Emergency Financial Assistance

Description from Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
Emergency Financial Assistance provides limited one-time or short-term payments to assist a HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Account for Emergency Financial Assistance (EFA) funds used to pay for otherwise allowable HRSA RWHAP services under the Emergency Financial Assistance category. Do not permit direct cash payments to clients.

Do not fund continuous provision of an allowable service to a client through Emergency Financial Assistance.

Virginia Ryan White Part B Service Unit Definition:
Payment for one 30-day or less prescription for Ryan White Part B formulary medication for uninsured clients; one food voucher; one month's rent; one essential utility payment; (**or**) short term emergency housing 7 days or less.

(EFA is limited one-time or short-term payments. Subrecipients must clearly document that Ryan White Part B is the payer of last resort for each EFA service provided to a client. It is expected that all other sources of funding will be effectively used prior to paying with Ryan White Part B funds. Continuous provision of an allowable service to a client should not be funded through EFA. Subrecipients cannot use EFA for medications on the ADAP formulary. Contact VA MAP to get ADAP formulary medication for the client.)

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

1.0 Intake and Eligibility
As outlined in HRSA HAB Policy Clarification Notice 21-02 Clarifications (PCN) on Ryan White Program Client Eligibility Determinations and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. **HIV Status:** A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02

2. **Low- Income:** The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

3. **Residency:** The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

Standard	Measure
Referral	
1.1) Documentation of referral for EFA by a Part B provider prior to initiation of the service.	1.1) Documentation of referral for EFA is present in the client's record, signed and dated.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services is determined. To be eligible for this service applicants must: a) Have an HIV diagnosis (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third-party payers such as private and commercial insurance plans, and other payers that provide the service they are seeking. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility.	1.2) Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Determination every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

• Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures the use of Part B services as the payer of last resort while vigorously pursuing other funding sources**.** Client must agree to participate in the insurance option that the client is eligible for and that best meets the client's medical needs regardless of preference. Submission of eligibility assessments should be through the Provide Enterprise® data system.	
Intake	
1.3) Complete eligibility screening and intake within 15 days of initial contact with client.	1.3) Documentation of intake and eligibility screening in record signed and dated.
Client Access Reviews/Continuation of Eligibility	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARS and continuation of eligibility is present in the client's record.
2.0 Key Services Components and Activities	
Standard	**Measure**
Documentation	
2.1) Emergency funds are allocated, tracked, and reported by type of assistance to include: • Number of clients and amount expended for each type of EFA • Summary of number of EFA services received by client • Methods used to provide EFA (e.g., payments to agencies, vouchers).	2.1) Documentation of EFA provided by type of assistance.

Must sign and date all reports.	
2.2) Client record must contain, at a minimum: • Need for EFA • Type(s) and date(s) of EFA provided • Method of providing EFA (e.g., vouchers, payment to agencies). *Note: Do not permit direct cash payment to client.* Must sign and date all reports.	2.2) Signed and dated reports verifying need, documenting assistance provided and method of providing EFA in the client's record.
Assessment/Service Plan/Provision of Services	
2.3) Complete a request for EFA prior to the provision of assistance.	2.3) Documentation of request for EFA in the client record signed and dated.
2.4) For those clients determined to need EFA services, develop an emergency assistance plan within 24 hours of providing emergency assistance.	2.4) For clients in need of EFA services, documentation of emergency assistance plan signed and dated.
2.5) Review the emergency assistance plan and reassess needs every 30 days for 3 months.	2.5) Emergency assistance plans reassessed every 30 days in client's record signed and dated.
2.6) Provide Emergency Financial Assistance (EFA) for essential services including: • Essential Utilities (including Water, Electricity, Sewage, internet service) • Housing (Emergency Housing 1-14 days and Short-term Housing 15-30 days) • Transportation • Food (including groceries, food vouchers, and food stamps) • Non-ADAP formulary medications. *Note: Brand name formulations may be paid for with Ryan White funds only if generic formulation is not available.*	2.6) Documentation of assistance provided for essential services with frequency and duration outlined in client's record signed and dated.

2.7) Any Food cards purchase with RW funds will not be allowed greater than 90 days from time of use because anything beyond that is considered pre-purchase and the RW program is a reimbursement program. If subrecipients were to exceed 90 days, they would have to demonstrate that they could issue, with supportive documentation, ALL of the cards they purchased within 90 days. Do not permit VDH to allow any subrecipient or second level provider to stock up on quantities past the 90-day use metric or to stock up for next year with end-of-year spending for their grants.	2.7) Documentation of food cards purchased and delivered and number of clients.
Transition and Discharge	
2.8) Client discharged when Emergency Financial Assistance services are no longer needed, goals have been met, upon death or due to safety issues. (*see 2.9*) Prior to discharge: Conduct discussion with client over reasons for discharge and options for other service provisions. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter* must be sent to client's last known address. If client is not present to sign for the letter, return to the provider. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.* Documentation: Client's record must include: a) Date services began	2.8) Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter*, if applicable. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*

b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable.	
<u>Transfer:</u> If client transfers to another location, agency, or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If client moves to another area, transferring agency will make referral for needed services in the new location.	Discharge summary and other records send with the patient
<u>Unable to Locate:</u> If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. The three attempts should start no later than three months prior to the due date. A certified letter* must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state case closure within 30 days from the date on the letter if no appointment is schedule with the provider. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	Document attempts made
<u>Withdrawal from Service:</u> If client reports no longer needing services or decides to no longer participate in the Service Plan, the client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure understanding reasons for withdrawal, or if client still needs services identify factors	

interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. <u>Administrative Discharge:</u> Discharge clients who engage in behavior that abuses the safety or violates the confidentiality of others. Prior to discharging a client for this reason, agency leadership according to that agency's policies must review the case. Provide clients discharged for administrative reasons written notification of and reason for the discharge and notify of possible alternative resources. A certified letter* that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	
Case Closure	
2.9) Case will close if client: a) Has met the service goals; b) Decides to transfer to another agency; c) Needs are more appropriately addressed in other programs; d) Moves out of state; e) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; f) Fails to maintain contact with the other Professional Services staff; g) Can no longer be located;	2.9) Documentation of case closure in client's record with clear rationale for closure.

h) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; i) Exhibits pattern of abuse as defined by agency's policy. j) Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or k) Is deceased.	
3.0 Client Rights and Responsibilities	
Standard	**Measure**
3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility, regardless of whether they receive other Part B services at your agency. All providers shall comply with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the American's with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering services based on fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	3.1) Written eligibility requirements and non-discrimination policy on file.
3.2) Each agency should have a Client's Rights and Responsibilities policy, which requires	3.2) Written policy on file.

each client to sign & date a form indicating they have been offered: a) explanation of the policy, and b) copy of *'Client's Rights and Responsibilities* and to communicate client's understanding of the policy.	
3.3) Provide explanation of *Client's Rights and Responsibilities* to each client. Client rights include: • Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services; • Reach an agreement about the frequency of contact the client will have either in person or over the phone. • File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; Have information released only when: • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law. Client responsibilities include: • Treat other clients and staff with respect and courtesy;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the client's rights and responsibilities.

• Protect the confidentiality of other clients; • Participate in creating a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible, phone to cancel or change an appointment time; • Stay in contact with the agency by informing the agency of change in address and phone number, respond to phone calls and mail and • Avoid subjecting the agency's staff to physical, sexual, verbal, and/or emotional abuse or threats.	
4.0 Grievance Process	
Standard	**Measure**
4.1) Grievance policy exists which requires each client to sign & date indicating they has been offered: a) explanation of the policy, and b) copy of *Grievance Procedure* and c) communication of client's understanding of the policy. Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines. Policy shall be available in languages and formats (e.g., for persons with disabilities) appropriate to populations served.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.
4.2) Provide explanation of *Grievance Procedure* to each client. Clients may file a grievance if denied their request for services, if they have any complaint, or concern about the services received.	4.2) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.

4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	4.3) Documentation of client grievances, status, and resolution.
4.4) Review of grievance policy yearly with client signature.	4.4) Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
5.0 Cultural and Linguistic Competency	
Standard	**Measure**
5.1) Health services are culturally and linguistically competent, client-guided and community based. At a minimum, provider's documentation should include: a) Experience with providing services to the diverse ethnic, linguistic, sexual or cultural populations targeted; b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; c) List of cultural competency trainings completed by staff.	5.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.
5.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.	5.2) Culturally and linguistically appropriate materials and signage accessible.
6.0 Privacy and Confidentiality (including securing records)	
Standard	**Measure**
6.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act.	6.1) Written Client confidentiality policy on file at provider agency.

6.2) Client's consent for release of information is determined.	6.2) Current *Release of Information Form* signed and dated by client and provider representative and located in client's record. Each release form indicates who may receive the client's information and has an expiration of not more than 12 months from date of signature.
6.3) Store each client file in a secure location with electronic client records protected from unauthorized use.	6.3) Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protection and access limited to appropriate personnel.
6.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	6.4) Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.
7.0 Quality Management	
Standard	**Measure**
7.1) Measure and report client health outcomes using Emergency Financial Assistance service measures approved by VDH.	7.1) Performance measurement data on the following indicators: • Percentage of persons with HIV and receiving Emergency Financial Assistance services, regardless of age, who will have at least two care markers in a 12-month period at least 3 months apart (Care marker is defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date). • Percentage of people enrolled in RW Part B-funded Program with HIV and receiving Emergency Financial Assistance, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

References

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