COORDINATION OF CARE AND SERVICES AGREEMENT (CCSA)

PURPOSE:

Coordination of care and services involves organizing client care activities and information sharing among all participants involved with a client's care, in order to achieve safer and more effective care. The main goal of coordinating care and services is to meet the client's needs and preferences in the delivery of high-quality, high-value medical care. This means that the client's needs and preferences are known and communicated to the appropriate people. Health care providers will work together to keep the client informed and to ensure that effective referrals and transitions take place.

The purpose of the Coordination of Care and Services Agreement is to allow the client and the agency that provides linkage services to identify and select available medical and community resources that align with the client's needs and preferences. This form provides the opportunity for the client to consent to allow confidential information to be shared among services providers to help coordinate services, assist with closing the referral loop and allow for easier linkages to care. This form is not intended to be a blanket consent form and information will only be shared among agencies the client selects or approves.

INSTRUCTIONS:

REQUIRED--For the agency that originates the form:

- Provide the agency name, name of the agency personnel completing the form, phone number, secure fax number and field record number (Local Health Departments only).

If the client DECLINES Coordination of Care and Services Agreement:

- **For PrEP Services only:** do NOT complete a form for that client.
- Complete **Section A** ONLY, then STOP.
  - Fill in the client's first name, middle initial, last name and date of birth.
  - Check the box for Client DECLINES Coordination of Care and Services.
  - Check the box for the reasons the client refused.
  - Sign and date (agency personnel that is completing the form).
  - **ACTION: Fax to form to VDH Central Office at (804-864-7970)**

If the client ACCEPTS Coordination of Care and Services Agreement:

- **Complete Section A**:
  - Fill in the client's first name, middle initial, last name and date of birth.
  - Check the box for Client ACCEPTS Coordination of Care and Services.
  - Go to **Section B**.
- **Complete Sections B-C**
  - Fill in the information that the client permits to be shared for the services selected
- **Complete Section D:**
  - Provide the agency name, name of the agency personnel who is providing linkage services, phone number, and secure fax number. Check the box if the client is already in medical care but wants coordination of other services.
- **ACTION: Fax entire form to the agency listed in section D if referring to an external agency for linkage services**
- **Complete Section E**: Complete this section if your agency has received a referral for linkage services OR if you are the original agency who will also be providing linkage services for the client.
  - ***REQUIRED:*** Medical Care Referral- provide the name of the agency and provider that the client is referred to for medical care. Include the date of referral, the date of the client's first appointment, and the date that the client's attendance of the appointment is verified.
    - If the client is already in medical care, but would like coordination of other services then provide the name of the agency and medical provider that the client is currently in care at.
    - *The client's date of appointment attendance **MUST** be verified.*
  - Other Types of Service Referrals- If the client has requested referrals for additional services then complete this for all additional service referrals.

REQUIRED: If the linkage agency received a referral for linkage services, then send a copy of the completed form to the originating agency. Also, please fax ALL completed forms to the Virginia Department of Health at the secure fax number: (804) 864-7970.

For all exchanges, please be sure to use a fax cover sheet and ensure all fax lines are secure.

COORDINATION OF CARE AND SERVICES AGREEMENT

Agency Name: _____ **Agency Staff/Personnel:** _____

Phone Number: _____ **Secure Fax Number:** _____

Field Record # (DIS only): _____

Section A: Acceptance of Care and Coordination of Services

Client Name: _____ _____ _____
First *MI* *Last*

DOB: ____/____/_____
(MM/DD/YYYY)

☐ Client **ACCEPTS** Coordination of Care and Services Agreement **(Go to Section B)**

☐ Client **DECLINES** Coordination of Care and Services Agreement **(Complete the Rest of Section A)**

Reason(s) Client Refused:

☐ Client is already in care and does not need coordination of care and services.
- Medical Provider Name: _____

☐ Client is unable to be located or contacted.

☐ Client did not provide a reason.

☐ Other, please specify: _____

Agency Personnel Signature: _____ **Date Refused:** ____/____/_____

STOP HERE IF CLIENT DECLINES COORDINATION OF CARE AND SERVICES, AND FAX FORM TO VDH AT (804) 864-7970

Section B: Consent of Care and Coordination of Services Agreement

I, _____ consent to receiving coordination of my care and services, including linkage to medical care.
(Print Full Name)

I understand that different agencies provide different services and benefits, and that each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

It is understood that this agreement for the coordination of my care services is valid for 24 months from the agreement date. In addition, it is understood that in order to assist in the coordination of my care, a health system navigator (HSN), or patient navigator (PN), or other type of linkage to care staff or personnel can attempt to contact me by the above-approved methods, in the event that I miss a scheduled medical or other type of appointment related to my HIV care.

I can withdraw this agreement at any time by informing all referred agencies. I have the right to know what information has been shared, why, when and with whom it was shared. If I ask, each agency will show me this information. All agencies selected can accept a copy of this form as a valid consent to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to provide my information. However, I understand that treatment and services cannot be conditioned upon whether I sign this agreement.

Client Signature: _____ **Agreement Date:** ____/____/_____

Section C: Client Information

Current Gender:
- ☐ Male
- ☐ Female
- ☐ Transgender-M to F
- ☐ Transgender-F to M
- ☐ Other, Specify: _____
- ☐ Declined

Race:
- ☐ Black/African American
- ☐ White
- ☐ Asian/Hawaiian/Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Other, Specify: _____
- ☐ Declined

Ethnicity:
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Declined

Testing/Diagnosis Information:
- ☐ HIV Negative — **Negative Test Date**: ____/____/_____
- ☐ HIV Positive — **First Diagnosis Date**: ____/____/_____
- ☐ Hepatitis C (HCV) — **Diagnosis Date**: ____/____/_____

COORDINATION OF CARE AND SERVICES AGREEMENT

Confidential Information ***(Check all that Apply)***

Allowed to be Shared:

- ☐ Contact Information
- ☐ Medical Diagnoses
- ☐ Demographic Information
- ☐ Medical Appointments
- ☐ Substance Abuse Diagnosis/ Treatment
- ☐ Testing Information
- ☐ Financial Information
- ☐ Individual Services Plan
- ☐ Mental Health Diagnosis/Treatment
- ☐ Pre-Exposure Prophylaxis (PrEP)
- ☐ Non-occupational Post-Exposure Prophylaxis (nPEP)

May be Released to:

- ☐ Medical Care Providers
- ☐ Other Core Medical Services
- ☐ Mental Health/Substance Abuse Services
- ☐ Medication Access
- ☐ Other Services, Specify: _____

Approved Contact Methods ***(Check all that apply)*****:**

☐ In Person *(at the address below)*

_____ _____ _____ _____

Street Address **City** **State** **Zip Code**

☐ Postal Mail/Letter *(at the address below, if different than above)*

_____ _____ _____ _____

Street Address **City** **State** **Zip Code**

☐ Home Phone: _____ May we leave a message? ☐ Yes ☐ No

☐ Cell Phone: _____ May we leave a message/text message? ☐ Yes ☐ No

☐ Work Phone: _____ May we leave a message? ☐ Yes ☐ No

☐ Email: _____

Section D: Linkage to Care and Services

Agency Linking Client to Care and Services ***(may be the same as the originating agency):***

Linkage Agency Name: _____ **Phone Number:** _____

Personnel Name: _____ **Secure Fax Number:** _____

☐ Client is already in medical care but would like coordination of other services

ACTION: FAX ENTIRE FORM TO THE AGENCY ABOVE IF REFERRING TO AN EXTERNAL AGENCY FOR LINKAGE SERVICES

Section E: Referrals to Care and Services and Confirmation of Linkage

If your agency has received a referral for linkage services ***OR*** *if you are the original agency who will also be providing linkage services for the client, please complete this section:*

(REQUIRED) Medical Care Referral: *(If client is already in medical care then list current medical provider)*

Medical Agency: _____ Date of Referral: ___/___/___

Medical Provider: _____ Appointment Date: ___/___/___

Date Attendance Verified: ___/___/___

Other Service Referrals:

Type of Referral: _____ Date of Referral: ___/___/___

Agency Referred to: _____ Appointment Date: ___/___/___

Type of Referral: _____ Date of Referral: ___/___/___

Agency Referred to: _____ Appointment Date: ___/___/___

Type of Referral: _____ Date of Referral: ___/___/___

Agency Referred to: _____ Appointment Date: ___/___/___

ACTION: PLEASE SECURELY FAX ALL COMPLETED FORMS TO THE ORIGINATING AGENCY (IF APPLICABLE) AND TO THE VDH CENTRAL OFFICE AT (804) 864-7970

Notes/Comments: