

**Ryan White Part A Program
Case Management Chart Review 2006**

Agency _____
 CIS# _____
 Agency ID# _____

Date of Review _____
 Reviewer _____
 Case Manager _____

Race: _____ Ethnicity: _____ Gender: _____ DOB: _____

Date of CM Intake: _____ Date of Last CM Service: _____

I. REQUIRED DOCUMENTS	YES	NO	N/A	DATE
1. Is there proof the client is HIV+? Please indicate the type of proof :				
2. Are there copies of CD4 test results?				
2a. What is the date of the most recent CD4 test result?				
*2.b. What are the dates of the next three most recent CD4 test results reported on or after 10/01/05?	1.			
	2.			
	3.			
3. Are there copies of viral load (VL) test results?				
3a. What is the date of the most recent VL test result?				
*3.b. What are the dates of the next three most recent VL test results reported on or after 10/01/05?	1.			
	2.			
	3.			
4. Is there proof the client is a Miami-Dade County resident? Please indicate the type of proof:				
5. Is there a picture ID?				
6. Is there a composite consent for enrollment?				
6a. Is it less than one year old?				/ /
7. Is there a signed SDIS Consent to Release and Exchange Information form?				/ /

Comments (Cite question number): _____

II. FINANCIAL ASSESSMENT – INITIAL	YES	NO	N/A	DATE
1. Is there an initial financial assessment?				/ /
2. Does the initial financial assessment include documentation of financial eligibility (proof of income)?				
Please indicate type(s) of proof:				
3. Is there evidence that client was assessed for 3 rd party health insurance payers during initial financial assessment?				
3a. Private				
3b. Medicare				
3c. Medicaid (all programs)				
3d. Medicaid Waiver				
3e. ADAP				
3f. AICP				
3.g Veterans Administration				
4. If there is evidence of 3 rd party health insurance payer (3a-3g), is there documentation of this coverage (insurance card, letter of eligibility, etc...)?				
5. Is there proof of Medicaid verification (ex. Medifax or progress note of verification)?				
6. Is there documentation of # in household?				
7. Is there documentation of Federal Poverty Level ?				
8. Are all sections of the initial financial assessment complete?				
III. FINANCIAL ASSESSMENT – MOST CURRENT	YES	NO	N/A	DATE
9. Is there a current (not > 6 months) financial assessment?- IF NO or NA Please note and skip to next section: OTHER ASSESSMENTS				/ /
10. Does the current financial assessment include documentation of financial eligibility (proof of income)?				
Please indicate type(s) of proof:				
11. Is there evidence that client was assessed for 3 rd party health insurance payers during the current financial assessment?				
11a. Private				
11b. Medicare				
11c. Medicaid (all programs)				
11d. Medicaid Waiver				
11e. ADAP				
11f. AICP				
11g. Veterans Administration				
12. If there is evidence of 3 rd party health insurance				

IV. HEALTH ASSESSMENT - INITIAL	YES	NO	N/A	DATE
1. Is there an initial health assessment? If NO, please mark NO and skip to the next section: OTHER ASSESSMENTS.				/ /
2. Does the initial health assessment include:				
2a. A list of medications? <i>This may be found on ADAP form or Part A certified referral.</i>				
2b. An assessment of adherence to prescription medications?				
2c. Is there a Primary Care Physician listed?				
2.c.1. If YES , Name of Primary Care Physician _____				
2.c.2. If NO , is there a CM referral to a PCP?				/ /
2.d. Assessment of adherence to physician appointments?				
3. Are all parts of the initial health assessment complete?				
V. HEALTH ASSESSMENT – CURRENT	YES	NO	N/A	DATE
4. Is there a current (not > 6months) health assessment? – If NO or NA please mark answer and then skip to the next section: OTHER ASSESSMENTS.				/ /
5. Does the current health assessment include:				
5a. A list of current medications? <i>This may be found on ADAP form or Part A certified referral.</i>				
5b. An assessment of adherence to prescription medications?				
5c. Is there a Primary Care Physician listed?				
5.c.1. If YES , Name of Primary Care Physician _____				
5.c.2. If NO , is there a CM referral to a PCP?				/ /
5.d. Assessment of adherence to physician appointments?				
6. Are all parts of the current health assessment complete?				

Comments (Cite question number):

VIII. PLAN OF CARE – INITIAL	YES	NO	N/A	DATE
1. Is there an initial Plan of Care (POC)? If NO please mark NO and skip to the next section: PROGRESS NOTES.				
2. Is the initial POC dated on or after 10/01/05?				/ /
3. Is it signed by the Case Manager?				
4. Is it signed by the client?				
5. Is the initial POC based on needs identified in the assessments?				
6. Does the initial POC include clear goals/plans to address identified needs?				
IX. PLAN OF CARE - CURRENT	YES	NO	N/A	DATE
7. Is there a current POC (not > 6 months)? If NO or NA please mark and proceed to the next section: PROGRESS NOTES.				
8. Is the current POC dated?				
9. Is the current POC signed by the Case Manager?				
10. Is the current POC signed by the client?				
11. Is the current POC based on needs identified in the assessments?				
12. Does the current POC include clear goals/plans to address identified needs?				

Comments (Cite question number):

XII. CASE CLOSING	YES	NO	N/A	DATE
1.Has the case been closed ? (If answer is NO please mark NO and skip this section/ If YES please indicate the date the case was closed.)				/ /
2. If the case is closed, is the reason for closing the case documented?				
3. If Yes, specify reason for case closure:				
4. Was patient contact information updated at case closing?				
5. Is there a final progress note that describes case disposition at the time of case closing? [Please indicate the date of the progress note indicating that the case was closed]				/ /

Comments (Cite question number):
