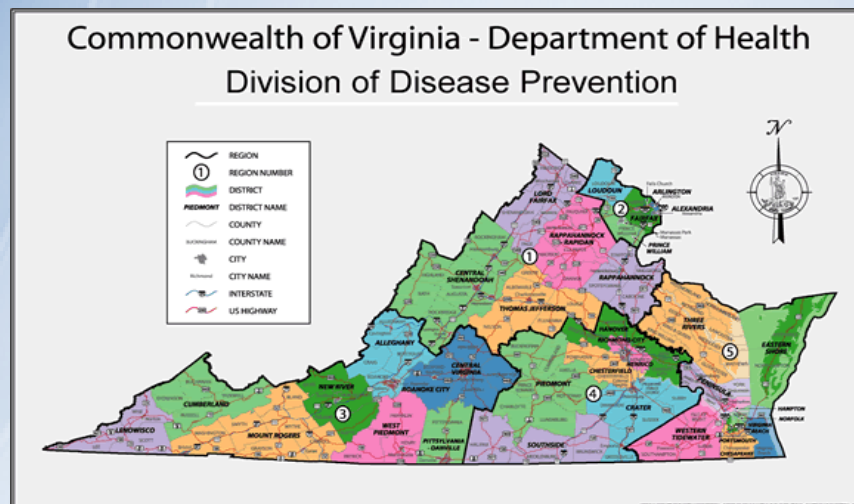


# HIV CARE SERVICES Contractor Guidelines 2011



Division of Disease Prevention

**VDH** VIRGINIA  
DEPARTMENT  
OF HEALTH  
*Protecting You and Your Environment*

## **Foreword and Acknowledgements**

The HIV Care Services (HCS) Unit of the Division of Disease Prevention (DDP) has composed these guidelines to provide information and support to our contractors. This document includes guidance on invoicing, reporting, contracting activities, resources and quality management (QM) practices. Our intent was to put useful information in one easily accessible document to serve as a reference for our contracting partners.

Our contractors are valued partners in the provision of HIV related services, providing a remarkable array of services and support across the state. With diligence, hard work and dedication, contractors play the most critical role in providing services to people living with HIV and AIDS. We value the work of our contractors as the vital link in ensuring the delivery of medical and support services.

I would like to thank those who contributed to this document. First, I would like to acknowledge our HIV Prevention Unit colleagues who initiated the development of contractor guidelines within the Division. They graciously shared their ideas and documents so that we could adapt it to the needs of HCS contractors. Next, I would like to thank the members of the HCS staff who contributed to this document. We hope you find them useful. If contractors have any questions about its contents, please contact your HIV Services Coordinator.

Sincerely,

Diana L. Jordan, RN, MS, ACRN  
Director of HIV Care Services  
Division of Disease Prevention  
Virginia Department of Health  
109 Governor St, Room 326  
Richmond, VA 23219  
Ph: (804) 864-7958 Fax: (804) 864-7629

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## What is the Ryan White HIV/AIDS Program?



Ryan White was diagnosed with AIDS at age 13. He and his mother Jeanne White Ginder fought for his right to attend school, gaining international attention as a voice of reason about HIV/AIDS. At the age of 18, Ryan White died on April 8, 1990, just months before Congress passed the AIDS bill that bears his name – the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. The legislation has been reauthorized four times since – in 1996, 2000, 2006, and 2009 – and is now called the Ryan White HIV/AIDS Program.

The Ryan White HIV/AIDS Treatment Extension Act of 2009 Part B funding is intended to help states increase the availability of primary health care and support services in order to reduce utilization of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life of those affected by the epidemic.

The Ryan White HIV/AIDS Program is the largest Federal program focused exclusively on HIV/AIDS care. The program is for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills gaps in care not covered by these other sources.

The Ryan White HIV/AIDS Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). For a thorough understanding of Ryan White legislation, you can visit the HRSA HAB website at: <http://hab.hrsa.gov>

The 2009 Ryan White legislation changed how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS across this country. Key changes included:

- Revised method for determining eligibility for Part A (formerly called Title I) funds gives priority to urban areas with the largest number of people living with HIV/AIDS while also helping mid-size cities and areas with emerging needs.
- Revised method for distributing Part A funds to metropolitan areas with the highest number of people living with HIV/AIDS. It also encourages outreach and testing, which will get people into treatment sooner and save more lives.

- More money will be spent on direct health care for Ryan White clients. Under the 2009 law, grantees receiving funds under Parts A, B, and C (formerly called Titles I, II, and III) must spend at least 75% of funds on core medical services.
- The 2009 law recognizes that HIV/AIDS has had a devastating impact on racial/ethnic minorities in the U.S. African Americans accounted for approximately half of all diagnosed HIV/AIDS cases. The 2006 law codified the Minority AIDS Initiative under the Ryan White HIV/AIDS Program.
- Of primary importance is the provision that states must spend or obligate 95% or more of their grant award from HRSA. States with 5% or more of their grant funds unobligated at the close of the grant year will have future grant awards reduced by the amount of the unspent balance. Contractors and subcontractors should closely monitor their budgets to make every effort to spend allocated funds.

Virginia receives funds to improve the quality, availability, and organization of health care and support services for individuals living with HIV disease and their families. The Department of Health oversees the implementation and funding for the Ryan White Part B (RWB) program in Virginia under the guidance of HRSA. These funds are managed by the HCS Unit of the DDP.

The DDP Web site <http://www.vdh.virginia.gov/Epidemiology/DiseasePrevention/> provides a thorough overview of the mission and scope of services provided with and by RWB funding. On this site, you can review a map of the Health Regions, obtain fact sheets, order printed materials, view statistics on sexually transmitted diseases including HIV, and/or get detailed information on all programs that are currently managed by the DDP. Details of specific programs can be accessed through the “Our Programs” link on the Division homepage. Visiting the link titled “HIV Care Services” is highly recommended

**VIRGINIA DEPARTMENT OF HEALTH DIVISION OF DISEASE PREVENTION  
HIV CARE SERVICES TEAM**

| Name               | Position  | Phone #        | E-Mail   |
|--------------------|---|----------------|--|
| Diana Jordan       | Director of HIV Care Services                   | (804) 864-7958 | <a href="mailto:Diana.Jordan@vdh.virginia.gov">Diana.Jordan@vdh.virginia.gov</a>             |
| Steven Bailey      | Assistant Director of HIV Care Services         | (804) 864-8065 | <a href="mailto:Steve.Bailey@vdh.virginia.gov">Steve.Bailey@vdh.virginia.gov</a>             |
| Lenore Drewry      | Lead HIV Services Coordinator                   | (804) 864-8022 | <a href="mailto:Lenore.Drewry@vdh.virginia.gov">Lenore.Drewry@vdh.virginia.gov</a>           |
| Rachel Rees        | AIDS Drug Assistance Program (ADAP) Coordinator | (804) 864-7919 | <a href="mailto:Rachel.Rees@vdh.virginia.gov">Rachel.Rees@vdh.virginia.gov</a>               |
| Ann Verdine-Lewis  | HIV Services Coordinator                        | (804) 864-8018 | <a href="mailto:Ann.Verdine-Lewis@vdh.virginia.gov">Ann.Verdine-Lewis@vdh.virginia.gov</a>   |
| Kate Cooke         | ADAP Operations Specialist                      | (804) 864-8019 | <a href="mailto:Kate.Cooke@vdh.virginia.gov">Kate.Cooke@vdh.virginia.gov</a>                 |
| Safere Diawara     | Quality Management Coordinator                  | (804) 864-8021 | <a href="mailto:Safere.Diawara@vdh.virginia.gov">Safere.Diawara@vdh.virginia.gov</a>         |
| Anne Rhodes        | Services Analyst                                | (804) 864-8013 | <a href="mailto:Anne.Rhodes@vdh.virginia.gov">Anne.Rhodes@vdh.virginia.gov</a>               |
| Jeannie Rector     | Executive Secretary                             | (804) 864-7965 | <a href="mailto:Jeannie.Rector@vdh.virginia.gov">Jeannie.Rector@vdh.virginia.gov</a>         |
| Lisa Laurier       | HIV Services Coordinator                        | (804) 864-7621 | <a href="mailto:Lisa.Laurier@vdh.virginia.gov">Lisa.Laurier@vdh.virginia.gov</a>             |
| Hunter Robertson   | HIV Services Coordinator                        | (804) 864-7412 | <a href="mailto:Hunter.Robertson@vdh.virginia.gov">Hunter.Robertson@vdh.virginia.gov</a>     |
| Jennifer Flannagan | ADAP Operations Specialist                      | (804) 864-7360 | <a href="mailto:Jennifer.Flannagan@vdh.virginia.gov">Jennifer.Flannagan@vdh.virginia.gov</a> |
| Mary Browder       | HIV Services Coordinator                        | (804) 864-7199 | <a href="mailto:Mary.Browder@vdh.virginia.gov">Mary.Browder@vdh.virginia.gov</a>             |
| Hilary Viens       | HIV Services Coordinator                        | (804) 864-7410 | <a href="mailto:Hilary.Viens@vdh.virginia.gov">Hilary.Viens@vdh.virginia.gov</a>             |
| Darren Whitfield   | HIV Services Coordinator                        | (804) 864-7411 | <a href="mailto:Darren.Whitfield@vdh.virginia.gov">Darren.Whitfield@vdh.virginia.gov</a>     |
| Sharon Woo         | Business Manager                                | (804) 864-7946 | <a href="mailto:Sharon.Woo@vdh.virginia.gov">Sharon.Woo@vdh.virginia.gov</a>                 |

**Fax Numbers**

|                      |                |
|----------------------|----------------|
| Health Care Services | (804) 864-7629 |
| ADAP                 | (804) 864-8050 |
| Jeannie Rector       | (804) 864-7983 |
| Sharon Woo           | (804) 864-8213 |

## RYAN WHITE PART B MINORITY AIDS INITIATIVE (MAI)



The Virginia Department of Health (VDH) receives funds under the Ryan White HIV/AIDS Treatment Extension Act of 2009 Part B Minority AIDS Initiative (MAI) Grant Program to provide case-finding, outreach and education services to increase access to the AIDS Drug Assistance Program (ADAP) and other prescription drug coverage for racial and ethnic minorities. Community-based organizations and health districts focus on identifying and referring individuals at risk for or infected with HIV in order to link them into ADAP, and those HIV-positive individuals who have been lost-to-care in order to re-engage them in ADAP and other needed care services. Linkage to medical care is supported by additional Part B funds to ensure complete access to treatment.

VDH will be identifying MAI contractors this year through a competitive process. HCS will provide notification when these contractors are selected.

## STATE EARLY INTERVENTION PROGRAMS (EIPS)



VDH receives funds from the State General Assembly to support HIV Early Intervention Programs in Central and Southwest Virginia. Continued funding for Early Intervention Programs (EIPs) ensures that individuals with HIV infection enter care as early as possible in their disease process. The EIPs strategically utilize these funds to improve or maintain access to HIV care and services. These programs not only provide treatment and counseling to clients to enable them to remain healthy and productive as long as possible, but also provide supportive care during the difficult psychological period after initial diagnosis of HIV infection. In addition, EIPs enable clients to improve their health and remain adherent to their anti-retroviral medication regimen, which is critical to quality of life. These programs also provide case management services that help newly-diagnosed clients apply for Medicaid, Medicare Part D, Social Security disability and/or supportive services.

### **Arthur Ashe Program (AAP)**

Virginia Commonwealth University (VCU) Health System  
PO Box 980049, Richmond, Virginia 23298  
**Street Address:** 1101 E. Street, MCV Station,  
Richmond, Virginia 23298-0049  
Phone # (804) 230-2087  
Fax # (804)230-2071  
ATTN: **Dr. C. Greg Childress, M.D., Director**  
Email: [clchildr@mail2.vcu.edu](mailto:clchildr@mail2.vcu.edu)

### **Central Virginia Health District (CVHD)**

PO Box 6056, Lynchburg, Virginia 24505  
**Street Address:** 1900 Thomson Drive,  
Lynchburg, Virginia 24505  
Phone # (804) 947-6777  
ATTN: **Dr. Katherine V. Nichols, M.D., District Director**  
Email: [Katherine.Nichols@vdh.virginia.gov](mailto:Katherine.Nichols@vdh.virginia.gov)

### **Fan Free Clinic (FFC)**

Fan Free Clinic  
PO Box 6477, Richmond Virginia 23230  
**Street Address:** 1010 N. Thompson Street  
Richmond, Virginia 23230  
Phone # (804)358-6343  
ATTN: **Karen Legato, Executive Director**  
Email: [KLegato@fanfreeclinic.org](mailto:KLegato@fanfreeclinic.org)

## **RYAN WHITE PART B AIDS DRUG ASSISTANCE PROGRAM (ADAP)**



ADAP provides HIV medication to low income persons living with HIV who have no medication coverage from private or third party insurance, including Medicaid. Funded by RWB and State Funds, it is the payer of last resort. In Virginia, two types of medication access are made available for eligible clients: (1) medication pick-up at a local health department (LHD) or other designated sites and (2) the Medicare Part D Assistance Program (MPAP), which includes the State Pharmaceutical Assistance Program (SPAP). All states and territories receive funding for State ADAP Programs. The best resource for current information regarding ADAP is the HCS ADAP website:

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/index.htm>.

### **Program Overview**

The program is administered centrally through VDH, with medications made available at all LHD and the Virginia Commonwealth University Health System (VCUHS). VDH's Central Pharmacy Services purchases and dispenses ADAP medications for all LHDs' ADAP clients with the exception of Fairfax County and Alexandria Health Departments. Fairfax County, Alexandria, and VCUHS are provided bulk ADAP medications from Central Pharmacy Services and dispense individual medications locally from in-house pharmacies. For all other sites, prescriptions are ordered through Central Pharmacy Services by LHD staff. The Central Pharmacy fills prescription orders and ships back to the LHDs. Clients come to the LHDs to pick up their medications. This delivery system ensures that all clients in the state have access to medications, as LHDs are located throughout every area of the state.

### **Eligibility and Formulary**

The ADAP website is the best resource for up-to-date eligibility criteria and formulary. The formulary document includes the criteria required for each medication. Some medications on the formulary require additional medical criteria. If a clinician desires to prescribe any of these medications, an ADAP Medication Exception Form will need to be completed and submitted for authorization (Attachment 6).

- Eligibility:  
<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/eligibility.htm>
- Formulary:  
<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/formulary.htm>

## **Policy Updates**

ADAP policy updates are routinely published and made available on the ADAP website. These updates are targeted towards program staff and are subject specific. Please visit the ADAP Update page to review the policy updates:

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/updates.htm>.

## **Centralized Eligibility & MPAP**

In 2008, HCS released a Request for Proposals (RFP) to identify a contractor to administer the centralized eligibility determination program for ADAP. A qualified candidate, Patient Services, Inc. (PSI), was selected and project planning began in early 2009 and continues today. Except for clients accessing ADAP through VCUHS, PSI will be responsible for all ADAP eligibility determinations. Medications will still be dispensed from Central Pharmacy to the LHDs for client pick up or VCUHS.

All new and returning applicants to ADAP must complete an application with PSI, with the exception of clients accessing medication through (VCUHS).

In addition to centralized eligibility, PSI manages the MPAP for Virginia. The MPAP provides financial support towards medication co-payments, deductibles, and premiums associated with a Medicare Part D plan for eligible individuals with income less than 400% of the federal poverty level (FPL). The SPAP will continue to cover premiums and related costs for eligible individuals with income less than 300% FPL.

An application can be submitted for either program by calling PSI at 1-866-1309. The ADAP website will reflect current programmatic information and eligibility criteria.

## **SEAMLESS TRANSITION PROGRAM**



The overall goal for this program is to provide a seamless transition in relation to HIV/AIDS medications for persons released from state correctional facilities as they re-enter Virginia communities. This project is a collaborative agreement between the Virginia Department of Corrections and VDH. The program was initiated in July 2000. Discharge plans are made prior to the release date of the inmate between the Department of Corrections and the LHD to ensure continuation of medical care and medications.

### **Virginia Department of Health (VDH)**

PO Box 2448, Room 326, Richmond, Virginia 23218

**Street Address:** 109 Governor Street,  
Richmond, Virginia 23219-2448

Phone # (804) 864-8019

Fax # (804) 864-8050

ATTN: **Kate Cooke, ADAP Operations Specialist**

Email: [Kate.Cooke@vdh.virginia.gov](mailto:Kate.Cooke@vdh.virginia.gov)

## **RYAN WHITE PART B STATEWIDE QUALITY MANAGEMENT PROGRAM**



The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, September 30, 2009) requires Clinical Quality Management (CQM) programs as a condition of grant awards. VDH/HCS is committed to improving the quality of care and services for people living with HIV and AIDS through continuous quality monitoring and improvement in a comprehensive performance measurement program. This effort requires ongoing communication with consumers, employees, stakeholders, consortia, contractors, subcontractors, Quality Management Advisory Committee (QMAC), Quality Management Leadership Team (QMLT), Peer Review Team, providers and all levels of management.

The Quality Management Program for Virginia emphasizes the importance of establishing and implementing protocols and policies to ensure that each and every person living with HIV/AIDS (PLWH/A) has access to a quality of medical care and support services consistent with appropriate standards and guidelines. VDH has adopted a Statewide Independent Peer Review Team and recently began collecting measurable indicators as benchmarks that will allow VDH to show areas of improvement or need for improvement. The team is being used to evaluate provider quality of care to clients and to ensure adherence to federal and state standards. The Independent Peer Review Team performs site visits to all service providers on a two-year cycle. The team consists of subject matter experts that include nurse practitioners, social workers, consumers, dentists, and VDH and/or Lead Agency representatives.

Services are reviewed both programmatically and at the direct service level through client record reviews using standardized modules. The modules include key indicators that evaluate compliance with service requirements (such as documenting eligibility) and adherence to established clinical guidelines (such as monitoring CD4 counts and viral loads at appropriate intervals). Administrative aspects of service delivery are reviewed by the VDH or Lead Agency representative. Deficiencies require a response from the service provider in the form of a corrective action plan that is time-specific and outcome-based.

In addition, in accordance with HRSA policy, RW-funded providers, subcontractors and direct contractors are required by VDH to develop and implement a QM plan with measurable objectives. Progress made in developing QM plans and in reaching identified outcomes is monitored by HIV Services Coordinators.

Under the leadership of the HCS Quality Management Coordinator, a 2010 QM Plan was written and approved. The developed QM Plan included input from stakeholders and consumers throughout Virginia and across Ryan White Programs. It can be found at online at: <http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/reportsandpubs.htm>. Soon to be approved, the 2011 QM Plan will be available at the same location.

The QM program utilizes various activities and tools including: Needs assessment, collaboration and coordination, client outcomes and satisfaction interview, collection and analysis surveys, chart review, Virginia Client Reporting System (VACRS) and other databases, reports audits, trainings, contractor monthly or quarterly reports, etc.

A number of our QM documents and reports are available online through the HCS Web site at <http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS>. These include:

- Statewide Coordinated Statement of Need and Final Survey Data Report
- HIV/AIDS Case Management Standards
- QM Plan
- Peer Review Standards and Modules
- Patient Safety and Clinical Pharmacy Services
- Ryan White Cross-Part Collaborative

In addition, there are many QM resources available online at other Web sites, including:

- HRSA's HIV/AIDS Bureau: Quality Management Manual: <http://hab.hrsa.gov/tools/QM>
- National Quality Center for HIV/AIDS Care: <http://www.NationalQualityCenter.org>
- HIV Clinical Resource- New York State Department of Health AIDS Institute : <http://www.hivqual.org>

The Peer Review Team is comprised of members with experience in specific service areas and includes members who have been diagnosed with HIV. The Statewide Peer Review Team annually reviews 50 percent of the agencies funded.

The RWB QM Program actively encompasses coordinating three collaborative projects from the HRSA/National Quality Center which are the Ryan White Cross-Part Collaborative and the Patient Safety and Clinical Pharmacy Services Collaborative and the DC Cross-Parts Collaborative.

The overall QM activities will reflect a continuous process, which improves and informs the delivery system of outcome results, and demonstrates a commitment to quality services for all individuals served within the RWB provider network.

**Virginia Department of Health (VDH)**

PO Box 2448, Room 326, Richmond, Virginia 23218

**Street Address:** 109 Governor Street,

Richmond, Virginia 23219-2448

Phone # (804) 864-8021

Fax # (804) 864-7629

ATTN: **Safere Diawara, Quality Management Coordinator**

Email: [Safere.Diawara@vdh.virginia.gov](mailto:Safere.Diawara@vdh.virginia.gov)

## **RYAN WHITE PART B DATA MANAGEMENT SERVICES**



Part B of Ryan White HIV/AIDS Treatment Extension Act 2009 requires that data be collected and reported to HRSA on a quarterly and annual basis for all funded programs. The Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University (VCU) developed and maintains a customized, web-based application, VACRS, to collect and report service data for care programs. Additionally, it has an established system to collect and report required data for the state ADAP. SERL has been providing data management services for Virginia's HCS data since the initiation of the program. Thus, SERL has developed sound knowledge and expertise related to these data collection and reporting requirements. Please contact SERL with any questions or concerns related to data reporting.

HCS also has an on-staff data analyst who analyzes and interprets statistical data related to HIV service delivery, and health services-related epidemiological trends associated with Ryan White programs (e.g., medications, treatment, transportation and mental health services) to evaluate program performance and forecast future needs. The analyst may be contacted for any questions related to needs for data or interpreting reports generated from VACRS or ADAP.

**Virginia Commonwealth University (VCU),**  
**Survey and Evaluation Research Laboratory (SERL)**  
**Street Address:** 921 West Franklin Street,  
Richmond, Virginia 23284  
Phone: (804) 828-0779, Fax: (804) 628-0646  
ATTN: **Kim Hunter, Research Specialist Senior**  
Email: [khunter@vcu.edu](mailto:khunter@vcu.edu)

## **RYAN WHITE PART B CONSORTIA**



A Consortium is generally an association of public, nonprofit private health care and support services providers, community-based organizations, community individuals, and individuals infected and affected by HIV/AIDS. The Consortium analyzes gaps in medical and support services in its area and develops a comprehensive plan to address these gaps.

The Lead Agency for the consortium conducts or updates an assessment of HIV/AIDS service needs for their geographical area, establishes a service delivery plan based upon prioritized services, coordinates and integrates the delivery of HIV-related services, assures the provision of comprehensive outpatient health and support services, evaluates its success in responding to service needs, and measures cost-effectiveness of mechanisms used to deliver comprehensive care.

### **Contractor/Subcontractor Resources:**

For your convenience, points of contact for each of the four lead agencies are provided below:

#### **VIRGINIA HIV CARE CONSORTIA:**

##### **Eastern Virginia HIV Care Consortium (EVHCC)**

Eastern Regional AIDS Resource and Consultation Center  
Eastern Virginia Medical School (EVMS)  
PO Box 1980, Norfolk, Virginia 23501-1980

**Street Address:** 358 Mowbray Arch, Suite 106, Smith Rogers Hall,  
Norfolk, Virginia 23501  
Phone # (757) 446-6170  
Fax # (757) 446-6035  
(800) 999-8385

ATTN: **Tanya Kearney, Program Director**  
Email: [kearnetk@evms.edu](mailto:kearnetk@evms.edu)

**Northern Virginia HIV Care Consortium (NVHCC)**

Northern Virginia Regional Commission (NVRC)  
**Street Address:** 3060 Williams Drive, Suite 510  
Fairfax, Virginia 22031  
Phone # (703) 642-0700  
Fax # (703) 642-5077  
ATTN: **Michelle Simmons, Program Director**  
Email: [msimmons@novaregion.org](mailto:msimmons@novaregion.org)

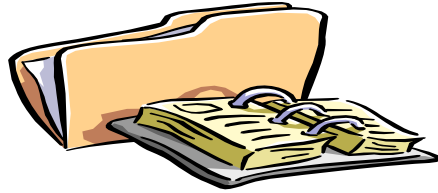
**Northwest HIV Care Consortium (NWHCC)**

Institute for Innovation in Health and Human Services  
James Madison University  
**Street Address:** 601 University Boulevard, MSC 9009  
Harrisonburg, Virginia 22807  
Phone # (540) 568-3178  
Fax # (540) 568-6374  
ATTN: **Gary Race, Program Director**  
Email: [rices@cisat.jmu.edu](mailto:rices@cisat.jmu.edu)  
**Jane Hubbell, Associate Director, IIHHS, JMU**  
Email: [hubbeljx@jmu.edu](mailto:hubbeljx@jmu.edu)

**Southwest/Piedmont HIV Care Consortium (SWVHCC)**

Council of Community Services (CCS)  
PO Box 598, Roanoke, Virginia 24004  
**Street Address:** 502 Campbell Avenue SW  
Roanoke, Virginia 24004  
Phone # (540) 985-0131  
Fax # (540) 982-2935  
ATTN: **Robert Morrow, Program Director**  
Email: [robertm@councilofcommunityservices.org](mailto:robertm@councilofcommunityservices.org)  
**Cathy Fisher, Grant Monitor**  
Email: [cathyf@councilofcommunityservices.org](mailto:cathyf@councilofcommunityservices.org)

## **WHAT TO EXPECT FROM YOUR VDH HIV SERVICES COORDINATOR**



Your HIV Services Coordinator is your first point of contact with the DDP regarding any contractual matters. You can expect the following from your HIV Services Coordinator:

1. He or she will address your questions or concerns within a timely manner. The HIV Services Coordinator will seek assistance from other Division staff when appropriate.
2. Once a new contract/memorandum of agreement (MOA) is signed, you will be provided with the following forms from your HIV Services Coordinator (as applicable): “Request for Payment” and “Budget Reallocation Request” forms.
3. Review of your monthly or quarterly progress reports with written feedback will be provided within 15 days after the receipt of the reports into the VDH office. Follow-up with further information/explanation may be requested.
4. Your HIV Services Coordinator will conduct at least one site visit per year. This visit may be programmatic and/or administrative. During this visit, your HIV Services Coordinator may request to review program policies and procedures, time and effort sheets, fiscal invoices and any other documentation relating to the operation of your contract/MOA. Written feedback of the site visit will be prepared within 30 days.
5. Your HIV Services Coordinator will provide technical assistance as appropriate and will notify you when work plan revisions and budget reallocations have been approved by the Division. (See more information under the Work Plan and Budget Reallocation Section.)
6. If the contract/MOA is to be renewed, your HIV Services Coordinator will notify you of the intent to renew approximately 90 days prior to the end of your current contract. The letter will indicate the contractual period and the amount to be awarded, as well as indicate when the contractor’s work plan is due to the Division.

## **WHAT VDH EXPECTS FROM IT'S CONTRACTORS**



### **Direct Service Providers and Subcontractors:**

The VDH DDP initiates direct agreements for some services instead of contracting through Consortia. Direct Service Providers are those entities that have direct agreements (MOA or contract) with VDH. Under the reauthorized Ryan White Treatment Extension Act of 2009, at least 75% of the service dollars must be used to provide core medical services as described under Ryan White legislation. All statewide services, including core medical services, delivered through Consortia are deemed support services (PHS Act Sec. 2614(a)[1-3]).

For the purposes of this manual, “subcontractors” are those entities that have agreements with entities that contract with VDH. Contractors are responsible for ensuring that subcontractors comply with all terms of funding, including federal and state polices and legislation.

### **Contractor and Subcontractor Responsibilities:**

- Delivery of quality services to HIV/AIDS eligible clients.
  - Ensure client eligibility.
  - Submit monthly or quarterly reports in a timely manner.
  - Comply with all components of the contract between VDH and the agency or the Consortium and the agency.
- Implement and maintain an invoice system using standard accounting practices; that when tallying receipts to request reimbursement on the invoice no rounding is allowed. VDH will reimburse the exact amount specified on the supporting documentation supplied with request. Client identifying data should be removed from all documents supplied with the invoice prior to submitting to VDH.
- Establish, implement and evaluate a continuous quality improvement system.
  - Participate with the Peer Review process (described earlier in this document).
  - Ensure that all clients who receive services use any and all available third party payer funds prior to using Ryan White funds; Ensures that RWB-funded copayment assistance provided by the contractor (or subcontractors) for antiretroviral medications (ARVs) occurs only after all alternative methods of payment, including Copayment Patient Assistance Programs (Copay PAPs), have been attempted.
  - Collect and maintain back-up documentation for all invoices submitted to the fiscal agent for payment
  - Ensure confidentiality of all client records
  - Maintain current policies and procedures manuals
  - Prepare and follow an annual work plan and budget approved by VDH or the Lead Agency
  - Comply with federal and state policies and legislation associated with funding
  - Maintain client level information in an approved database

Below is some further information that is specific to Ryan White Program funding.

**Eligible Clients:**

Eligible clients are individuals and families who are infected and/or affected by HIV disease and meet program income eligibility requirements. Proof of HIV diagnosis is required, with appropriate documentation of proof further defined in the “Policy on HIV Diagnosis Documentation” developed by HCS. This policy may be obtained through HIV Services Coordinators (Contract Monitor) if needed. Income eligibility requirements are updated annually and maybe accessed on the Web at <http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS/>.

Unemployed eligible clients are not required to purchase health insurance. Clients who have access to private insurance coverage through an employer or family member should utilize this option before relying on Ryan White funding, as Ryan White funding is considered a payor of last resort. Some clients may be unable to acquire available insurance due to an undue hardship, cost of the policy, or other concerns such as possible disclosure of status to a primary holder of the insurance. If a client is assessed to be unable to acquire available private insurance, the reason should be clearly documented as part of the eligibility determination record (e.g., cost of policy and explanation as to why this is not feasible for the client).

**Ryan White Co-payments:**

Specific to Ryan White legislation, co-payments for services are subject to certain conditions. Services provided under RWB funding must follow these conditions. A summary of the co-payment terms follows:

- In the case of individuals with an income less than or equal to 100 percent of the official poverty level (FPL), the provider will not impose co-pay charges on any individual for the provision of services;
- In the case of individuals with an income greater than 100 percent of the FPL, the provider will impose co-pay charges on each individual for the provision of such services and will impose charges according to a schedule of charges that is made available to the public;
- In the case of individuals with an income greater than 100 percent of the FPL and not exceeding 200 percent of the FPL, the provider will not, for any calendar year, impose charges in an amount exceeding 5 percent of the annual gross income of the individual involved;
- In the case of individuals with an income greater than 200 percent of the FPL and not exceeding 300 percent of the FPL, the provider will not, for any calendar year, impose charges in an amount exceeding 7 percent of the annual gross income of the individual involved, and;

- In the case of individuals with an income greater than 300 percent of the FPL, the provider will not, for any calendar year, impose charges in an amount exceeding 10 percent of the annual gross income of the individual involved.

### **Monthly or Quarterly Progress Reports/Evaluations:**

Monthly or quarterly reports are due by the 30<sup>th</sup> of the month following the end of the month or quarter. Contractors are offered the option of submitting electronically at the HIV Services Coordinator's discretion. The HIV Services Coordinator would then be responsible for printing a hard copy to maintain on file (hard copies are an audit requirement). If mailed, reports should be sent to the DDP Director, Virginia Department of Health, Division of Disease Prevention, 109 Governor Street, P.O. Box 2448, Room 326, Richmond, VA 23218-2448 or hand delivered.

**One original** report should be submitted in the following format:

- a) Highlights (a maximum of one page).
- b) Restatement of each objective.
- c) Activities undertaken to fulfill planned objectives.
- d) Problems and barriers encountered. If there were no barriers faced during the month or quarter, please state that none were identified during the reported period. This format allows for easy reading and assists HIV Services Coordinators in providing prompt technical assistance.
- e) Lead agency report (if applicable).
- f) Subcontractor reports that will include the number of clients served (if applicable).
- g) Other related activities.
- h) Data entry status into the VACRS or other approved system (if applicable). List problems or barriers encountered (if any).
- i) Budget status including percent of funding expended for the month or quarter and YTD.
- j) Document and report all activity related to medication access for clients on a monthly or quarterly basis as part of the contractually required monthly (or quarterly) progress reports.
- k) Contractor will ensure that case management services (both medical and non-medical) funded through RWB funds (either contracted or subcontracted) support medication access for case managed clients, including enrollment and maintenance in manufacturer Pharmaceutical Assistance Programs when appropriate. RWB-funded case managers are required to:

- Assess and document medication access for clients at every assessment and reassessment at appropriate time intervals directed in the HIV/AIDS Case Management Standards.
  - Initiate, coordinate and complete enrollment and re-enrollment requirements for medication access systems for case managed clients, including manufacturer Pharmaceutical Assistance Programs.
  - Serve as the primary contact for medical providers seeking medication access for their case managed clients.
  - Provide medication access resource information and education to clients and providers.
  - Document all activity related to medication access activity for clients in client charts, clearly noted on Assessments, Reassessments, Individual Service Plans and Issues Lists. This is subject to review by funder at any time.
  - Report activities related to these terms on a monthly basis as part of the contractually required monthly progress reports.
- 1) The contractor is responsible for ensuring that RWB-funded copayment assistance provided by the contractor (or subcontractors) for antiretroviral medications (ARVs) occurs only after all alternative methods of payment, including Copayment Patient Assistance Programs (Copay PAPs), have been attempted. Activities related to these terms must be reported as part of the contractually required monthly progress reports to VDH.

For Ryan White funded services also indicate in the report the number of unduplicated clients served by each service category that month/quarter and the number of people (unduplicated) served year-to-date, the number of service units provided that month/quarter and the number of service units provided year-to-date, along with expenditures by service category. Identify technical assistance needs.

## B. REIMBURSEMENT FOR CONTRACTUAL EXPENDITURES



Monthly or quarterly payments will be reimbursed within 30 days of receipt. Your HIV Services Coordinator will review the requests for payment for accuracy and will forward to the fiscal office within 7 days, unless there is a discrepancy.

Monthly or quarterly requests for payment are due by the 30<sup>th</sup> of the following month or quarter. Please refer to the Division Contract Line Item Format when submitting requests for payments (Attachment 5). The time frame should correspond to the funding time period of your contract. These categories are provided to ensure appropriate ordering of budget categories and placement of line items (Attachments 2 and 3). This document also describes what each line item entails. The invoice should reflect the line items in the approved budget.

Each Contractor must develop a budget that will enable it to comply with uniform administrative requirements to compare actual expenditures or outlays with budgeted amounts for each grant or sub-grant. Each contractor must develop a budget for each grant that it receives. The developed budget will be part of the grant application or competitive procurement process or as part of a grant renewal process. Contractors must develop budgets based on the allocations they receive from VDH. VDH recommends that each contractor include the following procedures for budget development:

- Identify expected allocations by contract, category and year of appropriation;
- Identify expenditures by functional classification and cost category;
- Develop written budget justifications and processes that specify the process by which the budget is developed, approved, implemented, monitored and revised; and
- Submit and maintain supporting documentation for budgeted amounts.

If VDH receives a request for payment for the current month or quarter, prior to the last day of that month or quarter, VDH will not process the request until the following month or quarter. Example: if the contractor requests payment for the month of December and the request for payment is received any day during the month, it will not be processed until the beginning of January.

All awarded monies must be obligated or spent by the last day of the grant year. Unexpended funds may not be carried over to the next funding year. However, contracts can be extended as long as the extension is still within the same grant period.

“Funds obligated” means there is written documentation between you and a vendor/provider for the service or products; however, the contractor has not yet received the actual bill or invoice.

The contractor shall be paid on the basis of invoices submitted, completion of objectives, and submission of required reports. VDH may elect to withhold payment if contractual obligations are not met.

Please put the grant program name, FIN/EIN number and *full* contract number on request for payments so that they will be routed to the correct HIV Services Coordinator. Use of agency given names for grant programs can delay processing. Invoices and requests for payment must be mailed. FAXED INVOICES will NOT be accepted. Occasionally the contractor may need to send in an invoice faster than through the mail. In those circumstances, at the discretion of the HIV Services Coordinator, invoices may be sent through email in a PDF format or scanned into a jpeg file.

**VDH Invoice Submission Guidelines:**

Updated documentation requirements follow: (effective April 1, 2009)

**Salary and fringe categories:** A spreadsheet or word document that includes an employee name (as it appears on the payroll-no nicknames), amount of salary and fringe charged to the contract requesting reimbursement for the current billing cycle. If the salary/fringe is allocated to numerous grants add two columns (one for salary and one for fringe) and key the amount charged for each grant impacted. Be sure to label columns appropriately. Timesheets or other documents which include personal employee information are not required but should be maintained for site review. The employee name, salary charged and fringe charged should be submitted as in the following example.

| June, 2009   |            | Grant #1<br>(enter grant title) |                 | Grant #2<br>(enter grant title) |                 |
|--------------|------------|---------------------------------|-----------------|---------------------------------|-----------------|
| Employee     |            |                                 |                 |                                 |                 |
| Last Name    | First Name | Salary                          | Fringe          | Salary                          | Fringe          |
| Trump        | Peter      | \$270.00                        | \$32.40         | \$270.00                        | \$32.40         |
| Bush         | Taylor     | \$175.50                        | \$21.06         | \$175.50                        | \$21.06         |
| Hall         | Alan       | \$367.50                        | \$44.10         | \$367.50                        | \$44.10         |
| Hale         | Danny      | \$185.95                        | \$22.31         | \$185.95                        | \$22.31         |
| Timely       | Elvis      | \$195.00                        | \$23.40         | \$195.00                        | \$23.40         |
| Esther       | Polly      | \$396.50                        | \$47.58         | \$396.50                        | \$47.58         |
| Freely       | Inga P.    | \$39.00                         | \$4.68          | \$39.00                         | \$4.68          |
| Romig        | Karen      | \$177.83                        | \$21.34         | \$177.83                        | \$21.34         |
| Parker       | David      | \$948.75                        | \$113.85        | \$948.75                        | \$113.85        |
| Hayes        | Rachel     | \$236.74                        | \$28.41         | \$236.74                        | \$28.41         |
| Woods        | Sharon     | \$546.00                        | \$65.52         | \$546.00                        | \$65.52         |
| Buquet       | Mercy      | \$84.50                         | \$10.14         | \$84.50                         | \$10.14         |
| <b>Total</b> |            | <b>\$3,623.27</b>               | <b>\$434.79</b> | <b>\$3,623.27</b>               | <b>\$434.79</b> |

**Supporting Documentation:** Contractors are required to provide supporting documentation with each request for payment to reflect *each line item expenditure*. To receive payment, these entities must submit vendor invoices to the agency that received the goods or services. The term,

invoice, refers to the original vendor prepared bill that must be attached to the payment as supporting documentation.”

Proof of payment must be included. Write at the top of each receipt the category that it matches as supporting documentation. This should indicate the line item to be charged on the payment request. Making this quick note will help the finance staff to process your request quicker. Although no receipts are required for indirect costs the negotiated percent needs to be noted as well as the items used to calculate the indirect cost.

Examples of supporting documentation may include, but are not limited to:

- Copy of a travel reimbursement request
- Copy of original receipt for equipment, supplies or other expenses
- Copy of the contractual agreement or contractor’s invoice for services rendered
- Copy of bill/invoice with the check number and date noted **or** copy of rental/lease agreement indicating agreement period and rental amount **or** copy of check with rental month noted on the memo line.
- Supplies:
  - Food expenditures - specify on the receipt the event where the food was served or distributed (i.e.: intervention, workshop, committee meeting)
  - General Office supplies – include copy of original receipt noted as supplies
  - Gift cards/incentives – specify on the receipt the intervention supported.

Contractors that divide costs for specific line items across multiple grants programs/funding sources should indicate on the documentation what portion or amount is being charged to the request submitted. If the supporting documentation does not match the total requested for reimbursement, it will not be processed until the discrepancy is resolved.

Please put the grant program name, **full** contract number and Federal Tax ID number (FIN) on each request for payment. Also, include on the payment request the name, phone number and email address of the individual to contact with any questions. This will help to expedite the payment request. Contractors must request reimbursement for the exact amount of money spent in each budget line item. VDH does not allow contractors to round costs to the nearest dollar.

## C. WORK PLAN AND BUDGET REALLOCATION REQUEST



Work Plan Revision: Contractors should send a letter **or email** of request indicating the proposed changes to their work plan to their HIV Services Coordinator who will route it through VDH for approval. The letter of request should be addressed to the DDP Director, Kathy Hafford, Virginia Department of Health, Division of Disease Prevention, P.O. Box 2448, Room 326, Richmond, VA 23218. VDH must approve all proposed changes prior to

the contractor implementing these changes. Your HIV Services Coordinator will provide written notification to you once approval is granted. At this time, you will need to provide a complete revised work plan to your HIV Services Coordinator.

### **Budget Reallocation:**

A completed budget reallocation form must be submitted to your HIV Services Coordinator who will route it through VDH for approval. The contractor must supply all information requested on the form. Budget reallocations must be submitted **no later than 30 days prior** to the end of the contractual year. Contact your HIV Services Coordinator to discuss exceptional or extenuating circumstances. Budget reallocations may be submitted by fax or by e-mail with an electronic signature.

Please do not assume that submission of a budget reallocation request means automatic approval. New expenditures should not be made until the reallocation is approved; therefore, the budget should not be changed on the request for payment form until approved by the Division. Once the signature of the Program Manager or designated appointee has been obtained, a copy of the approved budget reallocation request form will be forwarded to the contractor. The budget reallocation form is available on the VDH/DDP website at the following address:

[http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/ddp\\_customer\\_forms.htm](http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/ddp_customer_forms.htm)

A sample is also included in the Attachments Section as Attachment 4.

Carry-over Funds: Funds **cannot** be carried over to the following year. If you anticipate being unable to spend all funds by the end of the budget year, notify your lead agency or HIV Services Coordinator as soon as possible but no later than **30 days prior** to the end of the budget year.

## **D. OTHER CONTRACT INFORMATION**



### **Contract Renewals:**

Many contracts/MOAs allow for multiple renewals, depending on funding availability and other program factors. Contracts/MOAs are renewed at the discretion of VDH, generally based on performance.

The contractor is responsible for submitting a work plan and budget for the new contractual period. The work plan should include process and outcome objectives. Action steps/activities should be included under each process objective. Once all steps have been completed for the renewal process, an original signed contract will be forwarded to the contractor.

All contractors are now required to submit their workplans containing HRSA service categories, number of clients, number of service units and the service unit definitions.

### **Start-up Funds for New Contracts Only:**

Start-up funds are generally available for new agreements only. Start-up funds should be requested at the time of contract negotiations.

Once contracts/MOAs have been signed by the DDP and VDH administration, the DDP will process start-up fund requests. Letters requesting start-up funds should be submitted along with the budget and work plan to the DDP Director.

### **Audits:**

Agencies that receive more than \$100,000 in federal funding must submit a signed “Certification Regarding lobbying” form and, as appropriate, a “Disclosure of Lobbying Activities” to account for non-appropriated funds used for this purpose to the VDH within 90 days of the start of the funding period. Contractors are responsible to ensure they collect and submit this documentation for any subcontractors that receive more than \$100,000 in federal funding to VDH within the same time frame. (Regulations and forms can be obtained at <http://ecfr.gpoaccess.gov>.)

### **Contractor Quarterly Meetings:**

Contractors are required to attend a quarterly statewide Contractors' Meeting. Your HIV Services Coordinator will discuss this requirement with you. Updated contractual information and Division policies may be shared during these meetings. Technical assistance and/or capacity building/educational trainings are included in these meetings.

Contractors are expected to arrive on time, sign in and **remain for the duration of the meeting** unless other arrangements have been made with your HIV Services Coordinator *prior* to the meeting date.

### **Material Review:**

All educational materials supported with VDH funds must be approved by the **VDH Materials Review Panel**. Prior to release contractors will be responsible for any of the materials used by subcontractors. Educational materials include brochures, flyers, posters, video and audio tapes, questionnaires, surveys, curricula or outlines for educational sessions, public service announcements, web pages, etc. This approval is required **prior** to purchasing and/or distribution.

To submit materials to the panel for approval, please contact your HIV Services Coordinator. Items should be submitted electronically for fastest response. If mailed, seven copies of documents are required for any items submitted on paper. The review process may take 10 to 30 days, so please plan accordingly. It is helpful to describe the setting and audience for the materials. If materials are not approved by the review panel, contractors must not use

grant funds to purchase or pay for the cost of developing, printing and/or distribution of the unapproved materials.

### **Continuity of Operations Plan (COOP)**



Each contractor, lead agency and subcontractor is required to prepare a Continuity of Operations Plan (COOP) to ensure continued access to essential services and care for all clients, including their Ryan White and State funded clients, in case normal operations cannot continue (in case of a disaster or emergency). This plan should be reviewed and updated annually. See Attachment 7 for a list of resources for developing a COOP.

### **Guidance for developing a COOP:**

1. Perform a risk assessment to evaluate systems or processes that might be vulnerable in an emergency situation. Determine what kinds of hazards pose the greatest risks for your agency/area. Identify “mission critical functions” and resources that are necessary to deliver services to clients. Dissect the steps and procedures necessary to perform these functions. Evaluate which systems and/or processes might be affected by an emergency or disaster. Consider and develop alternative or supplemental methods of performing these duties/tasks should normal service delivery mechanisms be interrupted.
2. Identify staff necessary to perform “mission critical functions.” Create a personnel roster and identify key individuals associated with completing the essential functions as well as backup personnel who could complete those tasks. Establish an identified chain of command of appropriate staff with pre-assigned duties and authority.
3. Develop and implement a system to protect records, assets, data, equipment, and facilities; include a plan for data backup and storage on and off-site in a secure location(s).
4. Create a key personnel emergency call list. Update the list at least annually. Develop an internal and external communication plan to notify staff, clients, funders and external agencies and stakeholders about the status of services and programs. List the external agencies (federal, state, local, satellite offices, etc.) who must be notified when your work unit is unable to perform functions as usual.
5. Identify worksites (offsite or remote locations) to serve as alternative operations centers until services and programs can return to the original worksite. Develop relationships, agreements, and mechanisms with key organizations, stakeholders, and partnering agencies in order to ensure uninterrupted delivery of/access to services and care to clients.

6. Create an equipment and resource list that would be required for the essential personnel to function. Prepare a “to go” kit to maintain a mini operations center.
7. Assist staff and clients with creating their personal/family emergency needs plans. Disseminate disaster preparedness information to staff and clients. Encourage them to develop an emergency preparedness plan. Maintain a file of staff emergency preparedness plans and contact information in a secure location on and off site.

## WHAT TO EXPECT FROM THE CLIENTS



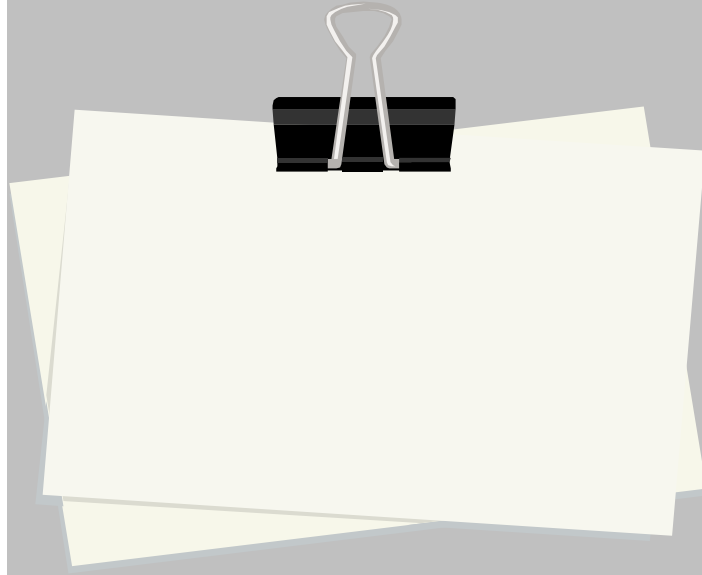
### **The client has the right to:**

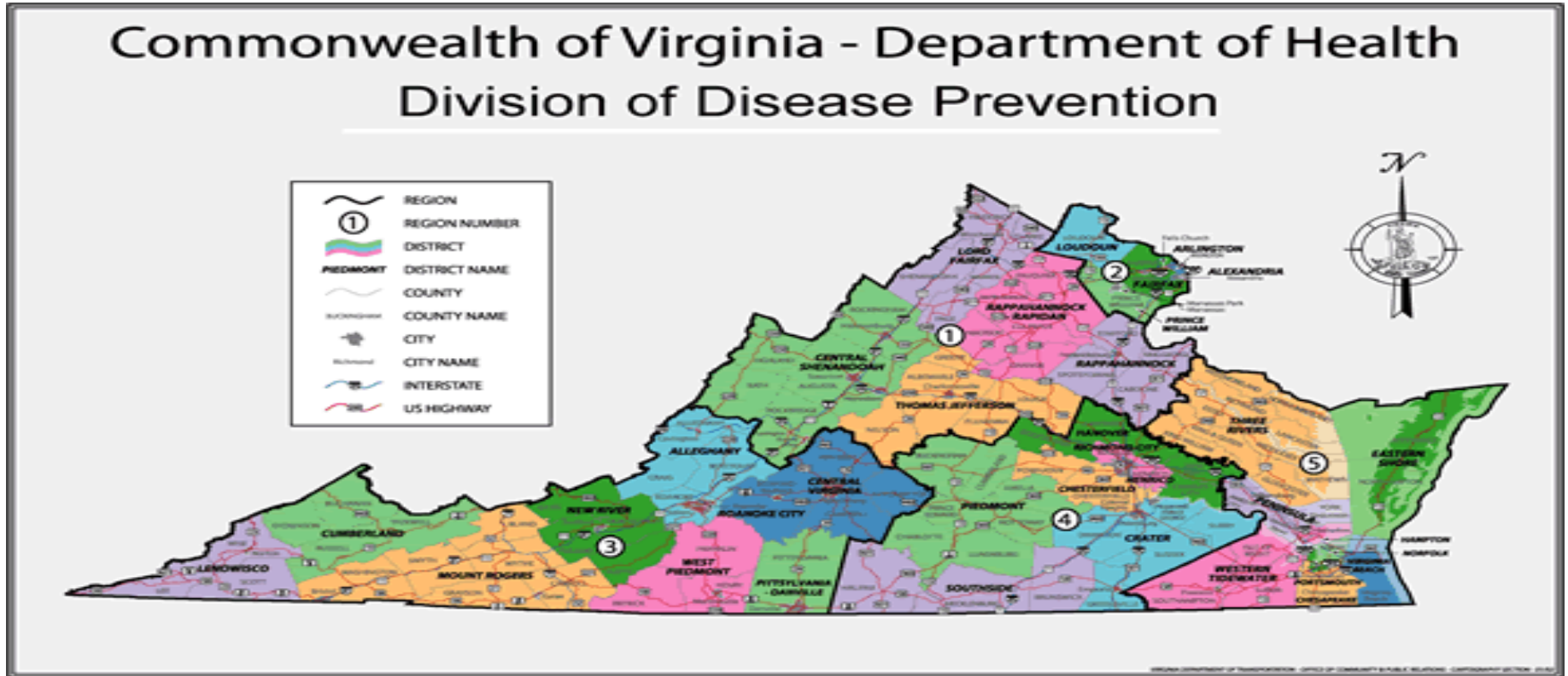
- Be treated with respect, compassion and sensitivity.
- Receive services and benefits without discrimination of any kind.
- Have all aspects of care and services treated with privacy and confidentiality.
- Have service providers' confidentiality policy explained.
- Make informed choices about what information is released and to whom.
- Be fully informed about all services available through the agency.
- Have agency grievance procedures explained.
- Have complaints responded to in a timely manner without risk of detrimental effect on client's services.
- Refuse care and /or discontinue services at any time.

### **The client has the responsibility to:**

- Treat agency staff and volunteers with respect and refrain from abusive language and behavior in communication or when communicating with them.
- Be an active participant in obtaining services and maintaining his/her personal well being.
- Notify service providers of any changes to address, phone number, and health, financial or living situation.
- Apply for all eligible benefits in 30 days.
- Keep appointments or cancel in advance.
- Respect the confidentiality of others.
- Provide adequate and accurate information to insure appropriate services are rendered.
- Provide feedback about the effectiveness of services rendered.
- Bring any complaint or grievance to the attention of the service provider.
- Allow your chart to be reviewed by the administrative agent to ensure that services are being provided and bills are being paid according to the standards set by service providers.

**ATTACHMENTS**





**Regions and Consortia**

- Region 1:** Northwest HIV Care Consortium
- Region 2:** Northern Virginia HIV Care Consortium
- Region 3:** Southwest/Piedmont HIV Care Consortium
- Region 4:** Central Virginia HIV Care Consortium
- Region 5:** Eastern Virginia HIV Care Consortium

**Virginia Department of Health**  
**Division of Disease Prevention**  
**Budget Line Item Format**

The following categories and format are being provided to ensure appropriate ordering of budget categories and placement of line items. The descriptions under each are examples of allowable costs but may not be approved/included in every contract. Specific line items and costs are negotiated in your initial contract with any modifications requiring approval. If you have any questions, please contact your HIV Services Coordinator.

**Caps on expenses:** Part B contractors can allocate up to 10% of their grant award for administration, planning and evaluation. VDH allows Consortia and selected contractors to allocate up to 5% of the total grant award for CQM if approved by VDH.

Include the following in the Budget Justification narrative:

**Personnel Costs:** Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percent full time equivalency, and annual salary.

**Indirect Costs:** Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term “facilities and administration” is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS’s Division of Cost Allocation (DCA). Visit DCA’s website at: <http://rates.psc.gov/> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

**Fringe Benefits:** List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

**Travel:** List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops.

**Equipment:** List equipment costs and provide justification for the need of the equipment to carry out the program’s goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of \$5000 and a useful life of one or more years).

**Supplies:** List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like;

medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. Remember, they must be listed separately.

**Subcontracts:** To the extent possible, all subcontract budgets and justifications should be standardized, and contract budgets should be presented by using the same object class categories contained in the Standard Form 424A. Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables.

**Other:** Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. (In some cases, grantee rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.)

**Start-up:** Start-up funds are available for new contracts only. This does not include renewals. Start-up funds should be requested at the time of contract negotiations. Once contracts have been signed by the DDP and VDH administration, the DDP will process start-up fund requests. Start-up funds may not exceed 1/12 of the total budget. Letters requesting start-up funds should be submitted along with the budget and work plan to the Division Director.

**PROGRAM:** \_\_\_\_\_  
**AGENCY:** \_\_\_\_\_  
**CONTRACT/MOA #:** \_\_\_\_\_  
**GRANT YEAR (specify start and end dates)** \_\_\_\_\_

|                | Direct Service | Administrative | Quality Management (If Allowable) | Planning and Evaluation (If Allowable) | <b>TOTAL</b> |
|----------------|----------------|----------------|-----------------------------------|--|--------------|
| 1. Personnel   |                |                |                                   |  |              |
| 2. Fringe      |                |                |                                   |  |              |
| 3. Travel      |                |                |                                   |  |              |
| 4. Equipment   |                |                |                                   |  |              |
| 5. Supplies    |                |                |                                   |  |              |
| 6. Contractual |                |                |                                   |  |              |
| 7. Other       |                |                |                                   |  |              |
| 8. Indirect    |                |                |                                   |  |              |
| 9. Start Up    |                |                |                                   |  |              |
| <b>TOTALS</b>  |                |                |                                   |  |              |

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Definitions**

**Direct Service** – Activities related to direct client service (i.e. personnel that work with clients and/or determine eligibility and those that directly supervise service provision)

**Administrative**– Activities related to operation of the agency, but not directly involved in client services (i.e. accountant, rent, agency operations, and administrative staff).

**Planning and Evaluation** (if allowable) - Activities related to needs assessments, client satisfaction, evaluation of effectiveness of system operations, etc.

**Quality Management** (if allowable) – Activities related to assessing and improving quality of service through meeting and improving outcomes.

**VIRGINIA DEPARTMENT OF HEALTH**  
**DIVISION OF DISEASE PREVENTION**  
**BUDGET REALLOCATION REQUEST**

ORGANIZATION: \_\_\_\_\_

CONTRACT/MOA # \_\_\_\_\_

BUDGET PERIOD: \_\_\_\_\_

GRANT PROGRAM \_\_\_\_\_

| <b><u>LINE ITEM</u></b> | <b><u>PREVIOUSLY APPROVED BUDGET</u></b> | <b><u>REQUESTED BUDGET REVISION</u></b> |
|-------------------------|--|---|
| • PERSONNEL:            | _____                                    | _____                                   |
| • FRINGE:               | _____                                    | _____                                   |
| • TRAVEL:               | _____                                    | _____                                   |
| • EQUIPMENT:            | _____                                    | _____                                   |
| • SUPPLIES:             | _____                                    | _____                                   |
| • CONTRACTUAL:          | _____                                    | _____                                   |
| • OTHER (SPECIFY):      | _____                                    | _____                                   |
| • INDIRECT              | _____                                    | _____                                   |
| • <b><u>TOTAL:</u></b>  | <b>_____</b>                             | <b>_____</b>                            |

**JUSTIFICATION (PLEASE ATTACH ADDITIONAL PAGES FOR JUSTIFICATION IF NEEDED):**

1. Reason why funds are available to be rebudgeted.

a. \_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATION:**

I certify that this rebudgeting is necessary to achieve project objectives, is consistent with contract/MOA terms and conditions and Virginia Department of Health policies, represents effective utilization of resources, and does not constitute a change in scope.

**CONTRACTING AGENCY:**

**VDH APPROVAL:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**INVOICE SAMPLE**

XXXXXX, Director  
 Division of Disease Prevention  
 P.O Box 2448, 3<sup>rd</sup> Floor  
 Richmond, VA 23218

Date: \_\_\_\_\_  
 Contract: \_\_\_\_\_  
 FIN: \_\_\_\_\_  
 Prog: \_\_\_\_\_

**Fiscal Contact Name:** \_\_\_\_\_  
**Email:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

Dear XXXXXXXX:

In accordance with the contract between the Virginia Department of Health and \_\_\_\_\_  
 \_\_\_\_\_ located at \_\_\_\_\_ . I am requesting payment for services rendered  
 during the time period \_\_\_\_\_ through \_\_\_\_\_ in the amount of \$ \_\_\_\_\_.

Expenditures by approved budget line items are as follows:

**Check here if new address** \_\_\_\_\_

**EXPENDITURES**

| Line Item      | Budget | JAN | FEB | MAR | APR | MAY | JUNE | JULY | AUG | SEPT | OCT | NOV | DEC | TOTAL | REMAINING BALANCE |
|----------------|--------|-----|-----|-----|-----|-----|------|------|-----|------|-----|-----|-----|-------|-------------------|
| Personnel      |        |     |     |     |     |     |      |      |     |      |     |     |     |       |                   |
| Fringe         |        |     |     |     |     |     |      |      |     |      |     |     |     |       |                   |
| Travel         |        |     |     |     |     |     |      |      |     |      |     |     |     |       |                   |
| Equipment      |        |     |     |     |     |     |      |      |     |      |     |     |     |       |                   |
| Supplies       |        |     |     |     |     |     |      |      |     |      |     |     |     |       |                   |
| Contractual    |        |     |     |     |     |     |      |      |     |      |     |     |     |       |                   |
| Other          |        |     |     |     |     |     |      |      |     |      |     |     |     |       |                   |
| Indirect       |        |     |     |     |     |     |      |      |     |      |     |     |     |       |                   |
| Start-up funds |        |     |     |     |     |     |      |      |     |      |     |     |     |       |                   |
| <b>TOTAL</b>   |        |     |     |     |     |     |      |      |     |      |     |     |     |       |                   |

Sincerely, \_\_\_\_\_



## VIRGINIA DEPARTMENT OF HEALTH ADAP MEDICATION/LAB EXCEPTION FORM

|  |             |                                |   |
|--|-------------|--------------------------------|---|
| <b>PATIENT NAME (Last, First, MI):</b>   |             |                                |   |
| <b>D.O.B. (mm/dd/yy):</b>  |             | <b>AGE:</b>                    | <b>SEX:</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| <b>ADDRESS</b>   | <b>CITY</b> | <b>STATE</b>                   | <b>ZIP</b>  |
| <b>RACE/ETHNICITY:</b> <input type="checkbox"/> White (non-Hispanic) <input type="checkbox"/> African American/Black (non-Hispanic) <input type="checkbox"/> Hispanic<br><input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian, Aleutian, Eskimo <input type="checkbox"/> Unknown |             |                                |   |
| <b>HEALTH DEPARTMENT PHONE #</b>   |             | <b>HEALTH DEPARTMENT FAX #</b> |   |
| <b>LOCAL HEALTH DEPARTMENT ADAP CONTACT PERSON:</b>  |             |                                |   |
| <b>PRESCRIBING PHYSICIAN NAME:</b>   |             |                                |   |
| <b>PHYSICIAN PHONE #:</b>  |             | <b>PHYSICIAN FAX #:</b>        |   |
| <b>FORM COMPLETED BY (Name):</b>   |             |                                |   |
| <b>TITLE:</b>  |             | <b>DATE (mm/dd/yy):</b>        |   |

|   |
|---|
| <b>MEDICATION/LAB TEST REQUESTED:</b>                                     |
| <b>REASON FOR EXCEPTION REQUEST (PLEASE REFER TO EXCEPTION CRITERIA):</b> |
|   |
|   |
|   |

**Specify other anti-retroviral medications patient is currently on**

| NAME OF MEDICATION | DOSE | DATE STARTED | DATE DISCONTINUED |
|--------------------|------|--------------|-------------------|
|                    |      |              |                   |
|                    |      |              |                   |
|                    |      |              |                   |
|                    |      |              |                   |

**LABORATORY HISTORY [Please start with the most current results (give at least two (2) results if available)]**

| VIRAL LOAD RESULTS* | DATE | CD4 COUNT RESULTS | DATE |
|---------------------|------|-------------------|------|
|                     |      |                   |      |
|                     |      |                   |      |
|                     |      |                   |      |

**\*For Trofile consideration, viral load MUST be greater than or equal to 1000 copies/ml.**

|  |   |
|--|---|
| <b>VDH USE ONLY</b>  |   |
| <input type="checkbox"/> Request Approved                    | <input type="checkbox"/> Request Denied |
| <b>Rationale:</b> _____                                      |   |
|  |   |
| <b>Signature:</b> _____                                      | <b>Date:</b> _____                      |
| <b>Date of Positive CCR5 assay/Maraviroc Approval:</b> _____ |   |

**Fax to: Central ADAP office at (804) 864-8050 [Phone: (804) 864-7965]**



## COOP RESOURCE LIST

If you would like specific information about developing a COOP, these sites are good places to start:

ADAP Emergency Preparedness Guide

[www.nastad.org](http://www.nastad.org)

American Medical Association (AMA)

<http://www.ama-assn.org>

American Medical Association Center for Public Health Preparedness and Disaster Response

<http://www.ama-assn.org>

American Red Cross Disaster Services

<http://www.redcross.org/services/disaster>

<http://www.redcross.org>

Are You Ready?: An In-depth Guide to Citizen Preparedness

<http://www.fema.gov/areyouready/index>

ASTHO

<http://www.astho.org/programs/preparedness>

Centers for Disease Control and Prevention Emergency Preparedness and Response

<http://www.bt.cdc.gov>

Emergency Email and Wireless Network Notification System

<http://www.emergencyemail.org>

Emergency Management Assist Compact

[www.emacweb.org](http://www.emacweb.org)

FEMA Preparedness Presentation

<http://www.fema.gov/pdf/areyouready/index>

FEMA Preparedness and Training

<http://www.fema.gov/government/prepare>

FEMA Risk Assessment Form

[http://www.fema.gov/areyouready/getting\\_informed](http://www.fema.gov/areyouready/getting_informed)

FEMA State Offices and Agencies of Emergency Management

<http://www.fema.gov/about/contact/statedr>

HAZUS Risk Assessment Software

<http://www.fema.gov/plan/prevent/hazus/index>

HRSA Emergency Planning

<http://www.hrsa.gov/emergency>

NACCHO

<http://www.naccho.org/topics/emergency>

Pandemic Flu

<http://www.pandemicflu.gov/index>

Ready America: Prepare, Plan and Stay Informed

<https://ready.gov>

Continuity of Operations Part 1 and Continuity of Operations Conclusion

<http://va.train.org>

**VIRGINIA RYAN WHITE PROGRAMS**

| <b><u>Ryan White Part</u></b>   | <b><u>Site</u></b>  | <b><u>City</u></b>              |
|---|---|---------------------------------|
| <b>A</b> Metro Area   | <u>Norfolk TGA</u>  | Norfolk                         |
| <b>A</b> Metro Area   | <u>Washington, DC Eligible Metropolitan Area (DC EMA)</u>                 | Washington DC/Northern Virginia |
| <b>B</b> State  | <u>Virginia Department of Health</u>                                      | Richmond                        |
| <b>C</b> Early Intervention   | <u>Carilion Medical Center</u>  | Roanoke                         |
| <b>C</b> Early Intervention   | <u>Centra Health, Inc.</u>  | Lynchburg                       |
| <b>C</b> Early Intervention   | <u>Inova Health Care Services</u>   | Alexandria                      |
| <b>C</b> Early Intervention   | <u>Mary Washington Hospital/Medicorp Health System</u>                    | Fredericksburg                  |
| <b>C</b> Early Intervention   | <u>University of Virginia</u>   | Charlottesville                 |
| <b>C</b> Early Intervention   | <u>Virginia Commonwealth University</u>                                   | Richmond                        |
| <b>D</b> Women, Infants, Children, Youth                                      | <u>INOVA Health Care Services</u>   | Alexandria                      |
| <b>D</b> Women, Infants, Children, Youth                                      | <u>Virginia Commonwealth University Medical Center</u>                    | Richmond                        |
| <b>F</b> AIDS Education and Training Center<br>Pennsylvania/Mid-Atlantic AETC | <u>Virginia Commonwealth University</u><br><br><u>INOVA Health System</u> | Richmond<br><br>Fairfax         |

**RYAN WHITE PART A AND PART B FUNDABLE PROGRAM SERVICES LIST**

| <b>Part A and Part B Allowable Program Services</b> |   |
|---|---|
| <b>Core Medical Services</b>                        |   |
| <b>a.</b>   | Outpatient /Ambulatory health services                    |
| <b>b.</b>   | AIDS Drug Assistance Program (ADAP) treatments            |
| <b>c.</b>   | AIDS Pharmaceutical Assistance (local)                    |
| <b>d.</b>   | Oral health care  |
| <b>e.</b>   | Early Intervention Services                               |
| <b>f.</b>   | Health Insurance Premium & Cost Sharing Assistance        |
| <b>g.</b>   | Home health care  |
| <b>h.</b>   | Home and Community-based Health Services                  |
| <b>i.</b>   | Hospice Services  |
| <b>j.</b>   | Mental health services                                    |
| <b>k.</b>   | Medical Nutrition Therapy                                 |
| <b>l.</b>   | Medical Case Management (including Treatment Adherence)   |
| <b>m.</b>   | Substance abuse services–outpatient                       |
| <b>Support Services</b>                             |   |
| <b>n.</b>   | Case Management (non-Medical)                             |
| <b>o.</b>   | Child care services                                       |
| <b>p.</b>   | Pediatric developmental assessment and early intervention |
| <b>q.</b>   | Emergency financial assistance                            |
| <b>r.</b>   | Food bank/home-delivered meals                            |
| <b>s.</b>   | Health education/risk reduction                           |
| <b>t.</b>   | Housing services  |
| <b>u.</b>   | Legal services  |
| <b>v.</b>   | Linguistics Services                                      |
| <b>w.</b>   | Medical Transportation Services                           |
| <b>x.</b>   | Outreach services   |
| <b>y.</b>   | Permanency Planning                                       |
| <b>z.</b>   | Psychosocial support services                             |
| <b>aa.</b>  | Referral for health care/supportive services              |
| <b>ab.</b>  | Rehabilitation services                                   |
| <b>ac.</b>  | Respite care  |
| <b>ad.</b>  | Substance Abuse Services-residential                      |
| <b>ae.</b>  | Treatment adherence counseling                            |

**NOTE: Ryan White Part A and Part B grant funds may be used to support ONLY the service categories listed above. The Ryan White Program Service Category Definitions list includes additional categories that are fundable under Ryan White Part C and/or Part D only.**

## RYAN WHITE PROGRAM SERVICE DEFINITIONS



### CORE SERVICES

#### Service categories:

- a. ***Outpatient/Ambulatory medical care (health services)*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under *Outpatient/ Ambulatory medical care*.**
- b. ***AIDS Drug Assistance Program (ADAP treatments)*** is a State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.
- c. ***AIDS Pharmaceutical Assistance (local)*** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients.

This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding.

- d. **Oral health care** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
- e. **Early intervention services (EIS)** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

**NOTE: EIS provided by Ryan White Part C and Part D Programs should NOT be reported here. Part C and Part D EIS should be included under *Outpatient/Ambulatory medical care*.**

- f. **Health Insurance Premium & Cost Sharing Assistance** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
- g. **Home Health Care** includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.
- h. **Home and Community-based Health Services** include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.
- i. **Hospice services** include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.
- j. **Mental health services** are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.
- k. **Medical nutrition therapy** is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical

nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

- l. ***Medical Case management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
- m. ***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

## SUPPORT SERVICES

- n. ***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
- o. ***Child care services*** are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training.

**NOTE: This does not include child care while a client is at work.**

- p. ***Pediatric developmental assessment and early intervention services*** are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

- q. ***Emergency financial assistance*** is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

**NOTE: Part A and Part B programs must be allocated, tracked and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).**

- r. ***Food bank/home-delivered meals*** include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.
- s. ***Health education/risk reduction*** is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.
- t. ***Housing services*** are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.
- u. ***Legal services*** are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.
- v. ***Linguistics services*** include the provision of interpretation and translation services.
- w. ***Medical transportation services*** include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.
- x. ***Outreach services*** are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in, care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

- y. ***Permanency planning*** is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
- z. ***Psychosocial support services*** are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.
- aa. ***Referral for health care/supportive services*** is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.
- ab. ***Rehabilitation services*** are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.
- ac. ***Respite care*** is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.
- ad. ***Substance abuse services—residential*** is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).
- ae. ***Treatment adherence counseling*** is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.