Kentucky HIV/AIDS Care Coordinator Program (KHCCP)

Guidelines Manual

Kentucky Cabinet for Health and Family Services
Department for Public Health
Division of Epidemiology and Health Planning
Infectious Disease Branch
HIV Section

Effective December 2016
Updated: November 2021

Contributions

This manual was developed in 2003 by members of the Kentucky HIV/AIDS Care Coordinator Program (KHCCP) Forms Committee. Each member contributed invaluable knowledge and time to this project. The purpose of this manual is to provide Standard Operating Procedures (SOP) and information to provider agency staff regarding procedures, policies, mandates and guidelines for the KHCCP.

The HIV/AIDS Section revised the manual in 2013 to assure compliance with the new Health Resources and Services Administration (HRSA) model of Care and the Ryan White legislative Requirements. This manual was updated again in 2016 to include the revised Standards of Care.

Kentucky HIV/AIDS Care Coordinator Program
Guidelines Manual

CONTENTS

Part I - KHCCP Guidelines

KHCCP Manual Appendices .... Page 4
A. Introduction/Goals/Objectives.. Page 5-6
B. Client Eligibility Criteria.. Page 6-8
C. Client and Medical Case Manager Rights/Responsibilities.............. Page 8-9
D. Client Intake/Assessment/Documentation.................................. Page 9-11
E. Informed Participation Agreement (IPA)..................................... Page 11
F. Individualized Care Plan (ICP).. Page 12
G. Release of Information (ROI).. Page 12
H. Grievance Procedures.. Page 12
I. Confidentiality.. Page 12
J. Retention of Records... Page 12
K. Accessing/Establishing Referral Services/Identifying Resources....... Page 12
L. Removal of Clients from KHCCP Program.................................. Page 12

Part II- Overview of Part B Programs

A. Kentucky AIDS Drug Assistance Program (KADAP)....................... Page 13
AIDS Drug Assistance Program... Page 13
B. Kentucky Health Insurance Continuation Program (KHICP)............. Page 13
Kentucky Home Health Program.. Page 13
C. Kentucky HIV/AIDS Care Coordination Program (KHCCP)............... Page 13

Part III-Service Categories

A. Introduction.. Page 14
B. Overview of Core and Support Services... Page 14

Part IV- Fiscal Management and Administration

A. Resource Directory.. Page 15
B. KHCCP Consumer Survey.. Page 15
C. Required Reports, Training and Conferences............................ Page 15
D. Funding Periods.. Page 16
E. Priority Services.. Page 16
F. Reallocation of KHCCP Funding... Page 17
G. Provider Agency Responsibilities .... Page 17
H. Failure to Comply with KHCCP Guidelines.................................. Page 17
I. Ownership of Equipment.. Page 17
J. Ownership of Client-Related Data.. Page 17
K. Brochures/Printed/Published Materials...................................... Page 18
L. Health Insurance Portability and Accountability Act (HIPAA)........... Page 17
M. Travel Procedures.. Page 18

KHCCP MANUAL APPENDICES

APPENDIX 1	Standards of Care
APPENDIX 2-a/b	Client Intake Report / Risk Factor Assessment
APPENDIX 3	Statement of No Income Form
APPENDIX 4	Medical Documentation Form
APPENDIX 5	Informed Participation Agreement (IPA)
APPENDIX 6	Release of Information (ROI) Form
APPENDIX 7	Individualized Care Plan (ICP)
APPENDIX 8	Security Forms/Non-Disclosure Forms
APPENDIX 9	KHCCP Statement of No Change Form
APPENDIX 10	Care Coordinator Program Locations
APPENDIX 11	KHCCP Grievances Procedures
APPENDIX 12	Client Survey
APPENDIX 13	HIPAA Release Form
APPENDIX 14	Clinical Information Form (CIF)
APPENDIX 15	Incarceration Policy

PART I
KHCCP GUIDELINES

A. Introduction/Goals/Objectives

The Kentucky HIV/AIDS Care Coordinator Program (KHCCP) is funded through Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009. The Ryan White Program is a federal program created to address health care and service needs of People Living With HIV/AIDS (PLWH/A). First enacted in 1990 as the Ryan White Care Act, the legislation was adjusted in 2006 to accommodate new and emerging needs, such as an increased emphasis on funding of core medical services and changes in funding formulas. The main goals of the Act are to: 1) reduce new HIV infections; 2) increase access to care and improve health outcomes for PLWH/A; 3) reduce HIV-related disparities and health inequities; and 4) achieve a more coordinated national response to the HIV epidemic.

Any Ryan White program should include the following principles:

- Local planning and prioritization of funding based on needs assessment;
- Involvement of PLWH/A ("consumers") in the planning process;
- Fund core and support services; and
- Provide quality of care.

The intent of the KHCCP program is to facilitate the provision of quality care and services to PLWH/A in a timely manner that is consistent across a continuum of care. It provides a range of core and support services to the Commonwealth's HIV infected individuals. Services are provided through contracted providers that offer clients local access to needed services. The KHCCP provides access to Ryan White Part B services, including the Kentucky AIDS Drug Assistance Program (KADAP) and the Kentucky Health Insurance Continuation Program (KHICP).

Goals and Objectives of the KHCCP:

The primary goal of the KHCCP is to assist HIV infected individuals to access the Ryan White Part B services by becoming a Part B client through an eligibility process. Objectives include:

1. To provide benefit/entitlement counseling and referral services by assisting clients to access KADAP services, public and private programs for which they may be eligible. These programs include ADAP, KHICP, Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other State and local health care and supportive services.

2. To provide timely and coordinated access to medically appropriate levels of health and support services and continuity of care through an ongoing assessment/reassessment of client needs and personal support systems.

3. To provide whenever necessary treatment adherence, counseling, initial assessment of medical and non-medical service needs through the development of a comprehensive,

Individualized Care Plan (ICP). This includes assessing the efficacy of the care plan by periodical evaluation and adjustment of the plan. The provision of adherence counseling by a medical case manager for complex HIV/AIDS medications requires:

a. Knowledge of the medication interaction and side effects;
b. An initial assessment of client medication regimen and medical treatment plan;
c. An initial assessment of the medical and non-medical service needs;
d. The development of an ICP;
e. Documentation of the coordination of services required to implement the ICP; and
f. Regular monitoring of the plan to assess efficacy.

4. To optimize the client's self-care capabilities by empowering him/her to become self-sufficient. This includes: (1) assisting clients in examining and assessing their particular situation, (2) obtaining pertinent information that enables them to make informed decisions, and (3) encouraging the client taking responsibility for as many aspects of his/her life as is mentally and physically capable.

5. To facilitate coordination between service providers, the physician and the available formal support systems.

6. To identify and establish a referral system with area health care and social service providers, community based HIV organizations, and HIV counseling and testing sites.

7. To ensure that duplication of services by formal and informal support systems does not occur.

8. To provide the client with educational information regarding disease transmission and maintenance of a healthy lifestyle, encourage good health habits, and provide secondary prevention methods over the course of continued case management.

9. To identify and document patterns of service needs and advocate for effective policies and resource development.

10. To facilitate the initial and on-going education of health care and social service providers to the issues related to HIV disease.

11. To ensure that Ryan White Part B funding is appropriately used to meet the documented needs of HIV infected individuals throughout the state in a manner that coordinates funding streams and makes use of existing community resources and services.

B. Client Eligibility Criteria for Ryan White Part B Services:

Client Reporting/Eligibility Guidelines:

Each client receiving services funded by the Ryan White Part B program must complete an application and provide the documentation required within 30 days of the first KHCCP visit or as necessary for any other required update:

Household Size

All those individuals living in a single residence including client, spouse, and children under the age of 18 and other family and non-family members that contributes toward the daily living expenses.

Eligibility

An individual may be considered eligible for KHCCP if he or she has a maximum gross household annual income less than or equal to **500% of the Federal Poverty Level.**

Income to be counted in determining eligibility (applies only to household members over 18) **may include:**

- Employment income
- Alimony payments
- Social Security Disability Insurance (SSDI)
- Supplemental Security Income (SSI)
- Unemployment benefits
- Veteran Administration benefits
- Benefits income of individuals' dependent children (survivors benefits)
- Retirement benefits
- Private disability
- Worker's compensation
- Interest income or other investment income
- Rental property income
- Cash support from family and friends
- Food stamps
- Labor pool employment

Documentation as evidence of income required annually

- Two most recent pay stubs or
- Most recent W-2 forms or 1099
- Award letter or statement from Social Security
- Unemployment check or letter
- Most recent calendar year's tax return
- Complete food stamp award letter
- If self-employed, provide complete tax return
- Worker's compensation letter
- Signed Self-Declaration Statement of No Income or no change (only for those clients who report having no income).

HIV status

Provide a complete name-linked verification of HIV positive status. The following items may be used to verify HIV status:

1. Two (2) reactive rapid HIV test conducted on the same day; or a positive confidential Western Blot test result;
2. Signed and dated written statement from a medical care provider utilizing the Clinical Information form (CIF);
3. A Testing counselor, who has been certified in the Centers for Disease Control and Prevention (CDC) training "Fundamentals of HIV Prevention Counseling," may sign and verify HIV status utilizing the CIF; or
4. A discharge summary or other hospital record that verifies HIV positive status.

Please note that documentation of HIV status is only required upon application. It does not need to be supplied for re-certification.

Residency
Client verification must match the physical address of record and be verified by one of the following:

1. Valid Kentucky driver's license or Kentucky Identification Card;
2. Copy of a signed lease agreement;
3. Current utility bill;
4. Other official mail; or
5. Statement from a person providing room and board.
6. An individual who is homeless can complete a self-declaration of no change in status and will be documented as Homeless in the client's case record. A note must also be placed in CAREWare.

- **Re-certification:**
  1. To maintain eligibility for KHCCP services, clients must be recertified at least every six (6) months. The purpose of the recertification process is to: (a) ensure that an individual's residency, income, and insurance statuses continue to meet the grantee eligibility requirements and (b) verify that Ryan White Part B is the payer of last resort. The recertification process includes checking for the availability of all other third party payers.
  2. A medical provider should complete a Clinical Information Form (CIF)(see Appendix 13) for all new clients and those applying for recertification. While a new CIF is expected with each annual recertification, it is not a condition of recertification approval. In other words, absence of a completed CIF should not be grounds for denying eligibility.
  3. Recertification is performed during an appointment six (6) months after the client's birth month. A statement of no change can be signed and submitted at the recertification appointment, provided there is in fact no change in the client's status or circumstances.
  4. At the six-month recertification appointment, the client may sign a self-attestation Statement of No Change (Appendix 8) in lieu of proof of income resident insurance (private, Medicaid, Medicare Part A, B, C and D) or a self-declaration of no change in insurance or residency status must be submitted, documented on the KHCCP Checklist, placed in the client's paper or electronic chart and recorded appropriately in CAREWare.

Other Requirements
Sign and date the Informed Participation Agreement (IPA).
Sign and date the agency's HIPAA Release of Information (ROI) form(s).

Incarceration Policy

- Please see Appendix 15 for the current Incarceration Policy

C. Client and Provider Agency Staff Rights and Responsibilities:

- **Client Rights:**
  1. To be treated with consideration, dignity, and respect regardless of age, race, gender, economic status, sexual orientation, mode of transmission, disability status, mental status, family status, nationality, ethnic origin, religious beliefs, or political affiliations.
  2. To be informed both verbally and in writing about services from the agency and the KHCCP.
  3. To refuse treatment or assistance and to be advised of the consequences of these decisions.
  4. To expect privacy and confidentiality of all information related to care and assistance within the required regulations and laws governing client files.
  5. To ask questions and make choices about available assistance and services provided.

6. To file a grievance regarding services provided or denied (please see Appendix 10 for details of the KHCCP Grievance Procedures). The proper grievance procedures must be followed in order to process any grievance.

- **Client Responsibilities:**
  In order to maintain services, the client is expected to:
  1. Provide accurate, certified as applicable, information and documentation, at all times, updating as needed and/or requested, regarding income, household size, residency, living expenses, insurance, medications, medical care, and HIV/AIDS status;
  2. Initiate and file the proper grievance procedure, as per agency and KHCCP procedure, in the event of necessity;
  3. Refrain from:
     a. Disclosure of information regarding other clients;
     b. Repeated disregard for the established ICP; and
     c. Frequently canceling and rescheduling appointments.

- **Provider Agency Staff Rights:**
  1. To be treated with consideration, respect, and dignity by clients and staff members, regardless of age, race, gender, sexual orientation, family status, religious beliefs, nationality, ethnic origin, or political affiliations.
  2. To expect the correct information from those seeking assistance, this includes but is not limited to, financial, social, and demographic information.
  3. To expect the cooperation and participation of clients in determining what course of action can be provided and what best fits the clients' situation with regard to services.

- **Provider Agency Staff Responsibilities:**
  1. To treat clients and staff members with consideration, dignity, and respect regardless of race, age, gender, income, sexual orientation, disability status, mental status, family status, religious beliefs, nationality, ethnic origin, or political affiliations.
  2. To ensure that all assisted clients fall within federal and state rules outlined in the KHCCP Guidelines.
  3. To sign, date, and comply with a confidentiality statement regarding client files.
  4. To maintain updated KHCCP guidelines, CAREWare database, and forms as provided by the KHCCP.
  5. To stay informed of current KHCCP requirements.
  6. To work with the client to help him/her explore the various consequences of his/her care plans, including minimizing or eliminating behaviors that put others at risk for HIV.
  7. To help the client develop a plan that would best fit his/her situation.
  8. To provide the client with an ICP that is signed and agreed upon by the client.
  9. To provide each client with a copy of the overview of services that is offered by the provider agency.
  10. To maintain updated client files in CAREWare and accurate reporting information as outlined in the KHCCP Guidelines.
  11. To encourage the client to see their medical provider at least two (2) times within a twelve (12) month period.

D. Client Intake/Assessment Documentation:

- **Client Intake:**
    1. Client demographic and personal information must be maintained in CAREWare and in a paper or electronic version of this form maintained in client's chart.
    2. All personal and demographic information for each client must be collected within 30 days of initial face-to-face contact.
    3. Information recorded must be of an objective, factual nature.
    4. Forms completed during an intake must be signed and dated by the client or designee, and the medical case manager who conducts the intake. The ROI must be signed by a witness.

- **Case Documentation:**
    1. A client's Enrollment Status must be documented in CAREWare as one of the following:
        - **Active -** a client who is new or returning to the KHCCP within one calendar year.
        - **Referred or Discharged -** a client who: (1) was referred to another KHCCP provider agency and will not continue to receive services at the agency, (2) was discharged from a KHCCP provider agency because they became self-sufficient and no longer need Ryan White Part B services, or (3) or who leaves voluntarily or refuses to participate in KHCCP.
        - **Removed -** a client who was removed from KHCCP due to violation of rules.
        - **Incarcerated -** defined as "an individual involuntarily confined in association with an allegation or finding of behavior that is subject to criminal prosecution. Thus, the policy applies to individuals who are involuntarily living in the secure custody of law enforcement, judicial, or penal authorities. Furthermore, this includes individuals who reside in a community setting (which is not part of the institutional setting of the prison system such as a pre-release residential half-way house) if the individual is still involuntarily confined to those settings."
        - **Relocated -** a client has moved out of the agency's service area and will not continue to receive Ryan White Part B services at the provider agency's location.

    2. A client's vital status must be documented in CAREWare as one of the following:
        - **Alive -** client is still living.
        - **Deceased -** client has died.
        - **Unknown -** client's vital status is unknown.

- **Continued Client Case Monitoring:**
    1. Provider agency staff is responsible for maintaining and updating all client information in CAREWare and maintaining a paper or electronic copy.
    2. Progress notes are to be recorded in PDA (Problem\Discussion\Action) format in a factual, non-subjective manner.
    3. Two (2) contacts with clients per year are required. Client contact includes:
        - One contact by way of face-to-face, phone, written, etc.
        - At least one contact **MUST** be made face-to-face.
    4. In the event a client is de-certified from the KHCCP program, the medical case manager must change the status in CAREWare to "Inactive" and provide an explanation as to why the client was decertified.
    5. Clients who return to the KHCCP will be recorded as "Active" in CAREWare. These clients are not considered new to the KHCCP.

- **Prescription Assistance:**
  a. **Non-KADAP formulary related medication assistance procedures:**
    - Non-KADAP formulary related medications are paid and entered under Outpatient/Ambulatory Health Services.
    - Prescription assistance is provided only as funding permits.
    - Examples of drug categories allowed for Non-KADAP formulary related medications include:
      1. Cardiovascular/Lipid/Triglyceride medications
      2. Hypertension medications
      3. Diabetes medications
      4. Mental health medications
      5. Neuropathy medications
      6. Other medications as determined by a medical provider

- **CAREWare:** Provider staff is required to track and report unduplicated client-level demographic, medical and other service data using the HRSA-provided CAREWare database for comprehensive data entry.
- Regional provider staff shall maintain, in real time, demographic and service data for all new and existing clients enrolled in KHCCP. CAREWare reports shall also reflect the total number of clients who have been made inactive, as well as the number of clients transferred, re-activated and those who are deceased.

- **Security:**
  - Paper client charts must be maintained in a locked file cabinet, desk, or behind a locked office door.
  - Electronic charts must be maintained according to HIPAA privacy requirements.
  - Client charts, whether electronic or on paper, shall be stored in a location or filing equipment that reduces the possibility of destruction of such records in case of natural or other type of disaster.
  - Computers with access to CAREWare must be password protected at all times.

- **Assessment:**
  - The KHCCP Client Intake Form (Appendix 2a) shall be utilized for new clients.

- **Case Numbering:**
  - Client paper or electronic chart shall be assigned the Uniform Resource Name (URN) number that is automatically assigned to the client record in CAREWare.
  - The URN number must be present in the paper copy or electronic chart.

E. Informed Participation Agreement (IPA):

- Written agreement between the client and the contracted agency.
- Provider agency staff is responsible for providing client a copy of the IPA.
- Provider agency staff must assist client in his/her understanding of the agreement and what it says.
- Once the client understands the IPA, the client or designee and the provider agency staff must sign and date the back page of the IPA.

- A copy of the IPA must be given to the client and the original signed copy of the IPA/Annual Renewal Form (ARF)/electronic signature must be maintained in the client's paper or electronic file.

F. Individualized Care Plan (ICP):

- The ICP is a step-by-step plan of actions that the client and provider agency staff develops together.
- The ICP is maintained according to the client's most immediate medical and/or support needs.
- Lack of income or medical payer source must be addressed on the ICP.
- The client will prioritize his/her needs with a list of activities/strategies that the client and provider agency staff will be responsible for doing in order to complete the ICP.
- The ICP must be evaluated at least every 6 months, with adaptations as necessary.

G. Release of Information (ROI):

- Clients will sign the applicable Health Insurance Portability and Accountability Act (HIPAA), ROI form each year and applicable program confidentiality forms.
- Client data is protected under HIPAA.

H. Grievance Procedures:

- Clients are informed about the provider agency's grievance procedures and KHCCP Grievance Procedures (Appendix 10) at the time of the initial intake and how she/he may access and initiate the process.
- At intake, client will sign the Grievance Procedure, and at annual re-certification client will initial the Annual Review Form.

I. Confidentiality:

- The confidentiality of all client files will be maintained regardless of their vital status.
- All information will be treated with the strictest confidentiality, and will not be released to any entity outside the Kentucky Division of Epidemiology and Health Planning unless the client authorizes the release of confidential information to others or as mandated by law.
- All provider staff must sign a confidentiality statement (see Appendix 7) that mandates no breeches of confidentiality.
- Copies of the signed statement must be sent to the KHCCP and maintained in the provider agency record.

J. Retention of Records

Client case management and or medical records are not to be destroyed under any circumstance. Billing, office records and contracts may be destroyed after five (5) years.

K. Accessing and Establishing Referral Services/Identifying Existing Resources:

- Provider staff must identify existing services available in the area.
- Provider staff is responsible for initiating contact with existing service agencies/organizations, in order to educate them regarding the KHCCP.

- Provider staff must maintain an updated list of service agencies/organizations.

L. Removal of Clients from KHCCP Program

No eligible client(s) may be removed from KHCCP or KADAP without the express approval of the Ryan White Part B Staff and the Program Manager.

Part II
Overview of Part B Programs

A. Kentucky AIDS Drug Assistance Program (KADAP)

Administered by the HIV/AIDS Section within the Infectious Disease Branch and the Division of Epidemiology of the Kentucky Department for Public Health, the Kentucky AIDS Drug Assistance Program (KADAP) is much more than a drug distribution program. KADAP provides access to health care to the residents of Kentucky with HIV infection who are uninsured or underinsured through the AIDS Drug Assistance Program (ADAP) and the Kentucky Health Insurance Continuation Program (KHICP).

- **Kentucky AIDS Drug Assistance Program (KADAP)**
  Pays for medications for the treatment of HIV/AIDS and opportunistic infections. The drugs paid for by KADAP can help people with HIV/AIDS live longer and treat the symptoms of HIV infection. KADAP can help people with no insurance or those under insured.

- **Kentucky Health Insurance Continuation Program (KHICP)**
  Pays for cost effective health insurance premiums for eligible participants with health insurance including, Medicare Part D, private insurance, employer sponsored policies, and insurance opportunities arising from the implementation of the Affordable Care Act (ACA) and Medicaid Expansion in Kentucky.

- **Kentucky Home Health Program (KHHP)**
  Pays for home care services for chronically medically dependent individuals as ordered by their doctor. The program covers home health aide services, intravenous therapy administration, supplies, and durable medical equipment provided through enrolled home health care agencies

B. Kentucky HIV/AIDS Care Coordination Program (KHCCP)

For the purpose of funding, the Part B formula service program is divided the state into six regions and at least one provider agency is funded in each region. Funding is awarded on a competitive basis to provider agencies through a Request for Proposal process. The flagship service of the KHCCP program is medical case management services, which assess the need and offers core and support services to the client. By making medical case management the focus of service delivery by referral to in-house or area services, the program is able to effectively monitor the client services and provide the client with a cohesive, comprehensive service delivery.

Part III
Service Categories

Introduction

Ryan White service categories listed below represent the only allowable uses of Ryan White Part B HIV/AIDS Program funds. The Kentucky HIV/AIDS Section, along with respective planning bodies, makes the final decision regarding the specific services to be funded under their grant.

The KHCCP has developed criteria by which the agencies will implement the core and medical services as defined by HRSA. When applying for Ryan White Part B funding for core and support services in the Commonwealth, please refer to the 2016 Standards of Care in Appendix 1.

Core Services:
Early Intervention Services (EIS)
Health Insurance Premiums and Cost-Sharing Assistance for Low-Income Individuals
Home and Community-Based Health Services
Home Health Care
Hospice Services
Medical Case Management, including Treatment Adherence Services
Medical Nutrition Therapy
Mental Health Services
Oral Health Care
Outpatient/Ambulatory Health Services
Rehabilitation Services
Substance Abuse Outpatient Care

Support Services:
Child Care Services
Emergency Financial Assistance
Food Bank/Home Delivered Meals
Health Education/Risk Reduction
Housing
Legal Services
Linguistic Services
Medical Transportation
Non-medical Case Management Services
Other Professional Services
Outreach Services
Permanency Planning
Psychosocial Support Services
Referral for Health Care and Support Services
Respite Care
Substance Abuse Services (residential)

The following core services are not part of the KHCCP:
AIDS Drug Assistant Program (ADAP)

Part IV

FISCAL MANAGEMENT AND ADMINISTRATION

A. Resource Directory:

- Provider agency staff is to maintain a resource guide of all service agencies/organizations in their area.
- The resource guide should be a detailed listing of the service area resources inclusive of the agency name, address, phone number, contact person as well as a summary of the specific service or services provided by each agency/organization.
- This listing should be available annually to the KHCCP Administrator.

B. KHCCP Consumer Survey:

- Each funded agency is required during the month of July to conduct a client satisfaction survey. The results must be submitted to the KHCCP Administrator by October 31st of each year.

C. Required Reports, Trainings, and Conferences:

CAREWare Reports:

1. Monthly electronic reports shall be submitted by each funded agency no later than the 1st day of each month. The following CAREWare reports shall generated and submitted to the KHCCP Administrator by the 1st day of each month:
   a. CAREWare Completeness Report
   b. CAREWare Validation Report
   c. CAREWare Client Report
   d. CAREWare Financial Report
2. Additional CAREWare reports may be required to assist the KHCCP Administrator in the submission of the annual Ryan White HIV/AIDS Program Services Report (RSR).

Monthly Financial Reports:

1. Invoices per service are to be submitted on provided format and are due by the 15th of each month.
2. Variance with budget versus expense reports are to be submitted with monthly invoices.

Quality Management/Assurance Report:

1. Quality management reports (chart audits) are due to the KHCCP Administrator 30 days following the preceding quarter. First Quarter reports (January-March) are due April 30; Second Quarter reports (April-June) are due July 30; Third Quarter (July-September) are due October 30; and Fourth Quarter (October-December) are due January 30.

Ryan White Part B Site Visits:

For the purposes of program, fiscal and quality management monitoring and technical assistance, annual visits will be scheduled by the KHCCP Administrator. **Ryan White Part B staff reserve the right to make unannounced site visits throughout the year.** All scheduled visits will be discussed and planned with agency staff prior to the visit. At a minimum, the visits will include:

a. Chart reviews
b. Review of fiscal documentation
c. Review and analysis of CAREWare data

d. Review of administrative and personnel documentation

Ryan White Part B Meetings:

1. Regional provider staff is required to attend each Ryan White Part B training, including the annual Kentucky Statewide Conference on HIV/AIDS.
2. Regional provider staff must notify the KHCCP Administrator if they are not able to attend an upcoming Ryan White Part B training, including the annual Kentucky Statewide Conference on HIV/AIDS.
3. Regional provider staff who are repeatedly absent from trainings may cited for contract non-compliance.
4. The supervisor of any regional provider staff will be contacted about absence from any Ryan White Part B training.

D. Funding Periods and Sources:

Ryan White Part B Provider Agencies:

1. Services are funded by Ryan White Part B grant funds from HRSA.
2. The Commonwealth of Kentucky provides some additional state funding to support providers under the Ryan White Part B program
2. The federal funding period for the Ryan White Part B program is from April 1-March 31 of each year.
3. The state funding period for the Ryan White Part B program is from July 1-June 30 of each year.

KADAP:

1. KADAP is funded by Ryan White ADAP earmark and supplemental federal dollars.
2. The federal funding period for KADAP is from April 1-March 31 of each year.
3. KADAP pays for cost effective, program-approved health insurance premiums for eligible participants with health insurance, including: (a) Medicare Part D private insurance, (b), employer-sponsored policies, and (c)insurance opportunities arising from the implementation of the Affordable Care Act and Kentucky's Medicaid expansion.
4. KADAP also pays for home care services for chronic medically dependent individuals infected with HIV, as ordered by their doctor. The program covers home health aide services, intravenous therapy administration, supplies, and durable medical equipment provided through enrolled home health care agencies.

KHICP

1. KHICP is funded solely with Ryan White ADAP Earmark and supplemental funds from HRSA.
2. The federal funding period for KHICP is from April 1to March 31 of each year.

E. Priority Services:

- HRSA's expectation is that the state set its annual service priorities for core and support services with the exception of ADAP and KHICP, which is based on need identified in Kentucky's as the Comprehensive Plan and Statewide Coordinated Statement of Need (SCSN).
- Once priorities are established, funding is allocated to each service category and a request for proposal (RFP) process is established to determine the funded agencies.

- Provider agencies can submit a written proposal detailing how the needs for the prioritized services are being met within their area/region.

F. Reallocation of Funding:

1. Ryan White Part B formula funding allocations for both Core and Support Services are made to each program.
2. ADAP earmark, supplemental and rebate funds that are used to allocate KHICP will be made to each region.
3. Adjustment in allocations between Core service and Support service budget line items in excess of ten percent (10%) must have the approval of the Ryan White Part B Grant Administrator.
4. Adjustment in allocations between Core and support budget line items and the KHICP program in excess of ten percent (10%) must have the approval of the HIV/AIDS Branch Office.
5. The Ryan White Part B program reserves the right to reallocate Ryan White Part B funding between service providers in the same region using reporting, usage factors, funding limitations, and/or compliance issues indicate the need to do so.

G. Provider Agency Responsibilities:

1. Each provider agency that seeks to subcontract with another agency must receive approval from the Kentucky Cabinet for Health and Family services before a subcontract is in place.
2. Provider agency staff is required to submit the necessary data collection and reports to the Ryan White Part B Office by the date designated by the KHCCP Administrator.
3. Provider agency (subcontractor) is required to submit any data and/or reports to the Ryan White Part B office by the due dates outlined in Part III, Section C.
4. Provider agency (subcontractor) is responsible for continued monitoring of the subcontractor to assure compliance with all terms and conditions set forth in the KHCCP Guidelines Manual.

H. Failure to Comply with KHCCP Guidelines:

- Failure of a provider agency to comply with the terms and conditions of the KHCCP Guidelines Manual, including required reports and maintenance of appropriate case and financial documentation, may result in a delay in funding, decrease in funding, or total loss of funding for that program.

I. Ownership of Equipment:

- Any equipment or software purchased with state and/or federal funds for any provider agency must be approved by the Part B Program and will be retained by the Ryan White Part B Program.
- While in the possession of the provider agency, software, computers, and equipment is designated for use in the conduct of business for KHCCP.
- Equipment, software, computers, office supplies, etc. may not be transferred to any other provider agency.

J. Ownership of Client-Related Data:

- Ownership of all client-related data (client charts and in CAREWare) is retained by the Commonwealth of Kentucky.

K. Brochures or Other Printed or Published Materials:

- Any materials (brochures, posters, etc.) produced by a provider agency in connection with KHCCP must be submitted to the KHCCP Administrator in draft form for review and approval **prior** to the printing or of these materials.
- Any descriptive content, including KHCCP data or information that is being considered for publication, must be submitted to and approved by the KHCCP Administrator prior to publication.

L. HIPAA:

- All provider agencies are to follow HIPAA as set forth by their agency.
- All provider agencies must sign the Employee Non-Disclosure forms upon assuming the duties of a medical case manager.
- Non-disclosure forms are provided by the KHCCP Administrator.
- Original, signed non-disclosure forms will be maintained by the KHCCP Administrator, with copies maintained by the provider agency.

M. Travel Procedures:

- All provider agencies shall abide by state regulations regarding travel, meal reimbursement, lodging reimbursement, mileage, and airfare.
- All reimbursement will be based upon an approved applicable per diem.
- Information regarding state rates may be obtained from the Kentucky HIV/AIDS Section.
- The Kentucky HIV/AIDS Branch reserves the right to restrict or deny any travel that uses federal and/or state funding.

Kentucky Ryan White Part B Services

STANDARDS OF CARE

Please see separate document for the Ryan White Part B Standards of Care

Appendix 2

KHCCP

Part B URN#________

CLIENT INTAKE REPORT

Client Part C #________
DATE: ____________

DEMOGRAPHIC TAB:

Name______________________/____________________/______________
(Last) (First) (MI)

Preferred name you want to be called: ____________________________________

Gender: ( ) Male ( ) Female ( ) Transgender ( ) Male to Female ( ) Female to Male
( ) Unknown

Marital Status: ( ) Single ( ) Divorced ( ) Separated ( ) Married ( ) Partnered ( ) Widowed

Ethnicity: ( ) Hispanic/Latino ( ) Non-Hispanic/Latino ( ) Unknown

Race: ( ) White ( ) Black or African American ( ) Asian ( ) Native Hawaiian/Pacific Islander
( ) American Indian/Alaskan Native ( ) unknown

Household Size: ______ **Household Income:** _________

DOB: __/__/____ **SS#** _____/_____/_______

Street Address____
City: ____________________________________ State: _____ Zip Code: __________

Mailing address (If different)

Address: ____
City: ___________________________________ State: _____ Zip Code: __________
County: _________________________________

Primary Telephone# ( ) _____-_____ Alternate Phone # ( ) _____-_______
May we contact you by phone? ( ) Yes ( )No By Mail? ( ) Yes ( ) No

Country of Birth: ________________________ Residency Status: __________________

Do you need an interpreter: ( ) Yes ( ) No Language: ______________________

Date of HIV Diagnosis__________________ Date of AIDS Diagnosis________________

____
Signature of Client or Representative **Print Signature** **Date**

____
Signature of Agency Staff **Print Signature** **Date**

Risk Factor Ascertainment

PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THE PATIENT HAD (Respond to ALL Categories)			
	Yes	No	Unk.
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9
Specify Disorder: 1 Factor VIII (Hemophilia A); 2 Factor IX (Hemophilia B); 8 Other (specify): ______			
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
First Mo. ___ Yr. ___ Last Mo. ___ Yr. ___			
• Received transplant of tissue/organs or artificial insemination	1	0	9
Date Mo. ___ Yr. ___			
• Worked in a health-care or clinical laboratory setting	1	0	9
(specify occupation): ______			

- Respond to each risk factor, selecting "Yes" for all factors that apply; "No" for those that do not apply, i.e. only select "No" if medical record specifically states this is not a risk factor; and "unk" for those for which investigation failed to yield an answer.

Sex with Male

- Select applicable response.
- Abstractor may presume "Yes" for the risk factor among males as anatomical site of sexually transmitted disease (STD) infection suggests (e.g., rectal gonorrhea in a male patient)

Sex with Female

- Select applicable response

Injected Nonprescription Drugs

- Select applicable response

Received Clotting Factor

- Select applicable response
- If "Yes" to "Other" disorder, specify disorder

Heterosexual relations with any of the following

- Relates only to risk ascertainment among **heterosexual sex partners** of the case patient

Intravenous/Injection Drug User

- Select applicable response

Bisexual Male

- Applies only to **female** cases
- Select applicable response

Person with Hemophilia/Coagulation Disorder

- Select applicable response
- Includes only partners who have a disorder of a clotting factor
- They do **not** include other bleeding disorders, such as thrombocytopenia
- If only a transfusion of platelets, other blood cells, or plasma was received by the partner, then select "No"

Transfusion Recipient with Documented HIV Infection

- Select applicable response

Transplant Recipient with Documented HIV Infection

- Select applicable response

Person with AIDS or Documented HIV Infection, Risk Not Specified

- Select "Yes" only if **heterosexual** sex partner is known to be HIV positive and that partner's risk factor for HIV is unknown

Received Transfusion of Blood/Blood components (Other than Clotting Factors)

- Select applicable response
- If "Yes" specify month and year of first and last transfusions before occurrence of patient's HIV diagnosis
- Investigate if occurred after March 1985 to determine if this was the only risk factor present

Received Transplant of Tissue/Organs or Artificial Insemination

- Select applicable response
- Specify month and year of transplant or artificial insemination
- Investigate if occurred after March 1985 to determine if this was the only risk factor present

Worked in Health care or Clinical Laboratory Setting

- Select applicable response
- If "Yes", specify setting
- Investigate apparent occupational exposures to determine if this was the only risk factor present.

Appendix 3

KHCCP
Statement of No Income

I, ______________________, declare that I currently have zero income. I am
(print your name)
meeting my daily living needs by ___________________________________

In the future, should I receive income, either through employment, Supplemental Security Income (SSI), Social Security Disability, or other means, I understand that I must notify KHCCP immediately.

I understand I will be notified by KHCCP if changes in my income affect my KHCCP eligibility.

______________________________ ________________
Client Signature Date

______________________________ ________________
Agency Staff Signature Date

Kentucky AIDS Drug Assistance Program (KADAP)
Kentucky Health Insurance Continuation Program (KHICP)

Medical Documentation Form

**This form must be completed by your Medical Provider or by their office.

1. Client Information:

Client name: ______________________________

Social Security #: ____________________ Date of Birth: ____________________

2. Medical Documentation:

Positive HIV test: Yes_____ No_____ Test date:____________________

CD4 %: ____________________ Test date: ____________________

CD4+ cell count:____________________ Test date:____________________

Viral load: ____________________ Test date:____________________

3. Medical Provider Information:

Stamp/Signature: ____________________ ***Date:*** ____________________

First name: ____________________ Last name:____________________

Mailing address: ______________________________

City: ____________________ State: __________ Zip: ____________________

Phone: (   ) ____________________

Please forward this form to:

KADAP/KHICP
Dept for Public Health
275 East Main Street HS2E-C
Frankfort, KY 40621-0001
(502) 564-6539 or (866) 510-0005

KENTUCKY HIV/AIDS CARE COORDINATOR PROGRAM

INFORMED PARTICIPATION AGREEMENT

Description of HIV Care Coordination

The Kentucky HIV/AIDS Care Coordinator Program (KHCCP) is funded through **Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009.** The Ryan White (RW) Program is a federal mandate that was created to address health care and service needs of People Living With HIV/AIDS (PLWH/A). First Enacted in 1990 as the Ryan White Care Act, the legislation in 2006 was adjusted to accommodate new and emerging needs, such as an increased emphasis on funding of core medical services and changes in funding formulas. The main goal of the act is to: 1) reduce new HIV infections; 2) increase access to care and improving health outcomes for PLWH; 3) reduce HIV-related disparities and health inequities and 4) achieving a more coordinated national response to the HIV epidemic.

1. Care Coordination consists of the following case management activities:

- Intake interview and initial assessment
- Defining responsibilities of client and Medical Case Manager
- Development of goals and Individualized Care Plan (Care Plan) for those seeking KHCCP services
- Implementation of the Care Plan
- Monitoring progress towards meeting goals
- Re-assessment of needs and revision of goals as needed
- Client and Medical Case Manager meeting face-to-face, at least annually
- On-going evaluation of progress

An Individualized Care Plan (ICP) must be developed with each client or the client's designee who is seeking HIV/AIDS services from KHCCP. The ICP identifies the client's needs, goals for meeting those needs, financial budgeting, and schedules for completion of goals and objectives. The client or designee is expected to actively participate and follow, in good faith, the ICP that is developed to meet the client's service and health care needs.

2. Client and Medical Case Manager Contact:

- Client and Medical Case Manager must have contact at least once every six (6) months by either phone, written correspondence, or face-to-face.
- Client and Medical Case Manager must have a face-to-face meeting once a year.
- During the annual meeting, a review of client's needs and circumstances is to be completed.
- A signed Informed Participation Agreement (IPA)
- Client must comply with the required documentation for KHCCP eligibility.
- Client must provide proof of insurance (if applicable) annually.

3. Client Responsibilities:

- Client must actively participate in the development and implementation of the Care Plan and agrees to cooperate with the interventions, goals, and objectives of the Care Plan.
- Client must provide factual information necessary to complete the KHCCP initial Intake within 30 days of the initial interview and Care Plan updates.

NOTE: Clients receiving KHCCP services (Part B) must meet all of the Client Eligibility Guidelines (see below).

4. Client Eligibility Guidelines:

Client receiving KHCCP services funded by Part B must fill an intake/application form and provide the documentation required within 30 days of the first KHCCP visit or as necessary for any other required update:

Household Size

All those individuals *living in a single residence* including client, spouse, and children under the age of 18 and other family and non-family members that contributes toward the daily living expenses.

Eligibility

An individual may be considered eligible for KHCCP if he or she has a maximum gross household annual income less than or equal to ***500% of the Federal Poverty Level****.*

Income to be counted in determining eligibility (applies only to household members over 18) may include:

- Employment income
- Alimony payments
- Social Security Disability Insurance (SSDI)
- Supplemental Security Income (SSI)
- Unemployment benefits
- Veteran Administration benefits
- Benefits income of individuals' dependent children (survivors benefits)
- Retirement benefits
- Private disability
- Workman's Compensation
- Interest income or other investment income
- Rental property income
- Cash support from family and friends and
- Labor pool employment

Documentation as evidence of income required annually

- Most recent W-2 forms or 1099; or
- Award letter or statement from Social Security
- Check stub or bank direct deposit evidence from Social Security Disability/Supplemental Security Income;
- Unemployment check or letter
- Most recent calendar year's Tax Return;
- Food Stamp award letter;
- Workman comp letter
- Signed Self-declaration statement of no income or no change (only for those clients who report having no income). He/she must state how he/she is meeting the needs of daily living.

5. Sign and date the Informed Participation Agreement (IPA).

6. Sign and date the agency's HIPAA Release of Information form.

7. Client agrees to abide by the established guidelines for conduct, agrees to participate in the development of the Care Plan and agrees to cooperate with the interventions, goals, and objectives of the Care Plan.

8. Incarcerated Individual:
   - Clients who are incarcerated will be documented closed in the client's file and will not be eligible for any KHCCP services during the period they are incarcerated.
   - A client may re-apply for KHCCP once released from jail/prison or within 30 days of release date. If application is approved, client will be eligible for services upon being released from incarceration.

General Care Coordinator Program Information:

- Care Coordinator Program services are advisory in nature and are only for individuals infected with HIV/AIDS who meet all eligibility requirements
- Some services may not be available in some provider regions.
- The Medical Case Manager will help identify personal practices that may help improve with a client's general health and well-being.
- It is the client's responsibility to notify their current Medical Case Manager of any changes in personal information (address, telephone number, emergency contact, employment status, income, etc.)
- Client confidentiality will be maintained according to Kentucky State statutes.

Client signature below confirms their intent to participate in the Kentucky HIV/AIDS Care Coordinator Program, and the client understands that they must adhere to all policies and guidelines set forth in the IPA. Client acknowledges that I have received a copy of the IPA and that it has been reviewed with the client.

_______________________________________ ____________

Signature of Client or Designated Representative **Date**

_______________________________________ ____________

Signature of Agency Staff **Date**

If a Designated Representative is indicated above, complete the following section: (Please Print)

Name of Representative_______________________________________

Mailing Address_______________________________________

Phone Number_______________________________________

Client's Initials_______________________________________

Division of Health & Epidemiology & Health Planning
Department for Public Health
HIV/AIDS Branch
Kentucky HIV/AIDS Care Coordinator Program (KHCCP)
275 East Main Street, Mailstop HS2C-A
Frankfort, KY. 40621

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Section A: Must be completed for all authorizations.

I hereby authorize the use or disclosure of my individually identifiable information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Patient name:______________________________ ID Number: ______________________________

Persons/Organizations authorized to release the information: ______________________________
Persons/Organizations authorized to receive the information include Division of Health and Epidemiology, Department for Public Health, HIV/AIDS Branch:______________________________
____

Specific description of information (including date(s)):______________________________
____
____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire ______________________________ Initials:________

2. I understand that I may revoke this authorization at any time by notifying KHCCP in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions KHCCP took in reliance upon my authorization before it received my revocation. Initials:________

3. Complete one:
   KHCCP will not condition your services on your completing and signing this authorization. ☐

   If you do not sign this form, KHCCP will not provide services to you because you are not in compliance with the Kentucky HIV/AIDS Care Coordinator Guidelines. ☐

Section B: Must be completed when KHCCP requests the authorization for its own use or for another covered entity to disclose information to KHCCP for services.

To be completed by KHCCP:

1. The purpose of the use or disclosure is:______________________________

2. KHCCP ☐ will ☐ will not receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: **You or your representative may inspect and/or copy your individually identifiable information in accordance with KHCCP's policies.**

<u>Section C: Must be completed for all authorizations.</u>

Patient Name:________________________________ **Patient Social Security Number:**______________
(Please Print)

____ __________________
Signature of patient or patient's representative **Date**

Printed name of patient's representative:____
Relationship to patient:____

Section D Revocation: Having been fully informed of the consequences of revoking this authorization, I revoke this authorization as of the date stipulated here:____________________

________________________ ____________ __________________ ____________
Client Signature Date AgencyStaff Signature Date

INDIVIDUALIZED CARE PLAN
(Page 1of 2)

KHCCP

Client name: ____________ Case # ________ CC Name: ____________ Date: ________

INDIVIDUALIZED CARE PLAN

LONG TERM GOAL: ______________________________

Short Term Goal: ______________________________
BARRIERS TO OVERCOME IN ORDER TO ACCOMPLISH GOAL: ______________________________

Tasks to Achieve Goal:	Person to Do Task	Date to be done	Date done
1.			
2.			
3.			
4.			

Short Term Goal: ______________________________
BARRIERS TO OVERCOME IN ORDER TO ACCOMPLISH GOAL: ______________________________

Tasks to Achieve Goal:	Person to Do Task	Date to be done	Date done
1.			
2.			
3.			
4.			

I have read/reviewed, understand and agree with the above Care Plan. I understand that I am responsible for carrying out the tasks assigned to me, and agree to do my best to do so. Also, I have been told what services are available to me, and what steps to take if I have trouble with any aspects of service delivery. This Care Plan is negotiable by approval of both the client and the agency's staff Care Coordinator.

- ☐ I do not wish to participate in the Case Management program at this time.

Client Signature: ____________ Date: ________ Agency Staff CC Signature: ____________ Date: ________

Additional Space on Back

INDIVIDUALIZED CARE PLAN
(Page 2 of 2)

Short Term Goal: ____________________
BARRIERS TO OVERCOME IN ORDER TO ACCOMPLISH GOAL: ____________________

____

____

Tasks to Achieve Goal:	Person to Do Task	Date to be done	Date done
1.			
2.			
3.			
4.			

Short Term Goal: ____________________
BARRIERS TO OVERCOME IN ORDER TO ACCOMPLISH GOAL: ____________________

____

____

Tasks to Achieve Goal:	Person to Do Task	Date to be done	Date done
1.			
2.			
3.			
4.			

(May use Task Numbers to Complete Review)

TASK OUTCOME AND REVIEW OF PLAN:

____________________ Initials of Reviewer ________ Date:

Revised 7/2013

Appendix 8

Employee Non - Disclosure Agreement (Staff or Contract)
Department for Public Health, Division of Epidemiology and Health Planning
HIV/AIDS Branch

The Employee Non – Disclosure Agreement is established in accordance with the following statutes, rules and regulations:

- KRS 194.060 – Confidentiality of records and reports
- KRS 205.175 - Confidential treatment of information and records – Persons to whom furnished
- KRS 214.420 – Records declared confidential – application
- KRS 214.625(5) – Confidentiality of HIV Infection test results
- KRS 341.190 – Records and reports – Confidential treatment
- KRS 434.840-860 – Unlawful access to a computer
- Privacy Act of 1974
- Centers for Disease Control Information Security Standards
- HIV/AIDS Surveillance Program Policies and Procedures

The undersigned employee has been advised that in order to perform the tasks required by the Department for Public Health, Division of Epidemiology and Health Planning, HIV/AIDS Branch, access to confidential information will be necessary. Both the information and the identity of the specific individual to whom the information applies is strictly confidential. Unlawful access to and disclosure of confidential information may result in dismissal and in other penalties including incarceration and fines (KRS 434.840-860), and prosecution may occur as a result of violation of those laws.

In addition, 42 CFR 431.301 – 431.307 states the extent to which medical history record information shall be treated as private and secure. The employee agrees to abide by the following terms and conditions:

1. The employee agrees to use any obtained medical history record information or otherwise classified information only as needed to fulfill the reporting requirements and analytical needs of the Kentucky HIV/AIDS Branch.
2. The employee agrees not to discuss, disclose, or otherwise reveal any medical information or classified information to individuals other than for the purpose of the Kentucky HIV/AIDS Branch.
3. The employee agrees neither to confirm nor deny the existence of any record or classified information on a specific individual to any person not employed by the Kentucky HIV/AIDS Branch.
4. The employee agrees to immediately notify the Kentucky HIV/AIDS Program Director of any requests by unauthorized individuals for information relating to the Kentucky HIV/AIDS Branch.
5. The Employee agrees to abide by the administrative and operational rules and policies developed by the Kentucky HIV/AIDS Branch concerning medical information and classified information.

I, ____, have read, understand, and agree to abide by the terms and conditions set forth by the agreement.

______________________________(Date)

If through contract:

____________________________________   ____________________________________

Name of Company   Company Authorized Representative

Appendix 8

Employee Oath of Confidentiality/Data Security Assurance
(To be used for initial and update employee security training purposes)

I, the undersigned, have read, understand, and agree to abide by the HIV/AIDS Branch Surveillance Program Non – Disclosure Agreement and Security Policy.

Furthermore, I understand that violation of these articles is subject to appropriate disciplinary action(s) on the part of the Cabinet for Health Services that could include being discharged from my position and/or being subject to other penalties.

By initialing the following statements, I further agree that:

Initial & Date Below

____________ Reports, records, or information shall be released only in accordance with established policies.

____________ Any documents to be disposed of that contain patient identifiers shall be shredded.

____________ All confidential files, including computer diskettes, shall be kept in a secured file cabinet when not in use.

____________ Any confidential files with which I am working shall be locked up when I leave my workstation unattended.

____________ When I leave my office, I shall lock the door and keep my keys with me at all times.

____________ I shall not receive visitors at any workstation designed as restricted area.

____________ I shall conduct telephone conversations and/or conference calls, requiring the discussion of identifiers, only in my work area and other confidential areas.

____________ When working on files on my computer, I shall log off when I am finished to prevent access to confidential files and databases.

____________ I shall not disclose my computer password or office access means to unauthorized person.

____________ The data generated and used while employed by the Department for Public Health, HIV/AIDS Branch, is the property of the Department for Public Health.

____________ I shall not discuss any identifying information except in the performance of job-related duties, being especially mindful that these discussions do not occur in hallways, elevators, lavatories, lunch rooms, or other public areas.

____________ Infringement of these rules shall be documented and placed in my personnel file, subject to appropriate disciplinary action including dismissal and other penalties.

________________________ __________________
Employee Signature Date

I hereby certify that I have provided the above employee with a copy of the pertinent laws and policies as Indicated in this document.

________________________ __________________
Supervisor's Signature Date

KHCCP
Statement of No Change

I, ____________________, declare that there has been no change in my;
(print your name)

- ○ **Medical Insurance**
- ○ **Income**
- ○ **Household size**
- ○ **Ky residency (address)**

____
____.

In the future, should there be a change with any of the aforementioned criteria, I understand that I must notify the KHCCP Administrator immediately. If minor change mark the correct box and attached supporting documentation.

I understand I will be notified by KHCCP if any changes affect my KHCCP eligibility.

______________________________ ______________
Client Signature Date

____
Witness (if client is unable to sign)

HIV Care Coordinator Regions

	Counties Covered:			
LIVWell Community Health Services 1903 Broadway Street Paducah, KY 42001 **(270) 444-8183, (877) 444-8183** **Fax: (270) 444-8147**	Ballard Caldwell Calloway Carlisle Christian	Crittenden Fulton Graves* Hickman	Hopkins Livingston Lyon Marshall	McCracken Muhlenberg Todd** Trigg
Matthew 25 452 Old Corydon Road Henderson, KY 42420 **(270) 826-0200, (866) 607-6590** **Fax: (270) 826-0212**	Allen Barren Breckinridge Butler Daviess Edmonson Grayson	Hancock Hardin Hart Henderson Larue Logan Marion	McLean Meade Metcalfe Monroe Nelson Ohio Simpson	Union Warren Washington Webster
U of L 550 Clinic ULSD KCCP 1212 S. 4th St. Suite 101 Louisville, KY 40203 **(502) 852-2008** **Fax: (502) 852-2510**	Bullitt Henry	Jefferson Oldham	Shelby Spencer	Trimble
Northern KY Dist HD 8001 Veterans Memorial Drive Florence, KY 41042 **(859) 341-4264** **Fax: (859) 578-3689**	Boone Campbell	Carroll Gallatin	Grant Kenton	Owen Pendleton
UK Bluegrass Care Clinic 3101 Beaumont Center Circle Suite 300 Lexington, KY 40513 **(859) 323-5544, (866) 761-0206** **Fax: (859) 257-3477**	Anderson Bath Bourbon Boyd Boyle Bracken Carter Clark	Elliott Estill Fayette Fleming Franklin Garrard Greenup Harrison	Jessamine Lawrence Lewis Lincoln Madison Mason Menifee Mercer	Montgomery Morgan Nicholas Powell Robertson Rowan Scott Woodford
Lake Cumberland Dist HD 500 Bourne Avenue Somerset, KY 42501 **(606) 678-4761, (800) 928-4416** **Fax: (606) 678-2708**	Adair Bell Breathitt Casey Clay Clinton Cumberland	Floyd Green Harlan Jackson Johnson Knox	Laurel Magoffin Martin McCreary Pike Pulaski	Rockcastle Russell Taylor Wayne Whitley
Kentucky River Dist HD 441 Gorman Hollow Road Hazard, KY 41701 **(606) 439-2361** **Fax: (606) 439-0870**	Knott Lee	Leslie Letcher	Owsley Perry	Wolfe
Graves County HD 416 Central Ave Mayfield, KY 42066 **(270) 247-3553**	Graves			
Todd County HD 205 Public Square Elkton, KY 42220 **(270) 265-2362**	Todd			

Updated 9/18/2020

HIV Care Coordinator Regions

*Graves County is currently being served by both Heartland CARES, Inc. and the Graves County HD.

**Todd County is currently being served by both Heartland CARES, Inc. and the Todd County HD.

For more information, contact the nearest Care Coordinator or the Care Coordinator Program Administrator: (502) 564-6539 or (800) 420-7431.

Updated 9/18/2020

THE KENTUCKY HIV/AIDS CARE COORDINATOR PROGRAM GRIEVANCE PROCEDURE

a. Types of grievances

i. Consumers may express their dissatisfaction with the Kentucky HIV/AIDS Care Coordination Program (KHCCP) in writing

ii. Provider agencies may express dissatisfaction with the KHCCP.

b. Grievance procedures

If a consumer, provider or agency wishes to address a concern with a KHCCP policy, the following procedure is recommended:

(1) The consumer, provider or agency is encouraged to address the concern with the KHCCP Administrator staff in writing or verbally.

(2) KHCCP staff will respond to concerns expressed in a timely manner either in writing or verbally.

(3) In the event that the staff cannot resolve the issue, he/she will document and forward the concern to the Ryan White HIV/AIDS Branch Service Program Manager.

(4) If necessary, the RW HIV/AIDS Branch Service Program Manager will review the concern(s) with the Ryan White Part B Program Manager and/or HIV/AIDS Branch Manager to determine the appropriate response and communicate that response to the KHCCP staff.

c. Filing a grievance

Persons wishing to file a grievance must follow noted grievance procedure with the Part B funded facility. **Each provider agency has its own grievance policies and procedures. Therefore the client/individual should request a copy of that agency's policy.**

*****If grievance is not resolved at the provider agency level, then the KHCCP grievance procedure must be followed*****

PLEASE SEE KHCCP GRIEVANCE PROCEDURE ON THE FOLLOWING PAGES

Kentucky HIV/AIDS Care Coordinator Program

Grievance Procedures

The Kentucky HIV/AIDS Care Coordinator Program (KHCCP) is part of the Kentucky HIV/AIDS Branch located within the Department for Public Health. All clients enrolled or participating in the Kentucky HIV/AIDS Care Coordinator Program (KHCCP) have a right to due process in filing a grievance if they feel they have not received fair treatment by the Kentucky HIV/AIDS Care Coordinator Program or staff at any of the Care Coordinator regional sites. Individuals not enrolled or participating in the Kentucky HIV/AIDS Care Coordinator Program also have the right to file a grievance. No client or individual will be harassed nor will punitive action be taken in the event a client or individual exercises this right. **Each Care Coordinator Regional Site has their own grievance policies and procedures, therefore the client/individual should request a copy of that region's policy.**

Any client or individual filing a grievance regarding the Kentucky HIV/AIDS Care Coordinator Program must use the following steps when filing a grievance:

Step 1:

If a client/individual encounters a problem/incident with the Kentucky HIV/AIDS Care Coordinator Program, the client/individual must discuss the problem directly with the Care Coordinator regional site in which the problem/incident occurred **within five (5) working days of the incident or time when client/individual became aware of the problem/incident.** For accurate record keeping, please record the date and time this discussion occurred, along with the name of the person the problem/incident was discussed with, as this information may prove helpful later.

Step 2:

If discussing the problem/incident with the Care Coordinator regional site in which the problem/incident occurred fails to resolve the problem, the client/individual should submit a **written** grievance to the director/supervisor of that care coordinator regional site (please contact the regional Care Coordinator site directly for current mailing address) within **ten (10) working days after the problem/incident was discussed.** The grievance **MUST** include:

(1.) Date and time(s) the problem/incident occurred;
(2.) Staff involved;
(3.) Description of the problem/incident;
(4.) Description of the discussion with staff of the Care Coordinator site involved

The client/individual should keep one copy of the grievance letter for their records.

Step 3:

If client/individual is not satisfied with the decision/response of the Care Coordinator regional site, the client/individual may forward all written materials within five (5) working days after receiving the decision/response to the particular program in which the grievance is being filled.

- **For grievances regarding Care Coordination send to:**
  Kentucky HIV/AIDS Branch
  KHCCP Administrator
  275 East Main St
  Mail Stop HS2E-C
  Frankfort, KY. 40621-0001
  1-800-420-7431

A response will be made in writing within ten (10) working days of receiving the grievance materials.

Step 4:

If the client/individual is not satisfied with the HIV/AIDS Care Coordinator Program response, the client/individual may forward all written materials of the grievance to the Ryan White Part B Section Supervisor within five (5) working days after receiving the Care Coordinator Program response to:

Kentucky HIV/AIDS Branch
Ryan White Part B Section Supervisor
275 East Main St.
Mail Stop HS2E-C
Frankfort, KY. 40621-0001

A response will be made in writing within ten (10) working days of receiving the grievance materials.

Step 5:

If the client/individual is not satisfied with the HIV/AIDS Section Supervisor's response, the client/individual may forward all written materials of the grievance within five (5) working days after receiving the response to the HIV/AIDS Branch Manager:

HIV/AIDS Branch Manager
Kentucky Department of Public Health
275 East Main St.
Mail Stop HS2E-C
Frankfort, KY. 40621-0001

The Branch Manager will respond in writing within ten (10) working days of receiving the written materials.

Step 6:

If the client/individual is not satisfied with the HIV/AIDS Branch Manger's response, the client/individual may forward all written materials of the grievance within five (5) working days after receiving the response to the Division Director:

Division Director
Division of Epidemiology & Health Planning
275 East Main Street HS2GWC
Frankfort, KY 40621-0001

The Division Director's decision will be final.

______________________________________ ____________
Signature of Client or Designated Representative Date

______________________________________ ____________
Signature of Agency Staff/Care Coordinator Date

KHCCP - Client Survey

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
1. I like the services that I receive.					
2. If I had other choices, I would still get service from this agency.					
3. I am treated with respect.					
4. Staff is willing to see me as often as necessary.					
5. Staff returns my phone calls in a timely manner.					
6. Services are available at times that are good for me.					
7. Staff believes that I can meet my goals.					
8. I understand what Ryan White case management services are available to me.					
9. I feel comfortable seeking resources for my medical care and medications.					
10. I understand grievance process & how to initiate it, if needed.					
11. Staff respects my confidentiality.					
12. I receive education on how to reduce risky behaviors.					
13. I have input into the development of my goals with my Care Coordinator.					
14. Staff is sensitive to my cultural background					
15. Staff provides the information I need to promote self-sufficiency in managing my illness.					

16. What are three things you like about this program?

1.____

2.____

3.____

17. What are ways you think the Care Coordinator Program could be improved?

1.____

2.____

KENTUCKY HIV/AIDS CARE COORDINATOR PROGRAM (KHCCP)

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION HIPAA

Section A: Must be completed for all authorizations.

I hereby authorize the use or disclosure of my individually identifiable information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Patient name:______________________________ ID Number: ______________________________

Persons/Organizations authorized to release/receive information includes: **Agency Name**
Persons/Organizations authorized to exchange information includes: **Division of Epidemiology and Health Planning, Department for Public Health,** ______________________________

Specific description of information to be disclosed (including date(s)): progress notes, Medical Documentation Form, medical history, laboratory test results, medication history, discharge summaries, treatment recommendations.

1. **The patient or the patient's representative must read and initial the following statements:**

   a) I specifically authorize the (Agency Name) to release to ______________________________ data and information relating to:
      - **Substance Abuse** (alcohol/drug testing & treatment) Initials:________
      - **Mental Health** (psychological testing & treatment) ___ Initials:________
      - **HIV-Related Information** (testing & treatment) Initials:________

   b) I understand that this authorization will expire ____________________ Initials:________

   c) I understand that I may revoke this authorization at any time by notifying the (Agency Name) in writing. If I do revoke this authorization, my revocation will not have an effect on any actions the (Agency Name) took in reliance upon my authorization before it received my revocation. Initials:________

2. **To be completed by the Care Coordinator (check only one):**
   a) (Agency Name) will not condition your services on your completing and signing this authorization. ☐
   b) If you do not sign this form, the(Agency Name) will not provide services to you because you have not completed enrollment into the Program. ☐

Section B: Must be completed when the (Agency Name) requests the authorization for its own use or for another covered entity to disclose information to the (Agency Name) for services.

To be completed by (Agency Name):

1. The purpose of the use or disclosure is: to provide case management services.
2. (Agency Name) ☐ will not receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: You or your representative may inspect and/or copy your individually identifiable information in accordance with (Agency Name) policies and procedures.

Section C: Must be completed for all authorizations.

Patient Name:______________________________ **Patient Social Security Number:**_______________
(Please Print)

______________________________ ____________________
Signature of patient or patient's representative **Date**

Printed name of patient's representative: ______________________________

Signature of Agency Staff:______________________________ **Date:**____________________

Ryan White Services Program
Clinical Information Form

Client Name: ______________________ DOB: ___________________________
SS#: ___________________________ Care Coordinator: __________________

This form is to be completed by your medical provider, their office staff, or medical case manager.

1. Please list the date of the patient's first outpatient/ambulatory care visit. If full date is not available, the month and year may be provided.
Date________________________________

2. In the past 6 months, has the patient had any outpatient/ambulatory care visits with a clinical care provider (physician, physician's assistant, nurse practitioner) related to HIV care?
☐ Yes ☐ No
If so, please list dates:________________

3. Date of Positive HIV test
____

4. CD4 Count/HIV Viral Load: Please report the value and test date for all CD4 count tests and HIV Viral Load tests administered in the past 6 months.

DATE	CD4 Cell Count	CD4%	HIV Viral Load

Medical Provider Information

Stamp/Signature ____________________________ *Date* ______________

First Name ________________________ Last Name _____________________________
Mailing Address ____

City __________________________ State _________ Zip ____________________________

Phone (_______) ______________________

*****Thank you in advance for completing this form. This information is used to enhance and guide medical case management services offered by the Kentucky Ryan White Services Program.**

Kentucky RW Part B Program
Policy and Procedure for Implementing HRSA/HAB* PCN 18-02

The Use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

Implications for Kentucky Ryan White Part B Program -

A. **Introduction of PCN-18-02 - The Use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved.**

Overview: The publishing of the new Policy Clarification Notice 18-02 (PCN 18-02) regarding Ryan White Programs providing care and medications for incarcerated persons is very important and may remove barriers to HIV testing and care. This PCN provides clarification on when, where, and how assistance may be provided using Ryan White Funds to provide services to persons living in local jails, state prisons, or jails.

In the past, all Kentucky Ryan White Programs were prohibited from providing care to all persons living in federal, state, and local prison, jails, or living in half-way houses during the former inmates discharge program.

The previous opinion was not based on a legal interpretation that stated incarcerated persons are ineligible for services, rather it was based on the Code of Federal Regulations financial requirement referred to as ***payor of last resort***. **Payor of last resort states "for any item or service to the extent that payment has been made, or can reasonably be expected to be made under . . . an insurance policy, or under any Federal or State health benefits program. . . ."[i] and other specified payment sources.**

Therefore, federal funds may not be used to pay for a service if there is another payor source that can reasonably be expected to pay for this service. This includes all other federal funding including federal payments for federal prisons, large state institutions, or payments from state governments to support prisons and jails.

B. **PCN 18-02 – Important Definitions – Creating Criteria for the Provision of Ryan White Services and Medications to Persons Living in Jails or Prisons.**

There are two classifications where the provision of Ryan White care is allowable to persons living in jails and prisons.

1. **Short Term – Applies to Local Jails.** "Short-term basis" refers to the time-limited provision of core medical and support services not prohibited by the statutory payor of last resort requirements. HRSA HAB defers to recipients/subrecipients for a determination of the time limitation. HRSA HAB recognizes that, in some instances, the time limitation will be commensurate with the duration of incarceration.

2. **Transitional - Applies to Prisons and Jail receiving Federal and State Funding.** "Transitional basis" refers to the time-limited provision of appropriate core medical and support services for the purpose of ensuring linkage to and continuity of care for incarcerated people living with HIV/AIDS (PLWH) that will be eligible for HRSA RWHAP services upon release, when such release is imminent. HRSA HAB defers to recipients/subrecipients for a determination of the time limitation, generally 180 days or fewer. The limitation may be extended based on circumstances.

C. **Clarification of Providing Ryan White Services and Medications in Local Jails** - It was always known that most local jails do not receive federal funds and the state and local funds they do receive are not used to pay for medications or clinical care. HIV medications are considered too expensive for many local jails to provide. This PCN clarifies that "***local payers, such as local jails, are not subject to the payor of last resort provision, and HRSA RWHAP[1] may be the primary payor,*** " based on statute.

PCN – 18-02 clarifies that the Kentucky RW Part B/ADAP Program is permitted to provide clinical care and support services in local jails. The RWHAP services are provided under the "short-term" definition of services.

D. Clarification of PCN 18-02 for Prisons and Jails that receive Federal and State funding to insure that federal payor of last resort rules are followed.

1. **"Transitional Basis" Only** - HRSA RWHAP recipients and subrecipients may provide HRSA RWHAP core medical services and support services to PLWH incarcerated in Federal and State prison systems on a transitional basis only (up to 180 days prior to discharge).

2. **Clarification of Eligible Ryan White Services** - The nature of these services must be defined by HRSA RWHAP recipients and subrecipients in collaboration with the Federal or State prison system to prevent duplication of services. When there is an agreement to work together, there should be documentation of the services that the correctional facility is expected to pay for and the services that the RWHAP may pay when there is not another payor source.

3. **Provision of Services to other Correctional Programs such as Halfway Houses.** HRSA RWHAP recipients and subrecipients may also provide HRSA RWHAP core medical services and support services to PLWH incarcerated in other correctional systems including those under community supervision on a short-term and/or transitional basis. The nature of these services must be defined by HRSA RWHAP recipients and subrecipients in collaboration with the correctional institution to

prevent duplication of services. When the responsibilities of each party, the correctional facility, and the RWHAP are defined, there should be an agreement that states each parties' roles and responsibilities.

Types of Issues Requiring Communication and Documentation. The following questions should be answered before agreeing to collaborate with a correctional facility. Determining the answers to these questions creates the guidelines for the services that the Correctional Facility should continue to provide and what services RWHAP is eligible to provide. The ability to document the roles and responsibilities of each party will prevent duplication of services and follows the federal payor of last resort rules.

1. What health services are legally expected to be provided within the correctional system;
2. How, and whether, the correctional system addresses the transitional needs of PLWH who are incarcerated, including: discharge planning, continuity of treatment, and community linkages;
3. What services will be provided with the HRSA RWHAP funds; and
4. Once the RWHAP Program has ascertained the correctional facility's role versus the RWHAP role, then the use of short-term or transitional time requirements will be agreed upon.

Kentucky KHCCP and KADAP Policy for Providing Care and Services to HIV+ Persons Living in Local Jails, Prisons, and State Jails.

Definitions:

a. **KHCCP – Kentucky HIV/AIDs Care Coordinator Program –** This program oversees the management of RW Part B grant funded core medical services and support services as designated in Ryan White legislation. Core medical services include: ambulatory medical care, laboratory testing, mental health services, oral health services, etc. Support services include: transportation, nutrition services, etc.

b. **KADAP – The Kentucky AIDS Drug Assistance Program** – This program is designed to ensure that every HIV+ person residing in the state of Kentucky receives life-saving and life-extending HIV medications. The medications that are provided under KADAP are listed on a KADAP drug formulary that is managed by a team of medical professionals.

c. **Subrecipients** – Subrecipient agencies are subcontractors of the KHCCP or KADAP programs. Subrecipients are selected either as regional providers or by their proximity to areas with above normal incidence of HIV.

Policy for KHCCP/KADAP Providing Care and Services to Incarcerated Persons in Kentucky

1. **The Kentucky KHCCP and KADAP Programs and their subrecipients will follow all current rules for providing care and services to incarcerated persons, regardless of whether it is a local jail, State of Kentucky Jail/Prison, or transitional community program.** This will protect both KHCCP/KADAP, as well as the subrecipients from failing to ensure that all payor of last resort requirements are followed when providing care and services to persons that are incarcerated.

2. **Confirmation of Payor of Last Resort Status** - When working with a facility that is responsible for incarcerating inmates – the following responsibilities for assuring duplication of services and federal payor of last resort requirements will not be violated and must be met if KHCCP or KADAP funds are used for an incarcerated client.
   a. **Provision of KHCCP Care and Services** – It is the responsibility of the KHCCP **subrecipient agencies** to work with the jails, prisons, and discharge programs to ensure that other Federal or local payor sources are not available. There should be written documentation regarding the services that the jail or prison has funding to pay for and the services that KHCCP may legally provide.
      Discussions regarding who has responsibility for discharge planning and connecting the incarcerated HIV+ individual to KHCCP services and KADAP medications immediately upon discharge should be documented with the jail or prison.
   b. **Provision of KADAP Formulary Approved Medications** – In the case of KADAP, only KADAP personnel are responsible for following the procedures for determining if the individual requesting KADAP medications is eligible for this program. KADAP may accept documentation from an outside KHCCP subrecipient agency through the provision of documentation that there is no other source available to pay for the KADAP eligible medications. Documentation of the incarcerated client's eligibility for KADAP medications must be maintained at the KADAP offices in Frankfort, Kentucky.

3. **Limitation on Services Provided to HIV+ Incarcerated Persons** - Only the following Core Medical and Support Services may be provided to an incarcerated HIV+ person under the KHCCP and KADAP Program. ***From HIV/AID Bureau Policy 16-02***

   KHCCP and KADAP Services
   1. AIDS Drug Assistance Program Treatments
   2. Early Intervention Services (EIS)
   3. Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals - In case that a person that is working in a community based program and has employer based health insurance coverage.
   4. Linguistic Services
   5. Medical Transportation

Procedures for Determining Participation of Jails/Prisons and Clients in the KHCCP/KADAP Programs.

Process for determining Payor of Last Resort Issues with Jails, Prisons, and Discharge Programs including Half-Way Houses/Independent Living Programs.

1. Meet with or arrange a phone call with appropriate level of jail/prison staff with knowledge of funding sources for the participating institution.

2. **Document all discussions**
   a. Ask how facility services are paid for?
      i. Do these payments include funding for clinical care?
      ii. Do these payments for clinical care include funding for patient medications?
      iii. Does the facility have a formulary of medications that they pay for with internal funds? Are HIV medications included in the formulary? Does the formulary medication list include all current "brand name" medications found on the KADAP Medication Formulary?
      iv. Do they run out of money for clinical care or medications during the course of the year?
      v. Does the organization provide qualified HIV care?
   b. Often jails receive a per diem payment rather than a full budget for a client's services – this per-diem may or may not include funding for clinical care or medications.
      i. Does the facility receive a per diem for each inmate?
      ii. Where does the per diem payment come from? Federal/State and/or local funds?
      iii. Does the per diem include funding for clinical care and medications?
      iv. If the per diem includes clinical care and medications – how much is the per diem? Determine whether the per diem is sufficient to cover the clients HIV care and medications.
   c. If HIV medications are provided by KADAP, how will the medications be kept secure?

3. **Meetings with Clients – Once approval of the provision of KHCCP and/or KADAP services within the facility or program, the RWHAP recipient or subrecipient program must meet with the HIV+ clients.**

   a. A documented in-person meeting with each client is preferred, however if transportation or security concerns, meetings could be arranged through skype or telephone. KHCCP and KADAP eligibility forms must be completed and submitted to the State of Kentucky HIV/AIDS Branch before any services or medications are provided.

   b. Client should be provided with and complete an intake interview and assessment.

c. A treatment plan must be created, the same as for any other KHCCP or KADAP client.

4. **Inmate – HIV+ Client Eligibility**
    a. Client must meet all KHCCP and KADAP eligibility requirements
        i. Proof of HIV Status
        ii. Proof Of Kentucky Residency
        iii. Proof of financial eligibility
    b. All KHCCP/KADAP clients must be enrolled in Ryan White Part B electronic databases – including the KADAP Portal and CAREware.
    c. Documentation of client eligibility must be maintained in a secure location to ensure client confidentiality.

5. **Provision of HIV Care –**
    a. Ascertain when the most recent complete lab testing was performed and obtain copies of the lab test results.
    b. If possible, tour clinic and meet with the clinical team.
    c. Ask clinical team of their experience treating HIV and whether they have participated in training from AETC or are interested in shadowing a qualified HIV clinical provider.
    d. Ask the team what their needs are in the care and treatment of persons with HIV within the facility.

6. **Access to Lab Testing Services –**
    a. Find out how lab testing is performed and if they use a reference lab.
    b. Find out if lab testing is performed based on current CDC standards.
    c. Find out if they need financial assistance with paying for lab tests.

7. **Provision of KADAP Medications –**
    a. Prescriptions will be filled by the Kentucky Clinic Pharmacy and shipped to the correctional facility to be administered per the established facility guidelines to ensure security of the medication and adherence to the prescribed regimen.
    b. The subrecipient will work with the correctional facility to determine an agreed upon process of notification when HIV+ clients come in to their facility and wish to receive Ryan White Part B Services.

Form to be completed by KHCCP Subrecipient Personnel or KADAP Personnel Pharmacy or State Employees

Documentation of Interview with Jail or Prison Representative

Before a KHCCP or KADAP Program is eligible to provide care and services for persons that are incarcerated, a representative must gather and document the following information to assure that the KHCCP and/or KADAP Programs are in compliance with all federal laws and rules related to duplication of services and payor of last resort.

The questions below do not include discussion of discharge planning, PCN-18-02 is fairly explicit that discharge planning may begin for any incarcerated person within 180 days of their anticipated or scheduled discharge.

KHCCP or KADAP Agency: ______________________ **Date:** ______________

Agency Representative: ______________________

Jail/Prison or Halfway House: ______________________

Location of Facility: ______________________

Jail/Prison or Halfway House Representative: ______________________

Estimated Number of residents with HIV living within the facility or using the program: __

1. **Questions related to funding of facility or program.**

   Does the facility or program receive Federal or State funding?

   If the agency states they do not receive Federal or State funding then HIV+ patients in their program are eligible for KHCCP and KADAP Services.

   If the agency representative states they do receive Federal or State funds, then the following questions must be asked. Please write narrative answers for each of the questions below.

2. **Questions related to clinical/HIV care.**
   a. **Does the facility provide clinical/primary care for HIV+ residents? If yes, explain.**

   b. **Where do the funds come from to pay for clinical services?**

   c. **Are these Federal or State funds?**

d. Do the funding sources that pay for clinical care cover all the clinical needs of the HIV+ residents?

e. Does the facility receive a State or Federal per diem rate for residents?

f. How much is the per diem rate?

g. Does the per diem rate cover clinical services for persons with HIV?

h. Does the facility run out of funding for clinical care during the course of the year?

3. <u>Questions related to HIV medications.</u>

a. Does the facility provide HIV medications for HIV+ residents? If yes, explain.

b. Where do the funds come from to pay for HIV medication services?

c. Are these Federal or State funds?

d. Do the funding sources that pay for medications cover all the medication needs of the HIV+ residents?

e. Does the facility receive a State or Federal per diem rate for residents?

f. How much is the per diem rate?

g. Does the per diem rate cover the medication needs for persons with HIV?

h. Does the facility run out of funding for medications during the course of the year?

Upon completion of the form –

KHCCP Forms – to Tiffany Bivins, Kentucky HIV Care Coordinator Program Administrator for all applications for KHCCP. Applications must be submitted by Secured Fax: 877-353-9380

KADAP Forms – to Todd Hurst, Kentucky AIDS Drug Program Administrator for all applications for KADAP. Applications must be submitted by Secured Fax: 877-353-9380