

HIV CASE MANAGEMENT AND SUPPORT SERVICES PROGRAM

PROGRAM POLICIES, SERVICES DEFINITIONS & GUIDANCE



Table of Contents

SECTION 1: Program Policies	4
PROGRAM PRIORITIES	4
CLIENT ELIGIBILITY	5
DATA MANAGEMENT/RW CAREWARE	5
GENERAL PROGRAM REQUIREMENTS	6
INCOME QUALIFICATION	8
SECTION 2: Locally Managed Services	14
+ AIDS PHARMACEUTICAL ASSISTANCE	14
CASE MANAGEMENT (Non-Medical)	15
EMERGENCY FINANCIAL ASSISTANCE	15
EYE CARE	15
HEALTH AID	16
MEDICAL BENEFIT PAYMENT	16
MEDICAL SERVICE	17
NON-PRESCRIPTION MEDICATIONS	17
OTHER- EFA	18
TRAVEL LODGING	18
SUPPLEMENTAL FOOD ASSISTANCE	18
UTILITIES	19
+ HOME HEALTH CARE	20
HOUSING SERVICES	20
RENT ASSISTANCE	22
HOUSING-RELATED DEPOSITS	23
RESIDENTIAL FACILITY	24
TRANSITIONAL HOUSING	24
LINGUISTICS SERVICES	24
+ MEDICAL CASE MANAGEMENT	25
+ MEDICAL NUTRITION THERAPY	26
NUTRITIONAL SUPPLEMENT	26
NUTRITIONAL COUNSELING	26
FOOD CARD/VOUCHER	27
MEDICAL TRANSPORTATION SERVICES	27
PUBLIC TRANSPORTATION-SINGLE TRIP	28
PUBLIC TRANSPORTATION-MONTHLY PASS	28
GAS CARD	28
TAXI FARE	29
OTHER SPECIAL TRANSPORT SERVICES	29
+ MENTAL HEALTH SERVICES	29
+ ORAL HEALTH CARE	30

+ = HRSA Core Medical Service

Program Policies, Services Definitions & Guidance

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+ SUBSTANCE ABUSE: OUTPATIENT TREATMENT.....	30
SUBSTANCE ABUSE: RESIDENTIAL TREATMENT.....	30
EXCEEDING SERVICE CAP DOCUMENTATION.....	31
SECTION 3: State Managed Services.....	32
+ HOME HEALTH CARE.....	32
+ MENTAL HEALTH SERVICES.....	33
+ ORAL HEALTH CARE.....	33
SUBSTANCE ABUSE SERVICES.....	34

SECTION 1: Program Policies

PROGRAM PRIORITIES

The program follows the core medical services requirement of Health Services and Resources Administration (HRSA), the federal administrative agency of the Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White Program). HRSA requires that Ryan White Program grantees assure that the core medical services are adequately met before spending resources on other support services. Per HRSA policy, remaining funds may be spent on support services, defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS.

Core Medical Services:

- Outpatient/Ambulatory Medical Care
- AIDS Drug Assistance Program
- AIDS Pharmaceutical Assistance
- Early Intervention Services
- Oral Health Care
- Health Insurance Premium and Cost Sharing Assistance
- Home Health Care
- Home and Community Based Health Services
- Hospice Service
- Mental Health Services
- Medical Nutritional Therapy
- Medical Case Management Services
- Substance Abuse Services Outpatient

Additionally, the program is committed to developing and maintaining an HIV Services Continuum of Care that meets the goals outlined in the Ryan White Program legislation. Ryan White Program Services are intended to:

- Ensure that all persons with HIV disease, and those affected by HIV disease, are served by a care system that provides a comprehensive continuum of primary care and supportive services that facilitate access to existing and emerging HIV/AIDS treatments.
- Ensure that women and children receive services funded by Ryan White Program funds proportionate to their HIV/AIDS prevalence in the state.
- Ensure that racial/ethnic minorities will receive services proportionate to their representation as indicated in the prevalence data.

- Ensure that the needs of emerging populations are addressed and that services and outreach efforts are designed to encourage early intervention and participation in HIV medical care and therapy by these populations.
- Ensure that services will be provided to all PLWH/A generally in proportion to the HIV prevalence.
- Ensure and document the impact of services on improving access to quality care and treatment.

CLIENT ELIGIBILITY

1. Client must have a verified HIV positive diagnosis. Affected family members or partners of HIV positive clients are eligible for some services in the following circumstances:
 - a. The service has as its primary purpose enabling the non-infected individual to participate in the care of someone with HIV disease or AIDS.
 - b. The service directly enables the infected individual to receive needed medical or support services by removing an identified barrier to care.
 - c. The service promotes family stability for coping with the unique challenges posed by HIV/AIDS.
2. Client must be enrolled in HIV Case Management as described by the HIV Case Management Standards of Service in order to receive local Ryan White Program, Part B financial assistance.
3. Client must define their primary residence as in Oregon. Primary residence can be determined by asking for proof of residency, which may include, a current valid drivers license or official State ID that includes address, a certificate of domicile, rent receipts, utility bill with address, or a notarized statement from the landlord.
4. It is not necessary to be a U.S. citizen to receive Ryan White Program services. Applicants do not have to document citizenship or immigration status in order to be eligible for services.
5. To qualify for Ryan White Program financial assistance a client's gross income can be **no more than 250% of Federal Poverty Level (FPL)**. Case Management and Support Groups are exempted from this requirement. Clients must submit proof of income. See Income Qualification to determine FPL.

DATA MANAGEMENT/RW CAREWARE

Please refer to the Oregon RW CAREWare User Guide.

GENERAL PROGRAM REQUIREMENTS

1. No expenditures will be incurred with Ryan White Program funds for any item or service, which can reasonably be expected to be paid through other state, federal or private benefits programs. **Ryan White Program funds must be used as dollars of last resort** and appropriate documentation must be included in the client file that supports this requirement (For example, documentation of all referrals and follow-up shows that attempts have been made to utilize other payers first). However, there are two groups of persons that are exempt from this principle: Veterans and Native Americans are not required to seek medical services from the entitlement programs they qualify for (i.e. VA and Indian Health Services).
2. Use of Ryan White Program funds for emergency assistance must be for limited amounts, limited use, and limited periods of time: provider(s) will be expected to establish clear eligibility standards for access to assistance and a limit for the amount of assistance a client may receive.
3. The Ryan White Program is a needs-based program; clients with the highest needs receive the greatest amount of service. Additionally, clients are not required to participate in case management if they do not require any Ryan White Program services. The Ryan White Program is not a federal entitlement program.
4. Clients receiving only CAREAssist services are not required to be in case management unless referred specifically by the CAREAssist program.
5. Service expenditures are expected to meet the minimum assessed need for the client, not necessarily the more expensive item that the client may request. If the HIV case manager is faced with authorizing a basic service/item versus a more costly service/item that serves the same purpose, the HIV case manager should select the basic service/item.
6. State Managed Services **not** allowed for reimbursement at the local level include: Home Health Care, Mental Health Treatment/Therapy or Counseling and Substance Abuse Treatment
7. Ryan White Program funds may not be used to pay for professional licensure or meet program licensure requirements. Subscription fees may be allowable, but require prior authorization by the HIV Care and Treatment Program.
8. Ryan White Program funds may be used to support specific HIV staff training, which enhances an individual's or an organization's ability to improve the quality of services to affected clients. You may not use "support services funds" to pay for staff training.
9. HIV Case Managers must pre-authorize any payment for client services. In no case may funds be used to pay any client bill in arrears (past due).
10. Ryan White Program funds cannot be used to support or qualify a client for access under the Medical Marijuana program defined by Oregon State Statutes and Rules.
11. Ryan White Program funds may not be used to pay for off-premise social or recreational activities (i.e. movies, vacations, gym membership, parties, or retreats).
12. In no case may Ryan White Program funds be used to make direct payments of cash or checks to a client. Where direct provision of the service is not possible or effective, vouchers or similar programs, which may only be exchanged for a specific service or commodity, must be used to meet the client need.
13. Every Ryan White Program, Part B funded case management program in Oregon must be in compliance with the State requirements for a Release of Information (as required under

New

ORS 192.518-192.524) in which a client authorizes in writing the disclosure of certain information about his/her case to another party (including family members). At a minimum, the Release of Information must specifically name Oregon Department of Human Services, Public Health Division, HIV Care and Treatment Program, CAREAssist/ADAP, HIV Data and Analysis, and Program Design and Evaluation Services programs, all of which require access to client-level data for reporting and evaluation purposes. Because this program requires an annual reassessment it is expected that a Release of Information will be reviewed and updated annually.

14. For all client transfers within the Oregon Part B service area, a **“RW CAREWare Client Electronic Record Transfer Form”** should be completed, with a copy of a current Release of Information (ROI) which names the current HIV Case Management agency, the new HIV Case Management agency and the Oregon Department of Human Services programs (see #11 above), and faxed to RW CAREWare Central Administration to secure a client transfer within the database. (See RW CAREWare User Guide.)
15. Clients accessing Housing Opportunities for Persons With AIDS (HOPWA) funds through the Oregon Housing Opportunities Program (OHOP) must continue in HIV Case Management and meet the program requirements of an annual Assessment.
16. All OHOP clients must have a current ROI in both the OHOP file and the HIV Case Management file. The intent of the OHOP program is that HIV Case Managers, OHOP Coordinators and eligible clients will work together to develop and implement a client Housing Plan. HIV Case Managers cannot deny the OHOP program direct access to clients that have been referred to OHOP for housing assistance. Additionally, HIV Case Managers cannot refuse access to local landlords that have been identified in a specific client’s Housing Plan.
17. All support service payments must be directly linked to documented need. Authorizing support service payments for one service to offset the client-identified need, which is either a disallowed service or for which the client has reached the service category cap, is not allowed. In other words, cost-shifting client expenses to offset a disallowed or “maxed” out service is not allowed.
18. Ryan White Program, Part B funds cannot be used to pay for any other support service (besides case management), primary medical care or prescription drugs for any incarcerated person in a local, State or Federal correctional facility (including city or county jails).
19. Per HRSA policy, funds awarded under the Ryan White Program, Part B funds **may NOT** be used for:
 - Inpatient Hospital Services: Funds may not be used to assist with inpatient care.
 - Clinical Trials: Funds may not be used to support the costs of operating clinical trials of investigational agents, treatments (to include administrative management or medical monitoring of patients) or the cost of transportation and travel for a client’s participation.
 - Clothing: Purchase of clothing.
 - Detox: Inpatient detoxification in a hospital setting (funds **MAY** be used if detoxification is offered in a separate licensed residential setting –including a separately-licensed detoxification facility within the walls of a hospital).
 - Employment Services: Support employment, vocational rehabilitation, or employment-readiness services.

- Funerals: Funeral, burial, cremation, or related expenses.
- Household Appliances: Household appliances.
- Mortgages: Payment of private mortgages.
- Needle Exchange: Syringe exchange programs.
- Pets: Pet foods or products.
- Taxes: Paying local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
- Vehicle Maintenance: Direct maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees.
- Water Filtration: Installation of permanent systems of filtration of all water entering a private residence.

INCOME QUALIFICATION

Five Steps to Qualify a Client:

1. If client is pre-qualified, no further steps required.
2. If client is NOT pre-qualified, determine family/household size.
3. Verify documentation of income.
4. Determine gross annual income for eligible family or individual (required for RW CAREWare.) Determine gross monthly income for eligible family.
5. Use Federal Poverty Guideline (FPL) to determine eligibility.

Topic	Guidance
Step #1: Pre-Qualified Clients	<p>As long as a client is currently active in the following assistance programs, they are pre-qualified for case management and support services:</p> <ul style="list-style-type: none"> ➤ Oregon Health Plan (100% FPL) ➤ Food Stamps (100% FPL) ➤ CAREAssist Group 1 (200% FPL) <p>To be pre-qualified, a client must produce proof of current participation in one of the above programs during the original Intake/Assessment and each annual Reassessment.</p>
Step #2: Family Definition <div style="border: 1px solid black; border-radius: 10px; padding: 5px; width: fit-content; margin-top: 10px;"> <p style="text-align: center;">Clarification</p> </div>	<p>A family of two or more is defined as a group of persons related by birth, marriage, adoption, or a legally defined dependent relationship (see definition below), who live together. For the purposes of determining income eligibility, family that meets the above definition AND lives together are considered a “household” as entered in CAREWare. Please note that this definition is not the same as the definition of household used by the OHOP program.</p> <p>Life partner, significant other, legally registered Domestic Partner, or roommate (with no children in common) is NOT counted as</p>

	family for purposes of income verification.
Household Definition	For purposes of determining income eligibility, family that meets the definition of family AND lives together are considered a household. <i>Please note that this definition is <u>not</u> the same as the definition of household for the OHOP program.</i>
Dependent Status	<p>Dependent household members are defined as those persons for whom the head of household has a legal responsibility to support, or for whom the head of household has voluntarily extended supports. These relationships are defined as legal adoptions and guardianships.</p> <ul style="list-style-type: none"> ➤ Adopted family members must conform to the program requirements listed below for dependent children. ➤ Guardianship status must be supported by court documents defining the guardian relationship/responsibility. <p>All income, from full or part time employment, produced by all dependents must be declared as part of the household income.</p>
Step #3: Allowable documentation	<p>Documentation or proof of income is required for all clients. HIV Client Services reserves the right to request additional information.</p> <p>The following are the most commonly presented types of documentation:</p> <ul style="list-style-type: none"> ➤ Social Security award letter (current year) ➤ Copy of Social Security check ➤ Bank statements showing automatic deposit of Social Security check <ul style="list-style-type: none"> • Pay stubs • Year-end 1099 form • W2 fax form from employer • Federal income tax return • Accounting paperwork (spread sheet, financial journal, account books, etc.)
Step #4: Gross/Net Income	<p>Gross: Income <u>BEFORE</u> any taxes or other withholdings are deducted.</p> <p>Net: Also known as “take home” income. Income after taxes and withholdings are deducted.</p>

Step #5: Federal Poverty Level	To qualify for Ryan White Program, Part B services outside the TGA, a client's gross income can be no more than 250% of FPL. Please note: CAREWare will be updated after the poverty level changes take affect; however, it can take some time to do so.
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Revised

Effective March 1, 2009 – February 28, 2010

Family Size	Annual Federal Poverty Guideline	100% per mo.	200% per mo.	250% per mo.
1	\$10,830	\$903	\$1,805	\$2,256
2	\$14,570	\$1,214	\$2,428	\$3,035
3	\$18,310	\$1,526	\$3,052	\$3,815
4	\$22,050	\$1,838	\$3,675	\$4,594
5	\$25,790	\$2,149	\$4,298	\$5,373
6	\$29,530	\$2,461	\$4,922	\$6,152
7	\$33,270	\$2,773	\$5,545	\$6,931
8	\$37,010	\$3,084	\$6,168	\$7,710

Important Notes About Federal Poverty Level (FPL):

- Do not annualize monthly amounts. All monthly figures must be based on annual limit (and rounded).
- You must enter gross annual income in RW CAREWare. If you enter the accurate Gross Annual Income and family size in RW CAREWare the data system will calculate the FPL percentage.
- The FPL amounts change every year on March 1st. Be sure to check that you are utilizing the most current numbers.

Dependent Status Policy

Dependent child status shall not extend beyond age 18, except when the dependent child is enrolled as a student. In the case of student status, the age at which the dependent child status shall end is age 24. The client must attach documents to show that the child is enrolled in an educational institution and must be submitted with re-assessment.

- All dependents claimed must appear on the client's Federal and State Income Tax Return for the most recent year. The program reserves the right to ask for a review from the Oregon Department of Revenue and/or State of Oregon contracted Certified Public Accountant (CPA).
- Clients may not claim dependent status for individuals who reside outside the United States, unless those persons are listed on his/her most recent Federal Tax Returns filed; and there is a judicial ruling in the United States that defines a legal relationship and dependent status.

- All persons over the age of 18 years (who are not covered by the student status extension, and whom the head of household is claiming dependent status) must be named specifically in a legally defined Guardianship Relationship approved by a U.S. Judicial proceeding. NO exceptions will be made to this requirement. Notarized copies of documents must be made available upon request to the program.
- Adults (i.e. elderly parents, disabled adult child, etc.) are approved dependents if they meet the criteria above.

Gross Monthly Income Determination

The following are program criteria for determining gross monthly income:

- **Employed clients:** Annual income, divided by 12 months, is used for clients who have been employed, by the same employer, for a continuous period of at least 12 months and can provide documentation that “trends” their annual income.

There are:

- 2080 work hours in a year
 - 52 weeks in a year
 - 26 every-other-week pay periods
 - 24 twice-a-month pay periods
- **Self-employed clients:** Annual income, divided by 12 months, is used for self-employed clients who can prove seasonal employment. (Seasonal employment often means income is generated during certain time periods, which may or may not be over the limit during that time period, but when annualized over 12 months is within limits.)

Self-employed clients must show documentation of GROSS MONTHLY RECEIPTS. Bank statements which show deposits, accounting records, payable/receivable records and a federal income tax return that show gross income are ways to document gross monthly receipts. A self-employed client must pay for the cost of maintaining their own business which is considered “overhead.” The program follows OHP guidelines and allows a 50% deduction from gross monthly receipts to cover the cost of maintaining a business. Divide a client’s gross monthly receipts in half to determine their monthly income. If a client contests this method, they may utilize the method described in OAR #415-145-0930 and are responsible for getting the re-calculation completed and submitted to the program for reconsideration. The HIV programs do not employ trained financial experts/accountants and, therefore, will not re-calculate income using this method.

- **Change in income or where there are no trends in income:** Annual income, divided by 12 months, shouldn’t be used for clients who have experienced a change in income that would make them eligible for the program. For example, a client who was ineligible might now qualify if they lose their employment or experience a substantially reduced

income for the foreseeable future. Within reason, the program attempts to “look forward” in income assessment. The current monthly income should be used to determine eligibility.

- Do not take into account garnished wages, liens, child support payments and the monies garnished from monthly SSDI awards, to include reimbursement of previous Social Security overpayments.
- Gross income includes the amount that is deducted from Social Security checks for Medicare Part B.
- Food stamps are not considered income.
- Federal income tax returns will help verify income from multiple part-time jobs and that the family size is accurate.
- **Hourly income:** Calculate both the monthly income based on the Year To Date (YTD) amount listed on their pay stub and annualize the hourly rate to find the gross monthly income, which is to the client’s best advantage.
- **Twice a month vs. every other week:** Carefully check the pay stub to determine which factor to calculate when determining annual income – 24 pay period per year for twice a month or 26 pay periods per year for every other week. Do not rely solely on the client’s report as to the type of pay period. Sometimes the difference between these two pay cycles can determine a client’s eligibility.

Watch for “taxable gross” on paychecks, which will show for clients with pre-tax deductions including IRAs, 401Ks, and health and other insurances. Use the true gross (before those items are deducted), NOT the taxable gross.

Income Sources

- Work Income (Overtime pay, tips, bonuses, and commissions are all counted)
- Long Term Disability/all disability payments
- Self employment income
- Pension / Retirement income
- Unemployment insurance income
- Child support
- Alimony
- Social Security Income (SSI)
- Social Security Disability Insurance (SSDI) (Income is “income **before**” the Medicare Part B is deducted)
- Income from interest paid by savings/checking accounts
- Survivor benefits
- Annuities
- Stocks, bonds, certificates and all other investments, if they pay dividends

- Rental properties (includes sublet of portions of the client's primary residence)
- Inheritance
- Viaticum payments (payments made to a client for the purchase of their life insurance policy by a third party.)

SECTION 2: Locally Managed Services

“Exceeding Service Cap Documentation”: See policy at the end of this section.

+ **AIDS PHARMACEUTICAL ASSISTANCE**

Also known as “Drug Reimbursement”

Maximum Allowable (per Fiscal Year, July-June): \$300 per client per year.

Clarification

Definition:

Service to pay for emergency access to approved pharmaceuticals/ medications (includes full pay or copay medication assistance). Medications include prescription drugs intended to prolong life, improve quality of life or prevent the deterioration of health.

Program Guidance:

The definition does not include medications that are dispensed or administered during the course of a regular medical visit, that are considered part of the services provided during that visit.

Prescription pharmaceuticals/medications listed on the state’s ADAP/CAREAssist Drug Formulary may not be purchased with locally administered support service funds unless documentation can be provided that the client is not eligible for CAREAssist/Bridge Program, or extenuating circumstances apply. Please call CAREAssist to discuss any extenuating circumstances. Documentation that the client is not eligible for CAREAssist must include, at a minimum: (1) a denial or restricted letter from CAREAssist or (2) notation of the reason(s) the client is not eligible for CAREAssist in the progress notes in the client’s file.

It is recommended that the case manager pursue pharmaceutical company patient assistance programs as an alternative to paying for HIV specific prescription medications with local Ryan White funds.

Reporting Requirement:

Unit: Prescription

Report in RW CAREWare under “Drug Reimbursement”

CASE MANAGEMENT (Non-Medical)

See HIV/AIDS Case Management Standards of Service document.

Definition:

Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Program Guidance: Case management activities provided by someone who is recognized as an HIV case manager but who does not meet “Nurse” definition. Any case management contact and/or activity (other than face to face contact) with or on behalf of the client. This includes phone contacts with the client and/or his or her representatives and contact of any kind with social services providers on behalf of the client. Ancillary activities related to the case management performed for a client, which include, but are not limited to visit preparation, chart notes, data entry, and written referrals, are reported here.

Reporting Requirement:

Unit: 15 minutes

Report in RW CAREWare under:

Face-to-Face Services:

- “NAF - Non-RN Intake & Assessment: Face-to-face”
- “NRF - Non-RN Reassessment: Face-to-face”
- “NIF - Non-RN Case Management: Face-to-face”
- “NTF - Non-RN Transfer & Discharge: Face-to-face”

Non-Face-to-Face Services:

- “NIN – Non-RN Case Management: Non-Face-to-face”
- “NTN – Non-RN Transfer & Discharge: Non-Face-to-face”
- “Non-RN Travel Time” (case management travel time on behalf of a client)

EMERGENCY FINANCIAL ASSISTANCE

Maximum Allowable (per Fiscal Year, July-June): \$1500 per client per year total for all sub-services in this category.

EYE CARE

Definition:

Services rendered by an Optometrist or Optician

Program Guidance:

This service category includes eye exams and eye glasses once every two (2) years. Contacts are not covered in this service category unless prescribed as medically necessary by a licensed professional.

Reporting Requirement:

Unit: Payment

Report in RW CAREWare under “Eye Care”

HEALTH AID**Definition:**

An assisting device, which is beneficial to physical health. This may include medical devices (such as crutches, slings, certified guide dogs, etc.) and hearing aides. Notes: Denture replacement or realignment are covered under Oral Health Care.

Program Guidance:

Insurance must be billed if applicable.

Reporting Requirement:

Unit: Payment

Report in RW CAREWare under “Health Aid”

MEDICAL BENEFIT PAYMENT**Definition:**

The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance to receive medical benefits under a health insurance program. This includes premium payments, risk pools, copayments, and deductibles.

Program Guidance:

CAREAssist Cost Share Payments: Cost Share payments to CAREAssist are allowed under the following circumstances:

- Documented emergency only
- One time payment only
- One payment per client per fiscal year (July-June)

Health Insurance: Health Insurance premium payments are allowed under the following circumstances.

- Documented emergency only
- One time payment only
- One payment per client per fiscal year (July-June)
- You must contact CAREAssist to find out about Health Insurance coverage options.

Reporting Requirement:

Unit: Payment

Report in RW CAREWare under “Health Insurance/Cost Sharing Assistance”

MEDICAL SERVICE**Definition:**

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 include 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).

Program Guidance:

Any service authorized under the category must coincide with an application/referral to CAREAssist. In Oregon it is rare that a person with HIV/AIDS will not qualify for health insurance/co-pay/deductible coverage through CAREAssist.

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.

Usual providers of medical care are: physicians, advanced practice nurses (e.g., nurse practitioners, certified nurse midwives, and clinical nurse specialists), physician assistants, and specialists (e.g., OB/GYNs, immunologists, cardiologists, etc.).

Service includes payment for labs, radiology and medical equipment. Medical equipment (and supplies) may include diabetic supplies, respiratory equipment (CPAP, BiPAP), oxygen equipment, ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies.

Reporting Requirement:

Unit: Payment

Report in RW CAREWare under “Medical Service”

NON-PRESCRIPTION MEDICATIONS**Definition:**

Case Manager approved, over-the-counter, non-prescription pharmaceuticals/medications, including vitamins.

Program Guidance:

Use of non-prescription medications must be recommended by the client's primary care provider.

Reporting Requirement:

Unit: Medication

Report in RW CAREWare under "Non-prescription medication - EFA"

OTHER- EFA**Definition:**

The provision of short-term payments to assist with emergency expenses.

Program Guidance:

No services are allowed under this category without prior authorization from the HIV Care and Treatment Program.

Reporting Requirement:

Unit: Payment

Report in RW CAREWare under "Other - EFA"

TRAVEL LODGING**Definition:**

Includes lodging necessary when traveling to receive medical care.

Program Guidance:

Travel Lodging must be pre-approved by the client's HIV case manager and documentation of the medical appointment requiring the travel must be in the client's file. Generally, clients traveling for 2 hours or more and/or 100 miles or more are eligible for this service. It is strongly recommended that if comparable medical services are available locally that case managers work with clients to transition to a local medical provider.

Reporting Requirement:

Unit: Day

Report in RW CAREWare under "Travel Lodging"

SUPPLEMENTAL FOOD ASSISTANCE**Definition:**

A card/voucher that cannot be converted to cash, allowing a client to purchase food products necessary to maintain health. The voucher should clearly state that purchase of alcohol and tobacco products are not allowed. Note: A voucher can also be defined as a payment to a store on behalf of a client.

Program Guidance:

Documentation that clients have exhausted other food services prior to authorization (i.e. food banks, food stamps) must be in the client's chart.

For clients who have been assessed by a RN to have a nutritional need for food assistance please refer to "Medical Nutritional Therapy, Food Voucher". Case managers may provide assistance to clients under either Medical Nutritional Therapy OR Supplemental Food Assistance as described in the client's most current Care Plan, but clients may not receive both at the same time.

Reporting Requirement:

Unit: Card of Voucher

Report in RW CAREWare under "Supplemental Food"

UTILITIES

Clients receiving public or private assistance such as, but not limited to, OHOP (HOPWA), LIEAP assistance, or any other publicly funded assistance specifically for the purpose of subsidized utilities, may be eligible for Ryan White Program assistance if:

- They qualify for the Ryan White Program, Part B program and are enrolled in active HIV case management;
- They have been assessed as having an emergency need;
- They provide current detailed documentation substantiating the amount of the subsidy for the particular utility requested;
- The utility bill is current; and
- The client's Care Plan includes goals that specifically address activities to assist the client in meeting their utility costs without emergency assistance from Ryan White Program funds.

Ryan White Program, Part B funds may be used to provide assistance ONLY for any portion of the client's utility not covered through a utility subsidy. Utility assistance is NOT allowed for any client who has received full utility assistance through any other program.

Definition:

A service often provided by a public utility and deemed as an essential service to the health and welfare of a client; to include: heat, basic local telephone service, water, electricity and garbage collection.

Program Guidance:

Note that the OHOP program has access to HOPWA and other resources that can often meet the short-term utility assistance needs of clients. Assist clients in completing an OHOP referral packet and consult with your regional OHOP Housing Coordinator to determine that Ryan White Program funds are the only resources available to meet a

client's utility assistance needs before using Ryan White Program funds for utility assistance.

Special telephone service features that cost a fee in addition to basic service (e.g. call waiting, caller ID, etc.) are not allowed. Long distance telephone calls and toll calls may be allowed in special circumstances if pre-approved by the client's case manager. Cable, satellite television service and Internet service are excluded. Clients should provide evidence of application for reduced rate telephone service and the state energy assistance programs.

Phone cards may be purchased under this category for the purpose of connecting clients to HIV care and treatment services. This includes the need to provide ongoing communication between the client and the Oregon Housing Opportunities in Partnership (OHOP) Housing Coordinator.

Ryan White Program, Part B Case Managers must pre-authorize any payment for client services. In no case may program funds be used to pay client bills in arrears.

Reporting Requirement:

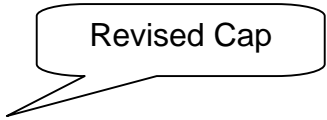
Unit: Payment

Report in RW CAREWare under "Utilities"

+ **HOME HEALTH CARE**

See Section 3.

HOUSING SERVICES



Revised Cap

Maximum Allowable (per Fiscal Year, July-June): \$1,000 per client per year total for all sub-services in this category.

The Oregon Housing Opportunities in Partnership (OHOP) program is a component of the HIV Care and Treatment Program, and OHOP regional Housing Coordinators are an important resource to clients with housing needs. Housing Coordinators facilitate in-depth client housing needs assessments and access to a full continuum of housing services provided directly through the OHOP program or through referral to other community-based housing providers. This continuum of housing services includes:

- Emergency shelter
- Transitional housing for homeless individuals and families
- Housing-related deposits
- Short-term rent, mortgage, and utility assistance to prevent people who are housed from becoming homeless
- Ongoing monthly rental assistance

In order to assure that Ryan White housing assistance funds are used as the funds of last resort, **Case Managers must assure that clients complete a Client Self-Assessment Form for the OHOP program whenever chronic client housing needs are identified.** Case managers submit this form as part of the OHOP Referral Packet in order to initiate ongoing consultation among the client, the Case Manager, and the local OHOP Housing Coordinator. Referral to the OHOP program does not preclude the use of Ryan White housing assistance.. When clients have emergency housing needs, HIV Case Managers should assist clients with those housing needs immediately, and then initiate contact with the local OHOP Housing Coordinator as soon as possible following provision of emergency housing services.

HIV Case Managers must consult with the OHOP Housing Coordinator in their service area if a client is determined to have chronic housing needs. Chronic housing needs are defined as: a person who needs ongoing supplemental housing assistance more than 2 weeks (14 days) in any fiscal year or a person whose needs are not met by the \$750 service cap/per FY. HIV Case Managers should call the program if they have any questions about client referral to the Housing Coordinator.

There are cases where the cost of housing service may exceed the criteria, i.e. OHOP is unable to assist a client within two weeks of initial referral, and the client is homeless or at risk of becoming homeless. An exception may be required in this circumstance. Please call the HIV Care and Treatment Program to discuss all exceptions to this policy.

Ryan White-funded housing assistance includes the provision of short-term assistance to support temporary or transitional housing to enable an individual or family to gain or maintain medical care. Related housing services may be housing in medical treatment programs for chronically ill clients (e.g., assisted living facilities), specialized short-term housing, transitional housing and non-specialized housing for HIV-affected clients. This category includes access to short-term emergency housing for homeless people.

Important: HRSA has revised the housing policy guidance describing the use of Ryan White Program funds for short-term or emergency housing services. Effective March 27, 2008 persons accessing Ryan White funds for short term or emergency housing services will be eligible to receive up to a lifetime of 24 months of cumulative assistance (beginning 3/27/08) per household. A month of assistance is defined as any amount provided within a calendar month regardless of the amount.

Ryan White Program Housing funds may not be distributed as direct cash payments to recipients for services. Additionally, Housing funds may not pay for: mortgage payments, recreational vehicles (RV), or any item that would increase the property value of the home (hot water heater, centralized heating and air conditioning, roof, vinyl siding, renovations, etc). Note that OHOP Housing Coordinators may be able to assist clients with these needs using OHOP or other non-Ryan-White funds.

Case Managers must pre-authorize any payment for client services. In no case may Ryan White Program funds be used to pay client bills in arrears.

If housing services include other services (i.e., meals, case management, etc.) these should also be reported under the appropriate category.

Clients accessing Housing Opportunities for Persons With AIDS (HOPWA) funds through the Oregon Housing Opportunities Program (OHOP) must continue in HIV Case Management and meet the program requirements of an annual Assessment. OHOP is a service component of the HIV Care and Treatment Program.

All OHOP clients must have a current ROI in both the OHOP file and the HIV Case Management file. The intent of the OHOP program is that HIV Case Managers, OHOP Coordinators and eligible clients will work together to develop and implement a client Housing Plan. HIV Case Managers cannot deny the OHOP program direct access to clients that have been referred to OHOP for housing assistance. Additionally, HIV Case Managers cannot refuse access to local landlords that have been identified in a specific client's Housing Plan.

RENT ASSISTANCE

Definition:

The full or partial monetary amount paid by a tenant or occupant of a dwelling to the owner/landlord for use of the dwelling in which the eligible client resides as their primary residence.

Program Guidance:

Use of Ryan White Program funds for short-term or emergency housing must be linked to medical and/or health care services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment. Client's care plan must document the necessity for this service and must be linked to the client's ability to stay in medical care.

Note that the OHOP program has access to HOPWA and other resources that can often meet the rent assistance needs of clients. Assist clients in completing an OHOP referral packet and consult with your regional OHOP Housing Coordinator to determine that Ryan White Program funds are the only resources available to meet a client's rent assistance needs before using Ryan White Program funds for rent assistance.

In a shared living situation, Ryan White Program funds may only be used to support that portion assigned to a client, based on the pro-rated portion of the private space used by the client in the rental unit (e.g. If a client shares a three-bedroom unit with two roommates, and has exclusive use of one of the three bedrooms, housing assistance funds may be used to support one-third of the total rental cost of the unit).

Reporting Requirement:

Unit: Week

Report in RW CAREWare under "Rent Assistance"

IMPORTANT: use the following matrix based on dollar amount of assistance versus full monthly rent amount to determine number of units to report:

<i>Assistance amount / Full monthly rent amount =</i>	<i>Units of Service</i>
<i>0.0 – 0.25</i>	<i>1 week</i>
<i>0.26 – 0.5</i>	<i>2 weeks</i>
<i>0.51 – 0.75</i>	<i>3 weeks</i>
<i>0.76 – 1.00</i>	<i>4 weeks</i>

For example: A client’s monthly rent amount is \$400. In order to gain or maintain access to HIV-related medical care or treatment, the client requires \$250 in rental assistance for the month. The assistance amount (\$250) divided by the full monthly rent amount (\$400) equals 0.63, so the Case Manager would record “3 weeks” as the unit of service.

Unit cost (“Price” in CAREWare) will be automatically calculated when you enter the total number of “Units” using the table above and the “Total” amount paid.

HOUSING-RELATED DEPOSITS

Definition:

Any monetary deposits required to secure and maintain housing for a client. This category could include security deposits, cleaning deposits, last month’s rent and utilities deposits (including telephone).

Program Guidance:

Note that the OHOP program has access to HOPWA and other resources that can often meet the housing-related deposit needs of clients. Assist clients in completing an OHOP referral packet and consult with your regional OHOP Housing Coordinator to determine that Ryan White Program funds are the only resources available to meet a client’s housing-related deposit needs before using Ryan White Program funds for housing-related deposits.

This category can also include application fees if the client is participating in the Oregon Housing Opportunities in Partnership Program (OHOP).

All refundable deposits must be returned to the agency paying the deposit, NOT directly to the client/tenant.

Reporting Requirement:

Unit: Payment

Report in RW CAREWare under “Housing-Related Deposits”

RESIDENTIAL FACILITY

Definition:

Housing services that include some type of medical or supportive service, including residential foster care and assisted living residential services.

Program Guidance:

Note that the OHOP program has limited access to HOPWA and other resources that can sometimes meet the residential facility needs of clients. Assist clients in completing an OHOP referral packet and consult with your regional OHOP Housing Coordinator to determine that Ryan White Program funds are the only resources available to meet a client's residential facility needs before using Ryan White Program funds for residential facilities.

Reporting Requirement:

Unit: Day

Report in RW CAREWare under "Residential Facility"

TRANSITIONAL HOUSING

Definition:

Transitional short-term emergency housing such as motels or hotels for purposes of moving or assisting an individual or family into a long-term stable living situation. This service may also apply to short term or emergency housing required to gain or maintain access to medical care.

Program Guidance:

The OHOP program does not have direct access to HOPWA or other resources that can meet the transitional housing needs of clients, but transitional housing assistance should be closely coordinated with planned access to long-term housing assistance for clients. Assist clients in completing an OHOP referral packet and consult with your regional OHOP Housing Coordinator to closely coordinate use of Ryan White Program funds for client's transitional housing needs with planned access to long-term housing assistance through OHOP and other housing resources.

Reporting Requirement:

Unit: Day

Report in RW CAREWare under "Transitional Housing"

LINGUISTICS SERVICES

Also known as "Translation Services"

Maximum Allowable (per Fiscal Year, July-June): \$250 per client per year.

Definition:

Provision of interpretation and translation services to include ASL (American Sign Language).

Program Guidance:

The intent of this service is to provide language for the purpose of assisting a client in understanding and accessing medical services. Ryan White Program, Part B funded providers should identify translation services which are available to clients for all commonly spoken languages.

Reporting Requirement:

Unit: 15 Minutes

Report in RW CAREWare under “Translation Services”

+ MEDICAL CASE MANAGEMENT

See HIV/AIDS Case Management Standards of Service document.

Definition:

A range of client-centered services that link clients 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 and support services and continuity of care, through ongoing assessment 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. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Program Guidance:

Case management activities under this category are provided by a licensed Registered Nurse or Nurse Practitioner. The individual will be educated in the scientific basis of nursing under defined standards of education and whose activities are related to the diagnosis and treatment of human responses to actual or potential health problems.

Reporting Requirement:

Unit: 15 minutes

Report in RW CAREWare under:

Face-to-Face Services:

- “RAF - RN Intake & Assessment: Face-to-face”
- “RRF - RN Reassessment: Face-to-face”
- “RIF - RN Case Management: Face-to-face”
- “RTF - RN Transfer & Discharge: Face-to-face”

Non-Face to Face Services:

- “RIN - RN Case Management: Non-Face-to-face”
- “RTN - RN Transfer & Discharge: Non-Face-to-face”
- “RN-Travel Time” (case management travel time on behalf of a client)

+ MEDICAL NUTRITION THERAPY

Maximum Allowable (per Fiscal Year, July-June): \$1300 per client per year total for all sub-services in this category.

Services provided with the intention of improving a client’s health through nutritional supplements, nutritional counseling and/or nutritious food.

NUTRITIONAL SUPPLEMENT

Definition:

An item that completes or adds to a client’s nutritional needs.

Program Guidance:

Nutritional supplements must be recommended by the client’s primary care provider.

Reporting Requirement:

Unit: Supplement

Report in RW CAREWare under “Nutritional Supplement”

NUTRITIONAL COUNSELING

Definition:

The provision of nutritional education and/or counseling provided by a licensed registered dietician outside of a primary care visit.

Program Guidance:

None.

Reporting Requirement:

Unit: Visit

Report in RW CAREWare under “Nutritional Counseling”

FOOD CARD/VOUCHER

Definition:

A card/voucher that cannot be converted to cash, allowing a client to purchase food products. The voucher should clearly state that purchase of alcohol and tobacco products are not allowed. *Note: A voucher can also be defined as payment to a store on behalf of a client.*

Program Guidance:

Food cards and vouchers under this category must be authorized by the RN case manager as a part of the client's nutritional assessment and be included as a part of the client's nutritional plan/care plan. Documentation of a current (within the past 12 months) Nutritional Assessment and identification of nutritional needs and goals in the client's Care Plan must be provided in the client's chart. Food provided under this category should be provided to a client with specific instructions for maintaining nutrition/overall health based on the RN assessment of need (i.e. client needs high protein food, low sodium, high fat meals, etc). RN case managers should coordinate with the client's primary physician when developing the client's nutritional plan.

Please see "Emergency Financial Assistance" for information on how to assist clients who are not determined to have a nutritional need for specific food products but that still need supplemental food assistance. Clients who qualify for food under EFA do not qualify for food assistance under Medical Nutritional Therapy.

Case managers may provide assistance to clients under either Medical Nutritional Therapy OR Supplemental Food Assistance as described in the client's most current Care Plan, but clients may not receive both at the same time.

For nutritional guidance:

<http://www.aids-etc.org/aidsetc?page=etres-display&resource=etres-193>

Reporting Requirement:

Unit: Card of Voucher

Report in RW CAREWare under "Nutritional Food Voucher"

Revised Unit
Definition

MEDICAL TRANSPORTATION SERVICES

Travel Lodging appears under "Other-EFA"

Ryan White Programs are required to focus resources on core medical services (see Section 1) and are required to provide assurances that funded support services are directly linked to assisting clients to access and successfully remain in HIV treatment. Therefore, support service documentation showing this linkage is required and case managers must document, in the client's file, the purpose of all transportation purchases. Transportation should not be authorized unless the client clearly identifies their need related to accessing a care provider, dentist,

pharmacy or a core medical service reflected in the client's care plan. It is recommended that the case manager request the client to return a signed "visit slip" to show the appropriate use of this service.

Maximum Allowable (per Fiscal Year, July-June): \$500 per client per year total for all sub-services in this category.

Definition:

Conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services. May be provided routinely or on an emergency basis. Medical Transportation should be provided through:

- A contract(s) with a provider(s) of such services;
- Voucher or token systems;
- Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed).

PUBLIC TRANSPORTATION-SINGLE TRIP

Definition: See Above

Program Guidance: None

Reporting Requirement:

Unit: Trip

Report in RW CAREWare under "Public Transport-single trip"

PUBLIC TRANSPORTATION-MONTHLY PASS

Definition: See Above

Program Guidance:

Bus passes should be purchased under the local transit system's disability rate wherever possible.

Reporting Requirement:

Unit: Month

Report in RW CAREWare under "Public Transportation-monthly pass"

GAS CARD

Definition: See Above

Program Guidance:

Mileage may not be reimbursed directly to a client. Estimated value for gas voucher/card should meet or exceed the fuel needed for the trip requested by the client. The amount of the gas voucher/card should be based upon (1) number of miles estimated for the trip,

divided by the (2) client-reported miles per gallon for their vehicle (if client does not know, the average is 15 miles-per-gallon), and multiplied by the (3) current market value of gasoline. (For example, client needs to visit specialist and the round trip is 150 miles. Divide 150 miles by 15 miles-per-gallon to equal 10 gallons of gasoline required for the trip. If the current market value is \$3.50 for regular gasoline. The gas voucher/card should be for \$35.00).

Reporting Requirement:

Unit: Card or Voucher

Report in RW CAREWare under “Gas Card”

TAXI FARE

Definition: See Above

Program Guidance: None

Reporting Requirement:

Unit: One-Way Trip

Report in RW CAREWare under “Taxi fare”

OTHER SPECIAL TRANSPORT SERVICES

Definition:

Conveyance services provided directly to a client by licensed Medical Transportation provider so that the client may access health care or support services. May be provided routinely or on an emergency basis.

Program Guidance: None

Reporting Requirement:

Unit: Payment

Report in RW CAREWare under “Other special transportation svcs.”

+ MENTAL HEALTH SERVICES

See Section 3.

+ **ORAL HEALTH CARE**

Also known as “Dental Services”

Definition:

Diagnostic, preventative, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Program Guidance:

This service does include medications dispensed or administered during the course of the service visit. Denture replacement or realignment is covered in this category.

Cosmetic procedure and restorations are not allowable unless they are necessary to alter, restore or maintain occlusion (close mouth) or nutrition. Exceptions may be made with program authorization for infants, children and youth.

This service is not available to “affected” family members.

Maximum Allowable Tier 1 Counties: (per Fiscal Year, July-June): \$500 per client per year. Tier 1 counties include all counties served by the Clock Tower Dental Clinic: Benton, Coos, Crook, Curry, Deschutes, Douglas, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Linn and Malheur.

Maximum Allowable Tier 2 Counties: (per Fiscal Year, July-June): \$1500 per client per year. Tier 2 counties include: Baker, Clatsop, Gilliam, Grant, Hood River, Lincoln, Marion, Morrow, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler,

Reporting Requirement:

Unit: Visit

Report in RW CAREWare under “Dental Services”

+ **SUBSTANCE ABUSE: OUTPATIENT TREATMENT**

See Section 3.

SUBSTANCE ABUSE: RESIDENTIAL TREATMENT

See Section 3.

EXCEEDING SERVICE CAP DOCUMENTATION

Exceptions to the “Maximum Allowable” service caps can be made locally for clients who meet the following eligibility requirements:

- Client is actively enrolled in HIV case management.
- The service cap waiver will facilitate the client’s access to one of the core medical services listed in Section 1.
- The client has a current HIV Case Management Care Plan that includes a plan to help the client meet the service need, without utilizing Ryan White funds, on an ongoing basis.
- The client has been assessed at Acuity Level 3 or 4.

New

Exceptions to the above policy may be made for service waivers requested for women, infants, children or youth.

Process:

Download and complete the “Exceeding Service Cap Documentation” form from the program website at www.healthoregon.org/hiv. The form includes the following required information:

- Total amount that is being requested to be waived;
- Acuity level and date acuity worksheet was completed;
- The reason for the requested waiver;
- How the requested service funding will facilitate the client’s access to core medical services (to be completed by the RN Case Manager); and
- The signature of the RN Case Manager.

Additionally, a copy of the client’s Care Plan (could include progress notes, RW CAREWare case notes or Care Plan form) and/or additional documentation to support the local decision to exceed maximum caps must also be attached.

Submit the required documentation and fax or mail to:

HIV Care and Treatment Program
800 N.E. Oregon Street, #1105
Portland, OR 97232
Fax: 971-673-0177

The HIV Care and Treatment Program will verify receipt of the documentation and that eligibility requirements for waiving a service cap are met. Email verification will be sent to the requesting case manager.

SECTION 3: State Managed Services

Program Policies:

See the State Managed Services Policies and Procedures and the State Managed Services Funding Request Instructions for the program policies and other information at www.healthoregon.org/hiv

+ **HOME HEALTH CARE**

Maximum Allowable (per Fiscal Year, July-June): \$2000 per client per year total for both Professional/Specialized and Paraprofessional Home Health Care.

PROFESSIONAL/SPECIALIZED HOME HEALTH CARE

Definition:

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.

Program Guidance:

This service is not available to “affected” family members.

Reporting Requirement:

Paid by State program. Local jurisdictions will not report this service in RW CAREWare.

PARAPROFESSIONAL HOME HEALTH CARE

Definition:

Non-medical care provided in the home setting for persons living with HIV/AIDS whose home care needs are not adequately covered by other resources. Non-medical care involves assistance with daily life activities: homemaker, home health aide, personal care and attendant care services.

Program Guidance: This category does not include inpatient hospital services or nursing home and other long term care facilities. This service is not available to “affected” family members.

Reporting Requirement:

Paid by State program. Local jurisdictions will not report this service in RW CAREWare.

+ **MENTAL HEALTH SERVICES**

Definition:

Provision of inpatient and/or outpatient psychological or psychiatric treatment and/or counseling services. Services to include individual therapy and groups, and case consultations with other service providers when appropriate.

This service is not available to “affected” family members.

Program Guidance:

Services must be provided by a mental health professional licensed or authorized within the State, including psychiatrists, psychologists, clinical nurse specialists, social workers, and counselors.

Maximum Allowable (per Fiscal Year, July-June): \$6500 per client per year.

Reporting Requirement:

Paid by State program. Local jurisdictions will not report this service in RW CAREWare.

+ **ORAL HEALTH CARE**

Also known as “Dental Services”

Definition:

Diagnostic, preventative, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Program Guidance:

This service also includes medications dispensed or administered during the course of the service visit (prescribed medications must be paid for by local funds and reported under “Drug Reimbursement”). Denture replacement or realignment is covered in this category.

Cosmetic procedure and restorations are not allowable unless they are necessary to alter, restore or maintain occlusion (close mouth) or nutrition. Exceptions may be made with program authorization for infants, children and youth.

This service is not available to “affected” family members.

Tier 1 Counties: Tier 1 counties include all counties served by the Clock Tower Dental Clinic: Benton, Coos, Crook, Curry, Deschutes, Douglas, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Linn and Malheur. The Clock Tower Dental Clinic, administered by HIV Alliance provides free dental care to persons living within the Tier 1 region. The HIV Alliance Dental Case Manager will assist case managers and clients to coordinate services and transportation to and from the clinic.

Case managers must consult with the HIV Alliance Dental Case Manager prior to utilizing Ryan White funds for oral health care services. If applicable, the Dental Case Manager will sign/authorize the SMS application prior to submission. Persons will be required to receive dental services from the Clock Tower Clinic unless extenuating circumstances apply and prior approval is received by the Clock Tower Clinic. SMS will not approve funding requests without the Dental Case Manager signature.

For more information on the dental services provided by the Clock Tower Clinic:
<http://www.hivalliance.org/dentalclinic.html>

Tier 2 Counties: Tier 2 counties may access SMS Oral Health Services directly through the HIV Care and Treatment Program, as stated in the State Managed Services program policies. These counties include: Baker, Clatsop, Gilliam, Grant, Hood River, Lincoln, Marion, Morrow, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco and Wheeler

Recommended Maximum Allowable (per Fiscal Year, July-June): \$1000 per client per year. HIV Case Managers have the ability to request funds based on the client need (a dental services plan must be provided with the State Managed Services Program Request Form. See the State Managed Services Program Request Form Instructions for details.

Reporting Requirement:

Paid by State program. Local jurisdictions will not report this service in RW CAREWare unless using local Ryan White Part B funds (see Section 2).

SUBSTANCE ABUSE SERVICES

Maximum Allowable (per Fiscal Year, July-June): \$5000 per client per year total for both Substance Abuse: Outpatient Treatment and Substance Abuse: Residential Treatment.

+ OUTPATIENT THERAPY

Definition:

Provision of treatment and/or counseling to address substance abuse (including alcohol) addictions, provided in an outpatient service setting, rendered by a physician or under the supervision of a physician.

Program Guidance:

Funds may be used for outpatient drug and/or alcohol substance abuse treatment. Such services should be limited to:

- the pre-treatment program of recovery readiness;
- mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse;
- outpatient drug-free treatment and counseling;

- methadone treatment;
- neuro-psychiatric pharmaceuticals; and
- relapse prevention.

Funds may not be used for syringe exchange programs.

This service is not available to “affected” family members.

Reporting Requirement:

Paid by State program. Local jurisdictions will not report this service in RW CAREWare.

RESIDENTIAL THERAPY

Definition:

Provision of treatment and/or counseling to address substance abuse (including alcohol) addiction, provided in a residential health service setting (short-term), rendered by a physician or under the supervision of a physician.

Program Guidance:

Funds may be used for outpatient drug or alcohol substance abuse treatment. Such services should be limited to:

- the pre-treatment program of recovery readiness;
- mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse;
- methadone treatment;
- neuro-psychiatric pharmaceuticals; and
- relapse prevention.

The following limitations apply to use of Ryan White Program Funds for residential services.

- Funds may not be used for inpatient detoxification in a hospital setting;
- However, if detoxification is offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of a hospital), Ryan White Program funds may be used for this activity;
- If the residential treatment facility is in a facility that primarily provides inpatient medical or psychiatric care, the component providing the drug and/or alcohol treatment must be separately licensed for that purpose.

This service is not available to “affected” family members.

Reporting Requirement:

Paid by State program. Local jurisdictions will not report this service in RW CAREWare.