Ryan White Program
Service Delivery Guidelines
Fiscal Year 2019
(Year 29)

Section VI –
Client Eligibility Requirements

Miami-Dade County
Office of Management and Budget
Grants Coordination

(NOTE: The following client eligibility requirements are effective March 1, 2019; including as edited in red below.)

Excerpt from the FY 2019 Extension to the FY 2018 Professional Services Agreement for Ryan White Part A and MAI-funded Services, as may be amended
(YR 29 Extension to YR 28 Continuation Contract shell)

Article VII
Reporting, Record-keeping, and Evaluation Studies

7.1 The SUBRECIPIENT shall keep adequate, legible records of program-eligible clients served and the services provided to those clients as required by the COUNTY and by the U.S. Department of Health and Human Services. Furthermore, the SUBRECIPIENT shall maintain, and shall require that its subcontractors and suppliers maintain, complete and accurate records to substantiate compliance with the requirements set forth herewith in the Scope of Services (Exhibit A). The SUBRECIPIENT and its subcontractors and suppliers, shall retain such records, and all other documents relevant to the services furnished under this Agreement for a period of five (5) years from the expiration date of this Agreement and any extension thereof, unless State of Florida laws or the COUNTY's record retention schedule require a lengthier retention period.

Documentation of client eligibility is required at initial intake and recertification of eligibility is required every six (6) months thereafter; and must include verification of low- income status, physical residency in Miami-Dade County, and that the Ryan White HIV/AIDS Program is the payer of last resort. The client's medical necessity (confirmatory HIV+ status) must be documented at least once, with additional documentation if there is a progression to AIDS.

A. At a minimum, the following records shall be kept:

(1) Documentation of the program-eligible client having HIV or AIDS. Said documentation shall include a copy of at least one (1) of the following: lab test results (e.g., 4th Generation HIV test, Multispot® HIV-1/HIV-2 Rapid Test, HIV Western Blot, ELISA with Western Blot, detectable viral load or culture result; a positive HIV viral culture or test result); or a certified referral form. The Project AIDS Care (PAC) Waiver Notification of Level of Care (Form 603) is no longer accepted as proof of a client's HIV+ status. For Out of Network clients who have a Medicaid HIV Specialty Plan only, a copy of the client's current and valid Positive Health Care Florida (PHC Florida) or Clear Health Alliance (CHA) Medicaid card will be acceptable forms of documentation to support the client's HIV+ status. Very limited medical care and medical case management services within thirty (30) calendar days, as detailed in these aforementioned local Ryan White Program Service Delivery Guidelines, may be provided to newly diagnosed clients with a preliminary HIV+ test result for the purpose of timely engagement in care. **However, aside from this limited exception, on-going Ryan White Program-funded services MAY NOT be provided to**

clients without documented proof of a confirmatory test result for HIV. See Exhibit A, Section 1, of this Agreement, and Section VI, Client Eligibility Requirements, of the local FY 2018 Ryan White Program Service Delivery Guidelines, for more details, as incorporated herein by reference.

(2) Documentation of the program-eligible client's economic status that establishes their gross household income. Said documentation shall include, but not be limited to, a copy of at least one (1) of the following: the client's paycheck stubs for the most current two (2) pay periods; Supplemental Security Income (SSI) checks or benefit/award letters; Social Security Disability Insurance (SSDI) benefit/award letters; Social Security Administration (SSA) benefit/award letter; Temporary Assistance for Needy Families (TANF) checks or benefit/award letters; HOPWA/Section 8 Rental Assistance Statement; other letters of Notification of Benefits [e.g., Food Stamps (e.g., the SNAP Program), Veterans Administration, Medicaid, Medicare, private disability, retirement/pension, Workers Compensation, Low Income Subsidy, Women, Infants and Children (WIC) Program, etc.)]; other public assistance checks; current Internal Revenue Service (IRS) W-2 Wage and Tax Statement Forms (valid through May of following year); current and signed Individual or Business Tax Return Forms (valid through May of following year); Third Party Query Procedure (TPQY) screenings for verifying SSA/SSI benefit information; a zero income letter from a shelter or residential treatment facility located in Miami-Dade County; income from rental property; child support or court order check; notarized Head of Household (HOH) letter detailing the client's relationship to the HOH and the level of financial assistance provided to the client; (for undocumented clients only) a letter from the employer indicating the level of pay provided to the client; a Statement of No Income and Local Residence Form (for clients up to 25 years of age, where applicable); a program-approved certified referral form; or in extreme and rare cases, a notarized self-declaration letter from the client indicating their income (which must be approved by a Ryan White Program Medical Case Management Supervisor or the Office of Management and Budget-Grants Coordination). For Out of Network clients who have a Medicaid HIV Specialty Plan only, a copy of the client's current and valid Positive Health Care Florida (PHC Florida) or Clear Health Alliance (CHA) Medicaid card will be acceptable forms of documentation to support the client's income at 400% of Federal Poverty Level (FPL); not applicable for service categories that require an income cap below 400% of the FPL. A "Correction Health Services Referral" (CHSR) form from the Miami-Dade County Jackson Health System's Jail Linkage Program (JHS/JLP) is also acceptable proof of Miami-Dade County residency if it is signed and dated by the client and the referring party from the JHS/JLP; this form is acceptable for the first six months after enrollment in Part A, only once the client is released from jail. See Exhibit A, Section 1, of this Agreement, and Section VI, Client Eligibility Requirements, of the local FY 2018 Ryan White Program Service Delivery Guidelines, for more details, as incorporated herein by reference.

In addition, SUBRECIPIENT shall check for Property Information on the property tax page of the Miami-Dade County Tax Collector website

(https://www.miamidade.county-taxes.com/public) to ensure that all Ryan White Program-eligible clients are screened at initial intake and at each 6-month re-assessment to identify if program-eligible clients have additional income from rental property. Clients who have more than one (1) property listed in their name must have their gross household income adjusted accordingly. Documentation to support the completion of this search (showing additional properties or no properties) must be filed in the client's chart or electronic medical/health record.

(3) Documentation of the program-eligible client's permanent physical residency in Miami-Dade County. Such documentation shall include, but not be limited to, a copy of at least one (1) of the following forms of documentation showing the client's physical living address in Miami-Dade County: the client's current and valid, government-issued State of Florida driver's license or State of Florida Identification Card; rental lease, mortgage or rent receipts in the name of the client; utility bills in the client's name; Declaration of Domicile (Form 578; also known as the Declaration of Residence) as issued by the Miami-Dade County Courthouse; Department of Corrections Certification; self-declaration of homelessness; zero income letter from a shelter or residential substance abuse treatment facility located in Miami-Dade County; Head of Household (HOH) letter only if the client physically resides with the person completing the HOH letter; property search of Miami-Dade County Tax Collector website (https://www.miamidade.county-taxes.com/public) if the residence is listed in the client's name and is the client's primary residence; a Statement of No Income and Local Residence Form (for clients up to 25 years of age, where applicable); any government (local, state, or federal) issued letter of award or benefits that is not older than 12 months from the date of issue and that includes the client's full name and a current address that agrees with the current address in the client file; or a program-approved certified referral form. A "Correction Health Services Referral" (CHSR) form from the Miami-Dade County Jackson Health System's Jail Linkage Program (JHS/JLP) is also acceptable proof of Miami-Dade County residency if it is signed and dated by the client and the referring party from the JHS/JLP; this form is acceptable for the first six months after enrollment in Part A, only once the client is released from jail. See Exhibit A, Section 1, of this Agreement, and Section VI, Client Eligibility Requirements, of the local FY 2019 Ryan White Program Service Delivery Guidelines, for more details, as incorporated herein by reference.

(4) Service eligibility determination must be made and documented based on the most current, local FY 2019 Ryan White Program Service Delivery Guidelines and the corresponding Ryan White Program Cost and Eligibility Summary Chart, as may be amended.

(5) Client records (electronic or hard copy) shall include:

Client-level (intake) information that is entered in the Ryan White Program Service Delivery Information System (SDIS), as required and as applicable, in order to receive reimbursement for services rendered that includes unique client identifier number(s), intake date, date of birth, confirmatory proof of HIV status, gender at birth, current gender, race, race sub-groups, ethnicity, ethnicity sub-groups, country of origin, primary language at home, assessment of disabilities from a functional perspective, risk-related behaviors, level of HIV infection, referral source, ZIP code, TB status, year of diagnosis, location of diagnosis, annual client income, gross household income, size of household, insurance status, identification as a new or established client, specific service(s) provided, number of service units provided, unit cost, multiplier rate if applicable, dispensing cost if applicable, and total monthly cost per service category.

Subrecipients funded for Ryan White Part A or MAI-funded Medical Case Management services must also utilize the SDIS to enter progress notes no later than two (2) business days after service provision. Payment for Medical Case Management and Peer Education and Support Network (PESN) services where progress notes are entered more than forty-eight (48) hours, excluding holidays and weekends, after the actual date of service may be denied, at the discretion of the COUNTY.

Handwritten notes in the client chart must be legible in order to be considered sufficient documentation to support client eligibility, service utilization, and billing.

(1) SUBRECIPIENT receiving a Ryan White Program Certified Referral or Out of Network (OON) Referral, or a client self-referral if applicable, must maintain a copy of the referral (cover sheet, checklist, documentation supporting program eligibility, and required lab test results) in the client's chart or electronic medical/health record. The OON Referral or client self-referral must be accompanied by the actual, program-allowable documentation to support client eligibility [a minimum of one form of documentation for HIV status, Miami-Dade County residency, and low income, as indicated in each of sections 7.1(A)(1, 2, and 3) above; plus a current – not more than six months old – viral load lab test result; and additional lab test results – CD4, complete blood count (CBC), etc. – that may be needed for Oral Health Care services].

(a) Failure of the referring agency to maintain appropriate eligibility documentation in the client chart or electronic medical/health record, or of the receiving agency to maintain the actual Ryan White Program Certified Referral in the client chart or electronic medical/health record, is subject to corrective action and fiscal repayment to the COUNTY.

(b) For the SUBRECIPIENT receiving an OON Referral, failure to maintain the actual OON referral and its allowable supporting documentation and consent forms on file in the client's chart or

electronic medical/health record is also subject to corrective action and fiscal repayment to the COUNTY.

(2) **Involuntary Disenrollment of Clients.** SUBRECIPIENT must establish and follow internal policies and procedures that specifically address when termination or dismissal of a client from the agency itself or the Ryan White Program is warranted under local, State, and Federal laws. In support of the SUBRECIPIENT's internal policies and procedures related to client rights and responsibilities, this Agreement allows for a client to be involuntarily disenrolled (dismissed) from the local Ryan White Part A/MAI Program, or from a specific subrecipient agency, for the following reasons:

(a) Fraudulent use of program assistance;
(b) Falsification of documents or purposeful omissions of information required to confirm program eligibility for services;
(c) Persistent noncompliance with the client's plan of care; or
(d) Disruptive, unruly, abusive, or uncooperative behavior to the extent that continued enrollment seriously impairs the SUBRECIPIENT's ability to furnish services to either the client or other clients. Such behavior includes, but is not limited to, threats or acts of violence, verbal abuse and harassment, criminal activity, and destruction or theft of property.

This disenrollment provision **does not apply** to clients with medical or mental health diagnoses if the client's behavior is attributable to such diagnoses.

An involuntary disenrollment **must be documented** in the client record/chart. This documentation must clearly indicate: 1) that the client received at least one (1) verbal **and** one (1) written warning of the full implications of their actions; 2) that SUBRECIPIENT's staff attempted to educate the client regarding their rights and responsibilities; 3) that SUBRECIPIENT's staff offered assistance that would enable the client to comply with the organization's rules of conduct; and 4) that appropriate staff determined the client's behavior is not attributable to the client's medical or mental health condition.

If involuntary disenrollment is warranted and appropriate after completing the four (4) aforementioned steps, SUBRECIPIENT's staff must attempt to connect the client to another service provider agency to ensure continuity of care. Depending on the circumstances, the SUBRECIPIENT is expected to make every effort to connect the client to another agency to ensure continued access to HIV medical care.

In all cases of involuntary disenrollment/dismissal of a program client, the County's Ryan White Program Administrator must be notified of such via a telephone call to 305-375-4742; then the COUNTY will provide further instructions.

The COUNTY will work with the SUBRECIPIENT to determine if the circumstances are a result of the client's disability, and if so, will ensure that any resolution to the case does not violate the Americans with Disabilities Act's (ADA) reasonable accommodations requirement. In such cases, the SUBRECIPIENT will be required to demonstrate its attempts to provide the client with reasonable accommodations.

(8) In accordance with HRSA Policy Notice No. 16-01 https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters), Ryan White HIV/AIDS Program recipients and subrecipients may not deny services, including prescription drugs, to a veteran who is eligible to receive Ryan White HIV/AIDS Program services. Ryan White HIV/AIDS Program recipients and subrecipients may not cite "payer of last resort" language to compel HIV-infected veterans to obtain services from the Veterans Administration health care system or refuse to provide services. Ryan White HIV/AIDS Program recipients and subrecipients may refer eligible veterans to the Veterans Administration for services, when appropriate and available. However, Ryan White HIV/AIDS recipients and subrecipients may not require eligible veterans to access medical or supportive services in the Veterans Administration health care system nor deny them access to health care and support services funded by the Ryan White HIV/AIDS Program.

This space for use by Ryan White Part A Agency RECEIVING referral only:

Start Date: _____ Stop Date*: _____ Client CIS#: _____

*(*NOTE: Maximum length of time for each Out of Network / Non-Certified Referrals is 6 months.)*

OUT OF NETWORK (OON) / NON-CERTIFIED REFERRAL

for Miami-Dade County Ryan White Part A/MAI Program Services

This form along with copies of required client eligibility documentation are required for EACH OON or Non-Certified Referral to Miami-Dade County Ryan White Part A/MAI Program services. See the accompanying "Client Eligibility Documentation Checklist for Miami-Dade County Ryan White Program Services" for a list of acceptable documents and special eligibility rules. Proof that the Ryan White Part A Program is PAYER OF LAST RESORT is also required.

Note to Ryan White Part A/MAI Service Providers: Upon receipt of this form and required documentation – and prior to rendering services, a current, signed, and dated SDIS Authorization for the Release and Exchange of Information, Composite Consent, and a Miami-Dade County Notice of Privacy Practices must be signed by the client and a Part A/MAI agency representative. These documents must be maintained in the client's chart.

REFERRAL FROM: (*Select One: Client Self-referred or Other*)

_____ Client self-referred

_____ Other (case manager, care manager, etc.). Please specify:

Name: _____ Position Title: _____

Agency Name: _____

Phone: _____ Fax: _____

REFERRAL TO:

(See last page of Client Eligibility Documentation Checklist for a list of available services, including special income criteria.)

Please list the needed service(s) below:

_____ Core Medical Service [Specify service(s) needed: _____]

_____ Support Service [Specify service(s) needed: _____]

Ryan White Part A Service Provider (Agency Name): _____

Phone: _____ Fax: _____

Special Instructions: _____

CLIENT INFORMATION:

Name: _____ DOB: ___/___/___ Social Security #: ___/___/____

Street Address _____ City _____ Zip _____

Phone: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

INSURANCE OR BENEFIT PROGRAM INFORMATION:

Medicaid ID#: _____ Medicare ID#: _____

- Managed Medical Assistance (MMA) Plan Name: _____
- Long Term Care (LTC) Plan Name: _____

Private Insurance ID# & Plan Name: _____

Ryan White Part: ___B ___C ___D

I attest that all documentation provided with this referral is complete, accurate, and true. I consent to this referral for services to be provided by the Miami-Dade County Ryan White Part A Program.

Client Signature: (required) _____ Date ___/___/___

Agency Representative's Signature: (if applicable) _____

Client Eligibility Documentation Checklist
for Miami-Dade County Ryan White Program Services

This Checklist must accompany the Out of Network Referral (OON) form, Client Self-Referrals, or the "General Revenue (GR) Short-Term Medication* Assistance through the JMH Specialty Pharmacy" form. When using this Checklist for these referral purposes, please place a check mark next to the corresponding item in the lists below and attach the required documentation to the appropriate referral transmittal form.

(*NOTE: the "GR Short-Term Medication Assistance" provides emergency access to antiretroviral (ARV), opportunistic infection (OI), or other medications as listed on the most current General Revenue Prescription Drug Formulary only.)

Acceptable forms of client eligibility documentation are listed below. At least ONE (1) document from EACH group (medical, financial, residency) below MUST accompany each referral to support Ryan White Part A/MAI Program eligibility:

1) **MEDICAL ELIGIBILITY:** ***(HIV+ status)***
   - □ **4th generation HIV test result (with supplemental confirmatory tests)**
   - □ **HIV-1/ 2 Ab-Differentiation Immunoassay test result (e.g., Multispot® HIV-1/HIV-2 Rapid Test, Geenius HIV-1/2/ Supplemental Assay, etc.) (with supplemental confirmatory tests) [NOTE: The Geenius Assay replaced the Multispot test as of July 2016.]**
   - □ **HIV Western Blot**
   - □ **ELISA with Western Blot**
   - □ **Detectable viral load or culture result**
   - □ **Positive HIV viral culture or test result**
   - □ **Preliminary reactive (presumptive positive) HIV test result -- [USE ONLY for a Test & Treat / Rapid Access (TTRA) client who needs GR Short-term Medication Assistance when prescribed antiretroviral medication that is not available through the TTRA protocol]**

1a) Acceptable for Out of Network Clients ONLY: ***(NOT for use with GR Short-Term Medication Assistance)***
   - □ **Clear Health Alliance Medicaid card**

2) **FINANCIAL ELIGIBILITY:** ***[Gross household income not to exceed 400% of the Federal Poverty Level (FPL) for Core Medical Services; FPL may vary for Support Services. See below for details.]*****
   - □ **Paycheck stubs for the most current two (2) pay periods**
   - □ **SSI, SSDI, SSA, TANF checks or benefit/award letters/ other public assistance checks**
   - □ **HOPWA/Section 8 Rental Assistance Statement**
   - □ **Veterans Administration (VA) benefits statement/award letter**
   - □ **Other Letters of Notification of Benefits [e.g., Private Disability, Retirement/Pension, Workers Compensation Statement, Medicaid, Medicare, Low Income Subsidy, Women, Infants and Children (WIC) program, etc.]**
   - □ **Current Internal Revenue (IRS) W-2, Wage and Tax Statement form**
   - □ **Current & signed Individual or Business Tax Return forms**
   - □ **Third Party Query Procedure (TPQY) screenings for verifying SSA/SSI benefit information**
   - □ **A zero income letter from a shelter or residential treatment facility located in Miami-Dade County**
   - □ **Income from rental property**
   - □ **Child support or court order check**
   - □ **Head of Household (HOH) letter detailing client's relationship to the HOH and the level of financial assistance provided to the client**
   - □ **Statement of No Income and Local Residence Form (for clients up to 25 years of age, where applicable)**
   - □ **"Correction Health Services Referral" form from Jackson Health System's Jail Linkage Program if signed and dated by client and referring party; form is acceptable for the first six months after enrollment in Part A, only once client is released from jail**

2a) Acceptable for Out of Network Clients ONLY: *(NOT for use with GR Short-Term Medication Assistance)*
- □ Clear Health Alliance Medicaid card

3) RESIDENCY ELIGIBILITY: *(permanent residency in Miami-Dade County residency/physical living address)*
- □ Current and valid government-issued ID card (e.g., State of Florida Identification Card or Driver's License in the name of the client with a Miami-Dade County address)
- □ Rental lease agreement (in client's name)
- □ Mortgage or rent receipts (in client's name)
- □ Utility bills with a Miami-Dade County address (in client's name)
- □ Declaration of Domicile letter (Form 578) as issued by the Miami-Dade County Courthouse
- □ Department of Corrections Certification
- □ "Correction Health Services Referral" form from Jackson Health System's Jail Linkage Program if signed and dated by client and referring party; form is acceptable for the first six months after enrollment in Part A, only once client is released from jail
- □ Self-declaration of homelessness
- □ A zero income letter from a shelter or residential treatment facility located in Miami-Dade County
- □ Head of Household (HOH) letter ONLY if the client physically resides at same address of person completing HOH letter
- □ Screen print from a property search of the Miami-Dade County Tax Collector website (https://www.miamidade.county-taxes.com/public) IF the residence is listed in the client's name and it is the client's PRIMARY residence
- □ Statement of No Income and Local Residence Form (for clients up to 25 years of age, where applicable)
- □ Any government (local, state or federal) issued letter of award that is not older than 12 months from the date of issue and that includes the client's full name and a current address in Miami-Dade County that agrees with the current address in the client file

4) ADDITIONAL REQUIREMENT FOR OUT OF NETWORK (OON) REFERRALS ONLY –

□ For all OON Referrals: Viral Load Lab Results *(CURRENT - less than 6 months old).*

(NOTE: Viral load tests should be ordered during the first Test & Treat / Rapid Access medical visit, but a copy of the test result is not required if this referral is for GR Short-term Medication Assistance.)

□ For Oral Health Care (dental) referrals only: attach a copy of most recent CD4 count and HIV viral load test results, provide name of HIV antiretroviral medication, and complete the following:

HIV Specialist/PCP Name: _____
Phone Number: _____ Fax Number: _____

List Any Known Allergies: _____

-- See next page for additional guidance --

**FEDERAL POVERTY LEVEL (FPL) CAPS: The financial requirements (% of FPL) vary depending on the core medical or support service for which a client is referred. For income eligibility related to a particular support service, please see below, call the agency to which the referral will be made, or review the local Ryan White Program Service Delivery Guidelines (SDG). The most current version of the local SDG is available at: http://www.miamidade.gov/grants/ryan-white-program.asp#Delivery.

CORE MEDICAL SERVICES (400% FPL): AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program), Health Insurance Assistance, Medical Case Management (including Treatment Adherence Services), Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services, and Substance Abuse Outpatient Care

SUPPORT SERVICES (maximum % FPL is indicated below) – THROUGH JUNE 30, 2019:
Food Bank (250%), Medical Transportation (250%), Other Professional Services (Legal Services and Permanency Planning) (200%), Outreach Services (400%), and Substance Abuse Services (Residential) (300%).

SUPPORT SERVICES (400% FPL) – BEGINNING JULY 1, 2019:
Food Bank, Medical Transportation, Other Professional Services (Legal Services and Permanency Planning), Outreach Services, and Substance Abuse Services (Residential).

This space for use by Ryan White Part A Agency RECEIVING referral only:

CIS#: _____

OUT OF NETWORK (OON) / NON-CERTIFIED REFERRAL DEMOGRAPHICS

for Miami-Dade County Ryan White Part A/MAI Program Services

Please complete the following demographic information for program reporting purposes, and include this page with the referral form and supporting documentation:

CLIENT INFORMATION:

DOB: ___/___/____ **Zip Code:** _____
mm / dd /yyyy

Birth Gender: ____ *Male* ____ *Female*

Self-Reported Gender: ____ *Male* ____ *Female* ____ *Other* ____ *Not reported/Unknown/Does Not Fit Within Available Options*

Race: *(Choose all that apply)*

- ___ *Asian*
  - ___ *Asian Indian*
  - ___ *Chinese*
  - ___ *Filipino*
  - ___ *Japanese*
  - ___ *Korean*
  - ___ *Vietnamese*
  - ___ *Other Asian (_____)*
- ___ *Black or African American*
- ___ *Native American /Alaskan Native*
- ___ *Native Hawaiian/Pacific Islander*
  - ___ *Native Hawaiian*
  - ___ *Guamanian or Chamorro*
  - ___ *Samoan*
  - ___ *Other Pacific Islander (_____)*
- ___ *White*

Ethnicity: *(Choose from the following, as applicable)*

- ___ ***Haitian***
- ___ ***Hispanic/Latino/a or Spanish origin***
  - ___ *Mexican, Mexican American, Chicano/a*
  - ___ *Puerto Rican*
  - ___ *Cuban*
  - ___ *Another Hispanic, Latino/a, or Spanish origin (_____)*

Birth Country: _____

Native Language: _____ **Preferred Language:** _____

Current HIV Level: ____ *CDC-Defined AIDS* ____ *HIV+ Asymptomatic* ____ *HIV+ Symptomatic*

Date of Diagnosis: ___/___/___

State where HIV diagnosis was made: _____ **Within Miami-Dade County: Yes/No** ____

Primary Risk Factor for HIV Infection:

- ___ MSM (male-to-male sexual contact)
- ___ IDU (injection drug use)
- ___ Heterosexual contact
- ___ Hemophilia/Coagulation Disorder
- ___ Receipt of blood transfusion, blood components, or tissue
- ___ Perinatal transmission
- ___ Risk factor not reported or not identified above

Current Housing/Living Arrangement:

___ Stable/Permanent ___ Temporary ___ Unstable

Ryan White Program Part A/MAI - Out of Network Registration Contact Information
Fiscal Year 2019

Subrecipient	RW Part A/MAI Services Provided to Client with OON Referral	Location where RW Part A/MAI Service/s Provided to Clients with OON Referral	Designated OON Referral Registration Staff Names	Designated OON Referral Contact E-mail	Designated OON Referral Telephone Contact	Designated OON Referral Fax Number
AIDS Healthcare Foundation (AHF)	AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program – LPAP)	2900 Biscayne Blvd, Miami, FL 33137	Andra Tucker Isabel Restrepo Noelia Roman Dahlia Palmer Milagros Hernandez Quantavia Woodard Stephanie Gonzalez	Andra.Tucker@aidshealth.org Stephanie.gonzalez@aidshealth.org	305-764-3780	305-764-3784
Better Way of Miami (BW)	Substance Abuse Outpatient Care and Substance Abuse Services (Residential)	800 NW 28th Street, Miami, FL 33127	Jennifer Gonel	jgonel@bwom.org	305-634-3409, ext. 110	305-779-0682
Borinquen Medical Centers of Miami-Dade (aka Borinquen Health Care Center)	Oral Health Care	Registration & Oral Health Care Services: 3601 Federal Highway, Miami, FL 33137: Nutrition: 100 NE 38th Street, Suite 3, Miami, FL 33137; 100 NE 38th Street, Suite #3, Miami, FL 33137 (J. Soto)	Juan Soto (Patient Navigator)	Jsoto@borinquenhealth.org	305-576-1675, ext. 3243	786-476-2831
Care Resource	Oral Health Care	1901 SW 1st Street, 3rd Floor, Miami, FL	Soani Fuentes (Midtown staff) Jasmin Ruiz (Department Manager)	sfuentes@careresource.org jruiz@careresource.org	305-203-5230	305-203-5231
Citrus Health Network (CHN)	Oral Health Care	Hialeah Dental Center, University of Florida College of Dentistry: 750 East 25th Street, Hialeah, FL 33013 - 3817 **(By referral only, through CHN)**	Alfredo Torres	ATGonzalez@citrushealth.com	305-424-3142, ext. 46056	786-209-2028
Community Health of South Florida (CHI)	Oral Health Care	**Doris Ison:** 10300 SW 216 Street, Miami, FL 33190; **MLK:** 810 W Mowry Dr., Homestead, FL 33030; **Perrine:** 18255 Homestead Avenue, Perrine, FL 33157; **South Miami:** 6350 Sunset Drive, South Miami, FL 33143; **West Kendall:** 13540 SW 135th Ave., Miami, FL 33186; **Everglades:** 19300 SW 376th Street, Florida City, FL 33034; **Naranja:** 13805 SW 264th Street, Naranja., FL 33032; **South Dade:** 13600 SW 312th Street, Homestead, FL 33033	Tabitha Hunter Joanne Montalvo Carla McCullough Laquicia Tuff	thunter@chisouthfl.org jmontalvo@chisouthfl.org cmccullough@chisouthfl.org lbtuff@chisouthfl.org	305-252-4964 305-252-4889 305-254-4912 305-254-4980	305-254-4986

Ryan White Program Part A/MAI - Out of Network Registration Contact Information
Fiscal Year 2019

Subrecipient	RW Part A/MAI Services Provided to Client with OON Referral	Location where RW Part A/MAI Service/s Provided to Clients with OON Referral	Designated OON Referral Registration Staff Names	Designated OON Referral Contact E-mail	Designated OON Referral Telephone Contact	Designated OON Referral Fax Number
Empower U	Substance Abuse Outpatient Care (SAOC) Mental Health Services (MHS)	7900 NW 27 Ave, Suite E-12., Miami, FL, 33147	Lirian Oquendo - (SAOC) Amethyst St. Thomas - (MHS)	astthomas@empower-u-miami.org	786-318-2337 ext. 124 786-318-2337 ext. 102	786-284-3096
Food for Life Network (FFLN)	Food Bank	3400 NE 2nd Avenue, Miami, FL 33137	Valjean Brookins (supervisor) Melody Johnson (support staff)	vbrookins@careresource.org mjohnson@careresource.org	305-576-3663 ext. 216 305-576-3663 ext. 215	305-576-1833
Jessie Trice Community Health System (JTCHS)	Oral Health Care	5361 NW 22nd Avenue, Miami, FL 33142	Roselaine Monestime-Christie	rmonestime@jtchc.org	305-637-6400, ext. 2143 or 786-368-7274	305-418-2756
Legal Services of Greater Miami (LSGMI)	Other Professional Services (Legal Services and Permanency Planning)	4343 West Flagler Street, Suite 100 Miami, FL 33134	Marjorie Comeau	mcomeau@legalservicesmiami.org	305-438-2543 305-438-3809	305-438-2533
Miami Beach Community Health Center (MBCHC)	Insurance Services, Oral Health Care, Outpatient/ Ambulatory Health Services, Specialty Care, Substance Abuse Outpatient Care and Substance Abuse Services (Residential), AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program – LPAP)	710 Alton Road, Miami Beach, FL 33139	Jose Saez	pepe@mbchc.com pepe@hcnetwork.org	305-538-8835, ext. 1129	305-538-9254 305-532-5766
PHT/P.E.T Center	Oral Health Care	615 Collins Avenue, Miami Beach, FL 33139	Valencia Davis Social Work Supervisor	vdavis@jhsmiamni.org	305-585-4200	305-535-5442
PHT/SFAN Main	Oral Health Care	1611 NW 12TH Ave, ACC East, Suite 102, Miami, FL 33136	Tamar Conyers, Associate Admin. Valencia Davis, Social Work Supervisor	tamar.conyers@jhs.miami.org vdavis@jhsmiami.org	Main - 305-585-5241 T. Conyers - 305-585-6212	305-585-1517
University of Miami - Comprehensive AIDS Program (UM CAP)	Bascom Palmer (Vision)	900 NW 17th Street, Miami, FL 33136	Karen Hilton Gladys Gonzalez	Khilton@med.miami.edu ggonzal3@med.miami.edu	305-243-6535	305-243-5550

Lab Test Results Reporting Form

(Required for Miami-Dade County Ryan White Program clients
who do not receive medical care from a local Part A/MAI medical provider)

Date: _____

Client: _____ **is currently under my care for HIV disease.**

CIS # _____ **DOB:** _____ **SS #:** _____

Most Current Laboratory Results: (Every 6 months)

CD4 Count_____ **Date**_____ **CD4%**_____ **Date**_____

Viral Load _____ **bDNA**_____ **PCR**_____ **Date**_____

Current Dx: _____**HIV Asymptomatic** _____**HIV Symptomatic** _____**AIDS**

Screenings (Once Annually):

Chlamydia	Pos	Neg	Date_____	If positive, treated?	Y N
Gonorrhea	Pos	Neg	Date_____	If positive, treated?	Y N
Syphilis	Pos	Neg	Date_____	If positive, treated?	Y N
TB	Pos	Neg	Date_____	If positive, treated?	Y N
Chest X-ray	Pos	Neg	Date_____		

Hepatitis B	Pos	Neg	Date_____	If positive, treated?	Y N
Hepatitis C	Pos	Neg	Date_____	If positive, treated?	Y N
Genotype	Yes	No	Date_____		

Immunizations:

Flu Shot Yes No Date_____ **Prevnar** Yes Date_____

Pneumovax Yes No Date_____

Hep B Series #1 Date_____ #2 Date_____ #3 Date_____

(Women Only):

OB/GYN Exam Yes No _____ Date: _____ **Mammogram** Yes No Date_____
PAP Smear Yes No _____ Date: _____

_____ _____ _____
Medical Practitioner Signature **Medical Practitioner Name (stamp or print)** **Date**

_____ _____ _____
Phone **Street Address** **City, State, Zip**

2020 HHS FEDERAL POVERTY GUIDELINES
Annual Income Ranges (Gross Household Income)
(Effective March 1, 2020 through February 28, 2021 for Ryan White Part A & MAI Services in Miami-Dade County, FL)

Family Size	A 100-135%	B 136-150%	C 151-200%	D 201-250%	E 251-300%	F 301-400%	G ≥401%
1	< or equal to $12,760 - $17,353	$17,354 - $19,267	$19,268 - $25,647	$25,648 - $32,027	$32,028 - $38,407	$38,408 - $51,167	$51,168 +
2	< or equal to $17,240 - $23,445	$23,446 - $26,031	$26,032 - $34,651	$34,652 - $43,271	$43,272 - $51,891	$51,892 - $69,131	$69,132 +
3	< or equal to $21,720 - $29,538	$29,539 - $32,796	$32,797 - $43,656	$43,657 - $54,516	$54,517 - $65,376	$65,377 - $87,096	$87,097 +
4	< or equal to $26,200 - $35,631	$35,632 - $39,561	$39,562 - $52,661	$52,662 - $65,761	$65,762 - $78,861	$78,862 - $105,061	$105,062 +
5	< or equal to $30,680 - $41,724	$41,725 - $46,326	$46,327 - $61,666	$61,667 - $77,006	$77,007 - $92,346	$92,347 - $123,026	$123,027 +
6	< or equal to $35,160 - $47,817	$47,818 - $53,091	$53,092 - $70,671	$70,672 - $88,251	$88,252 - $105,831	$105,832 - $140,991	$140,992 +
7	< or equal to $39,640 - $53,909	$53,910 - $59,855	$59,856 - $79,675	$79,676 - $99,495	$99,496 - $119,315	$119,316 - $158,955	$158,956 +
8	< or equal to $44,120 - $60,002	$60,003 - $66,620	$66,621 - $88,680	$88,681 - $110,740	$110,741 - $132,800	$132,801 - $176,920	$176,921 +
9	< or equal to $48,600 - $66,095	$66,096 - $73,385	$73,386 - $97,685	$97,686 - $121,985	$121,986 - $146,285	$146,286 - $194,885	$194,886 +
10	< or equal to $53,080 - $72,188	$72,189 - $80,150	$80,151 - $106,690	$106,691 - $133,230	$133,231 - $159,770	$159,771 - $212,850	$212,851 +
+1	$4,480	$6,720	$8,960	$11,200	$13,440	$17,920	$17,965 +

SOURCE: *https://aspe.hhs.gov/poverty-guidelines (Based on the table titled, "2020 Poverty Guidelines for the 48 Contiguous States and the District of Columbia")*

IMPORTANT NOTES:

1) Using the table above as a guide for families/households with more than ten (10) members, add $4,480 for EACH additional family/household member.

2) The Miami-Dade County Ryan White Program Service Delivery Information System (SDIS) will be programmed according to these guidelines, effective March 1, 2020 through February 28, 2021.

3) Income eligibility for the following Ryan White Part A Program-funded services in Miami-Dade County is limited to program-eligible clients who have a gross household income at or below 400% of the Federal Poverty Level (FPL). The 400% FPL income limit applies to all locally-funded Ryan White Part A and MAI Program service categories.

4) Percentage calculations in the table above are rounded to avoid gaps between whole number dollar amounts.

Head of Household Letter of Support

Date: _____

RE: Statement of Financial Support by me to _____

To: _____, _____

This letter documents that _____ lives with me and/or is supported by me as my select from dropdown
(other; specify: _____) at my address as listed below.

I attest to the following (check all that apply):

☐ I am a resident of Miami-Dade County, residing at _____, _____, _____ in Miami-Dade County. I am the head of the household at that address.

☐ _____ is financially unable to live independently, and I provide (him/her) with a place to stay. _____has been living with me in this arrangement since_____.

☐ _____ receives financial support from me in order to reside in (his/her) own residence at the address listed below.

☐ I am not legally married to _____.

☐ I do not claim _____ as a dependent on my income tax return.

I provide $_____ per month in financial support and/or value to _____ for housing/shelter $_____, food $_____, clothing $_____, utilities $_____, other (specify: _____) $_____.

If you have questions, please contact me at _____.

Signed: _____ **Date:** _____

Printed name: _____

My Address:

_____

_____

Client Address:

_____

_____

LIMITED PROCESS FOR ASSISTING RYAN WHITE PROGRAM CLIENTS IN OBTAINING JACKSON HEALTH SYSTEM (JHS) CARD(S) WITH "IO1" AND "J" DESIGNATIONS AS REQUIRED TO RECEIVE SERVICES AT JHS FACILITIES

Background:

For any client to receive a service in any of its facilities, Jackson Health System/Jackson Memorial Hospital (JHS/JMH) requires clients to go through a separate financial screening process. This is in addition to the Ryan White Program eligibility review or Certified Referral process. This additional step has created a barrier in timely access to care for many clients, sometimes adding up to three (3) months of wait time to get an appointment for the JHS financial review. A client cannot access services at JHS/JMH sites until this separate financial screening process is completed.

South Florida AIDS Network (SFAN) has Eligibility Specialists who currently facilitate this financial review process for SFAN's internal Ryan White Program clients. This assistance has proven to reduce the amount of time it takes for a client to obtain the "IO1" and "J" card designations (see below). SFAN and Miami-Dade County's Ryan White Program grantee office have agreed upon a process to help facilitate the JHS financial review for Ryan White Program clients who are referred from external Ryan White provider agencies. This will also help minimize the lengthy wait time for an appointment to complete JHS/JMH's internal financial screening process.

Eligibility Designation Codes for JHS/JMH Financial Tracking Purposes:

- The "IO1" designation is clearance for Ryan White Program-funded services available in a JHS facility.
- The "J" designation is clearance for other non-Ryan White Program-funded services available at a JHS facility for which the client may qualify.

How SFAN Eligibility Specialists Can Assist with the JHS/JMH Financial Screening Process for Ryan White Program Certified Referrals from External Ryan White Program Service Providers (i.e., other than Ryan White Program-funded JHS/JMH/PHT clinics):

- IMPORTANT NOTE: Unfortunately, due to very limited staffing of Eligibility Specialists at SFAN, the following process will not guarantee an immediate turnaround for obtaining the "IO1" and "J" card, but it should accelerate the process.
    - Urgent cases may be addressed more quickly.
- The Ryan White Program client's medical case manager (MCM), not the client, should call SFAN's main telephone line, (305) 585-5241, and request to "Make an appointment with the Eligibility Specialist."
    - These calls will initially be routed to the SFAN MCM Supervisor to identify when the financial assessment can be scheduled. SFAN's MCM Supervisor will then assign the case to a SFAN Eligibility Specialist.

How SFAN Eligibility Specialists Can Assist (cont'd):

- The client's MCM should prepare a Ryan White Program Certified Referral for the service that is needed, according to local Ryan White Program guidelines.
    - NOTE: The "IO1" and "J" cards expire when the Ryan White Program Certified Referral expires.
- To facilitate the Eligibility Specialist's review process for BOTH the "IO1" and "J" card designations, the client should take a hard copy of the Certified Referral and a copy of the client's most current Medicaid application form, Medicaid acceptance or denial letter, or a statement/notation as to why the client is not eligible to receive Medicaid.
- Once the client has received clearance from JHS/JMH's financial screening process (i.e., client has received the "IO1" and "J" card designations) they can make an appointment for services.

Instructions for the "Statement of No Income and Local Residency" Form
(for Adolescents 18-25 years of age only)

The corresponding "Ryan White Program Statement of No Income and Local Residency" form has been adapted from a similar document used by our colleagues in Ryan White Part B Program. This form is intended to be used solely by adolescents and young adults up to 25 years of age who are non-emancipated minors or dependents and do not wish to disclose their HIV status to their parent(s) or legal guardian(s). This completed form may be used to support the client's Miami-Dade County residency and financial eligibility requirements; and must be reviewed and updated as needed at each six (6) month reassessment until the client no longer qualifies to use this document.

To use this "Ryan White Program Statement of No Income and Local Residency" form, the first paragraph option must apply and must be checked. Then, either the second or the third paragraph option must apply **and** one of these two options must be checked. This form must be signed and dated by the client and the client's medical case manager. The section at the bottom of the form regarding how the client's food, shelter, and utility needs are met should also be completed, as applicable.

Use of this new form is approved locally, effective immediately, in an effort to reduce barriers to accessing care for these young clients. If you have question regarding the use of this document, please contact Carla Valle-Schwenk, Program Administrator, at 305-375-4742.

Client ID (Ryan White Program CIS #): _____

Client Name: _____ SSN (if available): _____ DOB: _____

RYAN WHITE PROGRAM
STATEMENT OF NO INCOME AND LOCAL RESIDENCE
(Please check the following options as appropriate)

___ I hereby affirm that I am currently unemployed, am not receiving unemployment compensation benefits, am not receiving Social Security benefits, am not receiving any other disability benefits, and have no income at this time.

AND

___ I hereby affirm that I am a dependent (18-25 years old); however, I do not wish to disclose my status to parents/guardians/caregivers. I am seeking primary medical care services.

OR

___ I hereby affirm that I am a minor (under age 18 years) and not legally emancipated; however, I do not wish to disclose my status to parents/guardians/caregivers. I am seeking primary medical care services.

My current local address is: _____

_____

I agree to notify my case manager or the eligibility specialist immediately if, in the future, I begin to receive income, there is a change in my local address, or I disclose my status to parents/guardians/caregivers.

I certify that all information provided on this form is true and correct.

Client Signature: _____ Date: _____

Medical Case Manager Signature: _____ Date: _____

Medical Case Manager Name (Printed): _____

Medical Case Management Agency Name: _____

If the client has been without income for more than one month, please add an explanation below describing how this client's food, shelter, and utility needs are managed:

_____

_____

Client Signature: _____ Date: _____

Medical Case Manager Signature: _____ Date: _____

Self-Declaration of Income

Client Name: _____ **Date:** _____

Date of Birth: _____ **CIS #:** _____

Complete the information below as appropriate. Check all that apply:

- ❑ I do not receive retirement, disability, survivor or dependent benefits, Social Security (SSA) or Supplemental Security Income (SSI), or Medicare benefits.
- ❑ I am paid in cash and/or in kind.
- ❑ I have no other way to show proof of my income.

Occupation/Source of Income:

_____

Enter the amount (or value of the amount) you receive on a monthly basis:

Last three (3) months	Amount/Value
	$
	$
	$

My average income per month is $_____

Read the following and sign below

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine my financial eligibility for the Ryan White Program in Miami-Dade County. I understand that any misrepresentation of my income will jeopardize my ability to receive services from the Ryan White Part A/MAI Programs in Miami-Dade County.

I understand that I must submit a copy of the Social Security Benefit Verification Letter [formerly known as Third Party Query (TPQY)] (available at https://www.ssa.gov/myaccount/proof-of-benefits.html) to Ryan White Part A/MAI Program Medical Case Management subrecipient of my choice within forty-five (45) days of signing this form. I understand that a valid social security number is required to obtain a copy of the Social Security Benefit Verification Letter from the Social Security Administration.

_____ _____

Signature of Client **Date**

Reviewed by MCM Supervisor:

_____ _____ _____

Print Name of MCM Supervisor **Signature of MCM Supervisor** **Date**