Encounter	\$7.50 / Encounter	400%	I, II, III	Yes

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Oral Health Care	Client Office Visit, Oral Health Care Procedure Provided, and Unduplicated # of Clients Served	Multiplier applied to procedure rate listed in the State of Florida Medicaid Dental Services Fee Schedule, most current as of March 1, 2010; reimbursement rates based on the American Dental Association's Current Dental Terminology CDT 2009-2010, codes for dental procedures	<p>Maximum Multiplier Rate of 3.0</p> <p>Maximum Annual Limit (Fiscal Year) for Oral Health Care Services: \$3,000 per client</p> <p>Very limited exceptions to the annual cap may be approved by the County, with consultation from the Miami-Dade HIV/AIDS Partnership's Oral Health Care Subcommittee as needed, on a case-by-case basis for the provision of preventative oral health care services only.</p>	400%	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Mental Health Therapy/ Counseling (Level I) Individual and Group  (PhD, EdD, or PsyD; <u>and</u> licensed as a LCSW, LMHC, or LMFT)	½ Hour Counseling Session and Unduplicated # of Clients Served	<b>Individual:</b> ½ Hour Counseling Session per Client  <b>Group:</b> ½ Hour Counseling Session per Counselor	<b>Individual:</b> \$32.50 per unit  (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service)  <b>Group:</b> \$35.00 per unit (minimum of 3 Ryan White clients to maximum of 15 total clients)	400%	I, II, III	Yes
Mental Health Therapy/ Counseling (Level II) Individual and Group  (MS, MA, MSW, or MEd; <u>and</u> licensed as a LCSW, LMHC, or LMFT)	½ Hour Counseling Session and Unduplicated # of Clients Served	<b>Individual:</b> ½ Hour Counseling Session per Client  <b>Group:</b> ½ Hour Counseling Session per Counselor	<b>Individual:</b> \$32.50 per unit  (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service)  <b>Group:</b> \$35.00 per unit (minimum of 3 Ryan White clients to maximum of 15 total clients)	400%	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Substance Abuse Counseling – Residential (including MAI)	# of Days of Residential Substance Abuse Treatment per Client and Unduplicated # of Clients Served	Cost of One Day of Residential Counseling Treatment Per Client	\$125.00 per client day  [up to a maximum of 120 days within a 12-month period; 12-months begins on the 1 <sup>st</sup> day of client's residential treatment regardless of Part A / MAI provider] [includes the cost of family member(s) participating in the substance abuse counseling session provided during day of treatment]	300%	I, II, III	Yes  A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Insurance Services (AIDS Insurance Continuation Program)	Dollars per Insurance Premium, Unduplicated # of Clients Served, and Dollars Expended per Client	Dollars Expended per Insurance Premium Per Client Plus a Dispensing Rate of \$15 per month	Reimbursement will be based on documentation of dollars expended per insurance premium plus a dispensing rate.  Maximum amount of assistance a client may receive on a monthly basis in \$750.	400%	I, II, III	Yes  Client must have insurance under a group, individual or COBRA policy.  Client must be willing to sign all required forms and to provide eligibility information.  A complete financial assessment and disclosure are required.

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Insurance Services (Insurance Deductibles)	Dollars per Deductible, Unduplicated # of Clients Served, and Dollars Expended per Client	Dollars Expended per Client per Deductible Plus a Dispensing Rate	Reimbursement will be based on documentation of dollars expended per deductible plus a dispensing rate.  Maximum amount of assistance a client may receive on an annual basis is \$2,500.	400%	I, II, III	Yes  A complete financial assessment and disclosure are required.
Insurance Services (Prescription Drugs Co-payments & Co-insurance)	Dollars per Co-payment, Unduplicated # of Clients Served, and Dollars per Client	Dollars Expended per Co-payment Plus a Dispensing Rate	Reimbursement will be based on documentation of dollars expended per co-payment plus a dispensing rate.  Assistance is restricted to those medications listed on the current approved Ryan White Program Prescription Drug Formulary	400%	I, II, III Physician's Prescription	Yes  A complete financial assessment and disclosure are required.

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Substance Abuse Counseling – Outpatient (Level I) Individual and Group	½ Hour Counseling Session and Unduplicated # of Clients Served	<p><b>Individual:</b> ½ Hour Counseling Session per Client &amp; Family Member</p> <p><b>Group:</b> ½ Hour Counseling Session per Counselor</p>	<p><b>Individual:</b> \$30.00 per unit</p> <p><b>Group:</b> \$34.00 per unit  (minimum of 3 Ryan White clients to maximum of 15 total clients)</p>	400%	I, II, III	Yes
Substance Abuse Counseling – Outpatient (Level II) Individual and Group	½ Hour Counseling Session and Unduplicated # of Clients Served	<p><b>Individual:</b> ½ Hour Counseling Session per Client and/or Family Member, as appropriate</p> <p><b>Group:</b> ½ Hour Counseling Session per Counselor</p>	<p><b>Individual:</b> \$27.00 per unit</p> <p><b>Group:</b> \$30.00 per unit  (minimum of 3 Ryan White clients to maximum of 15 total clients)</p>	400%	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Outreach Services (including MAI)	Type of 15 Minute Outreach Encounter [Face-to-Face or Other (i.e., Telephone Contact, Referral Activity, etc.)] and Unduplicated # of Clients Served  At least 25% of the people contacted through Part A / MAI outreach services and billed for must be brought and/or returned into medical care and/or other core services on a quarterly basis	Line Item Budget  Reimbursement will be based on a line item budget (for actual expenses incurred per month by the outreach service provider).	Outreach services will be paid based on full-time employees (FTEs) at a salary to be negotiated between the provider and the County, as well as on the basis of other direct and administrative costs.  Reimbursement will be based on the approved budget and productivity as recorded by hours spent conducting outreach activities, people contacted, their risk factors; and the # of people actually brought and/or returned into medical care and/or other core services on a quarterly basis. All indirect expenses (other than those associated with the delivery of outreach services) are capped at 10%.	N/A	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Food Bank	Food Bank Occurrence	<p>Dollars per Food Bank Occurrence (weekly bag of groceries, including personal hygiene products), Plus a Dispensing Rate</p> <p>Providers will also submit a quarterly reconciliation of actual expenditures for food costs, staffing, and other line items listed on the approved budget.</p>	<p>Food Bank Services may be accessed on an emergency basis ONLY.</p> <p>The provision of this service will be limited to twelve (12) occurrences in a Ryan White Program Part A fiscal year. One (1) occurrence is defined as all food bank services provided within one (1) calendar week.</p> <p><b>General Provision:</b> Groceries, including personal hygiene products when available, can be picked up on a <b>weekly or monthly</b> basis.</p> <p><b>Weekly</b> client limit = \$50.00 per week at each pickup.</p> <p><b>Monthly</b> client limit = \$50.00 per week multiplied by the number of times the original day of pick-up occurs in the month.</p>	250%	<p>I, II, III Client eligibility for this service must be certified by the Medical Case Manager</p> <p>Medical Case Management Referral and has applied for Food Stamps, as appropriate.</p>	<p>Yes</p> <p>A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.</p>

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Food Bank (continued)	Additional Food Bank Occurrence	Dollars per Food Bank Occurrence (weekly bag of groceries, including personal hygiene products), Plus a Dispensing Rate	<p><b>Additional Occurrences:</b> A severe change to the person's medical condition (i.e., new HIV related diagnosis/symptom, wasting syndrome, protein imbalance, recent chemotherapy, etc.) may also warrant additional occurrences of food bank services.</p> <p><b>Provision for Families:</b> Each additional adult who is HIV+ and lives in the same household is eligible to receive an additional \$50 per week in groceries, subject to the same general provisions above. Each dependent (i.e., minors under 18 years of age and living in the same household as the client who is HIV+) is also eligible to receive \$20 per week, subject to the same general provisions above.</p>	250%	<p>The client must be reassessed for the "warranting" medical condition every three (3) months.</p> <p><b>Additional occurrences</b> require a Ryan White Program Nutritional Assessment Letter for Food Bank Services to be completed by an independent physician or registered dietician not associated with the Part A food bank provider.</p> <p><b>For Families:</b> The client must provide documentation to prove the dependent's age and place of residence.</p>	<p>Yes</p> <p>A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.</p>

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SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Psychosocial Support Services (Level III) Individual and Group  (Bachelor's degree or Unlicensed MSW or MS in appropriate counseling field)	½ Hour Counseling Session and Unduplicated # of Clients Served	<b>Individual:</b> ½ Hour Counseling Session per Client  <b>Group:</b> ½ Hour Counseling Session per Counselor	<b>Individual:</b> \$25.00 per unit (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service)  <b>Group:</b> \$27.00 per unit (min. of 3 Ryan White clients to max. of 15 total clients)	300%	I, II, III	Yes  A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.
Psychosocial Support Services (Pastoral Care) Individual and Group  (Master's or Doctoral Degree in a Related Field)	½ Hour Session and Unduplicated # of Clients Served	<b>Individual:</b> ½ Hour Counseling Session per Client  <b>Group:</b> ½ Hour Counseling Session per Counselor	<b>Individual:</b> \$25.00 per unit (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service)  <b>Group:</b> \$27.00 per unit (min. of 3 Ryan White clients to max. of 15 total clients)	300%	I, II, III	Yes  A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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Psychosocial Support Services (Level IV) Individual and Group  (Trained and Supervised Peers)	½ Hour Counseling Session and Unduplicated # of Clients Served	<p><b>Individual:</b> ½ Hour Counseling Session per Client</p> <p><b>Group:</b> ½ Hour Session per Counselor</p>	<p><b>Individual:</b> \$15.00 per unit (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service)</p> <p><b>Group:</b> \$20.00 per unit (min. of 3 Ryan White clients to max. of 15 total clients)</p>	300%	I, II, III	Yes  A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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Home Delivered Meals	# of Home Delivered Meals	Cost per Meal	\$6.25 / Meal (Frozen or Hot)  (rate must include cost of nutritional counseling)	300%	III Physician's Certification of Client's Homebound** and Impaired Status  [**as defined by Florida Medicaid Project AIDS Care Waiver (PAC Waiver)]  Case Management Re-certification for a "warranting" medical condition is required every three (3) months.  A copy of the Physician's Certification must remain in the client's chart on-site at the home delivered meals provider facility.	Yes  A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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**IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.**

SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Transportation Vouchers (Discounted EASY Ticket)	Dollars per Voucher, # of Vouchers, and Unduplicated # of Clients Served	Dollars per Voucher Plus a Dispensing Rate Not to Exceed 15%	Cost of Vouchers Plus Dispensing Rate Not to Exceed 15%	150%	I, II, III Medical Case Management Referral  Case Manager re-certification required every 6 months.	Yes  Clients must be screened for eligibility of Miami-Dade County Golden Pass Program, Special Transportation Services (STS), Miami-Dade Transit Transportation Disadvantaged Program, Medicaid, etc.  A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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\*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

<p align="center"><b>RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2010-2011 (YEAR 20)</b>  <b><u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></b></p>						
SERVICE CATEGORY <i>(listed in priority order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2010 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Legal Assistance	Hour of legal consultation and/or advocacy provided by an attorney or paralegal	Cost of one hour of legal consultation and/or advocacy provided by an attorney or paralegal	\$90.00 per Hour	200%	I, II, III	Yes  A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.
Transportation Services (Vans)	One-Way Trip	Cost of One-Way Trip	\$13.00 per One-Way Trip	150%	I, II, III	Yes  A Ryan White Program Certified Referral or an Out-of-Network Certified Referral is required for this service.

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\*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

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