AGREEMENT
RYAN WHITE HIV/AIDS PROGRAM PART A

THIS AGREEMENT is made between the **CITY AND COUNTY OF DENVER**, a municipal corporation of the State of Colorado (the "City") and **COLORADO HEALTH NETWORK, INC.**, a Colorado nonprofit corporation with an address of 6260 East Colfax Avenue, Denver, Colorado 80220 (the "Contractor", and collectively ("the Parties").

1. WORK TO BE PERFORMED: The City, acting by and through the Denver Department of Public Health and Environment (the "Agency"), has received federal funds to provide emergency and financial assistance programs pursuant to the Ryan White Comprehensive AIDS Resources Emergency Act, as amended by the Ryan White HIV/AIDS Extension Act of 2009, (and generally referred to as the Ryan White Grant program), as may be amended from time to time. The Contractor, under the general direction of, and in coordination with, the Agency's Executive Director (the "Executive Director") or other designated supervisory personnel, shall diligently and professionally provide the services described in the Contractor's Scope of Work, a copy of which is marked as **Exhibit A,** attached hereto and incorporated herein by reference. The Contractor shall faithfully perform the work required under this Agreement in accordance with the standards of care, skill, training, diligence and judgment provided by highly competent professionals who perform work of a similar nature to the work described in this Agreement.

2. TERM: The Agreement will commence on **March 1, 2021** and will expire on **February 28, 2022** (the "**Term").** Subject to the Executive Director's prior written authorization, the Contractor shall complete any work in progress as of the expiration date, and the Term of the Agreement will extend until the work is completed or earlier terminated by the Executive Director.

3. COMPENSATION AND PAYMENT:

A. Fees and Expenses: The City shall pay and the Contractor shall accept as the sole compensation for services rendered and costs incurred under the Agreement an amount not to exceed **TWO MILLION THREE HUNDRED ONE THOUSAND SEVEN HUNDRED SEVENTY-NINE DOLLARS and 00/100 ($2,301,779.00)** (the **"Maximum Contract Amount"**), to be used in accordance with the budget contained in **Exhibit B**. Amounts billed may not exceed the budget set forth in **Exhibit B**. The Contractor certifies the budget line items in **Exhibit B** contain reasonable allowable direct costs and allocable indirect costs in accordance with 2 C.F.R., Subpart E.

B. Invoices: Funds will be disbursed in appropriate monthly increments, upon receipt and approval of Contractor's monthly invoices and any City required budget documents or reports. Contractor's invoice(s) will include any and all appropriate supporting documentation, including time sheets, payroll records, receipts, and any other document which may be pertinent in light of the nature of the services performed or expenses incurred under this Agreement. Contractor's invoice(s) will reflect in detail the services performed within the period for which the payment is requested and will address all completed project outcomes. Contractor's invoices must identify reasonable allowable direct costs and allocable indirect costs actually incurred in accordance with the budgeted categories and amounts contained in **Exhibit B** and any applicable rate schedule approved by the City. Funds payable by the City hereunder shall be

distributed to the Contractor on a reimbursement basis only for work performed and costs incurred during the prior month. Invoices submitted for payment must be received by the Agency on or before the day identified in **Exhibit B**. Invoices submitted for services rendered that are submitted after such deadline are considered to be untimely and must be submitted separately to be considered for payment. Payment for such late-submitted invoices shall be made only upon a showing of good cause for the late submission.

If applicable, time sheets must reflect the amount of time, in hours and tenths of hours, attributable to each activity performed under this Agreement. In the event that Contractor allocates allowable costs to more than one grant, project, or contract, then timesheets must further identify the allocation of allowable costs for each grant, project or contract.

C. Budget Modifications: Budget line items may only be modified by the written approval of the Executive Director, if in the Executive Director's sole judgment such modification is reasonable and appropriate. However, such budget modifications will not alter the **Maximum Contract Amount**. Any modification to **Exhibit B** shall not take effect until approved in writing. Any modification to **Exhibit B** agreed to by the parties that requires an increase in the **Maximum Contract Amount** shall be evidenced by a written Amendatory Agreement prepared and executed by both parties in the same manner as this Agreement.

D. Maximum Contract Liability: Any other provision of this Agreement notwithstanding, in no event shall the City be liable for payment for services rendered and expenses incurred by the Contractor under the terms of this Agreement for any amount in excess of the **Maximum Contract Amount**. The Contractor acknowledges that the City is not obligated to execute an amendment to this Agreement for any further phase of work other than the work described herein, and that any work performed by Contractor beyond that specifically described is performed at the Contractor's risk and without authorization under this Agreement. The Contractor understands and agrees that any and all payment obligations of the City under this Agreement, including any extensions or renewals thereof, whether direct or contingent, shall extend only to funds approved and appropriated by the Denver City Council for the purpose of this Agreement, encumbered for the purpose of this Agreement, and paid into the Treasury of the City. The Contractor acknowledges that (1) the City does not by this Agreement, irrevocably pledge present cash reserves for payments in future fiscal years, and (2) this Agreement is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the City.

E. Federal Funds Contingency: The Contractor understands that this Agreement is funded, in whole or in part, with federal funds. It is further acknowledged that as of the date of the execution of this Agreement, the total amount to be awarded to the City pursuant to the Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program (Ryan White Part A) (**CFDA #93.914**) may not have been fully determined, finalized, or paid. Should a reduction in City awarded funds under such Grant Program necessitate a reduction to the Contractor award hereunder, then the City reserves the right to make a *pro rata* reduction affecting all contractors with the City under the City's Ryan White Part A Program.

F. Recovery of incorrect payments: If, as a result of any audit or program review relating to the performance of the Contractor or its officers, agents or employees under this agreement, there are any irregularities or deficiencies in any audit or review, then the Contractor will, upon notice from the City, correct all identified irregularities or deficiencies within the time

frames designated in the City's written notice. If corrections are not made by such date, then the final resolution of identified deficiencies or disputes shall be deemed to be resolved in the City's favor unless the Contractor obtains a resolution in its favor from the responsible official conducting the audit or review. In any event, the Contractor shall be responsible to indemnify and save harmless the City, its officers, agents and employees, from and against any and all disallowed costs.

G. Non-Federal Match Requirement: The Ryan White Part A Program does not have a cost sharing or matching requirement.

H. REPORTS/CLOSELOUT PROCEDURES/CORRESPONDENCE:

(1) Reports and Closeout Procedures: The Contractor shall provide the program area of the Agency with the reports described in **Exhibit A** (Scope of Work) in such a format as may be designated by the City. Such reports may be submitted electronically by disk or e-mail, followed by hard copy transmittal. In addition, the Contractor shall comply with any and all contract closeout procedures directed by the Executive Director to be performed under this Agreement for final reimbursement, including but not limited to final review of payments, invoices, referrals, and required reporting documents, including close-out signature.

(2) Submission of Correspondence and Invoices: All written correspondence concerning procedural or administrative contract matters (other than notices required to be provided to the Executive Director and others as described in paragraph 19 (**NOTICES**)) shall be delivered to Robert2.George@denvergov.org, or by U.S. mail to:

Attn: Robert George, Program Manager
Department of Public Health and Environment
101 W. Colfax Avenue
Suite 800
Denver, Colorado 80202.

Invoices shall be delivered to Bridget.Tetteh@denvergov.org, or by US Mail to:

Attn: Financial Services
Department of Public Health and Environment
101 W. Colfax Avenue
Suite 800
Denver, Colorado 80202.

4. PERFORMANCE MONITORING/INSPECTION: The Contractor shall permit the Executive Director to monitor and review the Contractor's performance under this Agreement. The Contractor shall make available to the City for inspection any and all files, records, reports, policies, minutes, materials, books, documents, papers, invoices, accounts, payrolls and other data, whether in hardcopy or electronic format, used in the performance of any of the services required hereunder or relating to any matter covered by this Agreement in order to coordinate the performance of services by the Contractor in accordance with the terms of this Agreement. All such monitoring and inspection shall be performed in a manner that will not unduly interfere with the services to be provided under this Agreement.

5. STATUS OF CONTRACTOR: The Contractor is an independent contractor retained to perform professional or technical services for limited periods of time. Neither the Contractor nor any of its employees are employees or officers of the City under Chapter 18 of the Denver Revised Municipal Code, or for any purpose whatsoever.

6. TERMINATION:

A. The City has the right to terminate the Agreement with cause upon written notice effective immediately, and without cause upon twenty (20) days prior written notice to the Contractor. However, nothing herein shall be construed as giving the Contractor the right to perform services under this Agreement beyond the time when such services become unsatisfactory to the Executive Director.

B. Notwithstanding the preceding paragraph, the City may terminate the Agreement if the Contractor or any of its officers or employees are convicted, plead nolo contendere, enter into a formal agreement in which they admit guilt, enter a plea of guilty or otherwise admit culpability to criminal offenses of bribery, kick-backs, collusive bidding, bid-rigging, antitrust, fraud, undue influence, theft, racketeering, extortion or any offense of a similar nature in connection with Contractor's business. Termination for the reasons stated in this paragraph is effective upon receipt of notice.

C. If the Agreement is terminated without cause the Contractor will be compensated for work requested and satisfactorily performed. Upon termination of the Agreement by the City, with or without cause, the Contractor will not have any claim against the City by reason of, or arising out of, incidental or relating to termination, except for compensation for work requested and satisfactorily performed as described in the Agreement.

D. If the Agreement is terminated, the City is entitled to and will take possession of all materials, equipment, tools and facilities it owns that are in the Contractor's possession, custody, or control by whatever method the City deems expedient. The Contractor shall deliver all documents in any form that were prepared under the Agreement and all other items, materials and documents that have been paid for by the City to the City. These documents and materials are the property of the City. The Contractor shall mark all copies of work product that are incomplete at the time of termination "DRAFT-INCOMPLETE".

7. EXAMINATION OF RECORDS:

A. The Comptroller General of the United States of America or the Comptroller General's authorized representative, and any authorized agent of the City, including the City Auditor or his or her representative, has the right to access and the right to examine, copy and retain copies, at the Comptroller General or City's election in paper or electronic form, any pertinent books, documents, papers and records related to Contractor's performance pursuant to this Agreement, provision of any goods or services to the City, and any other transactions related to this Agreement. Contractor shall cooperate with Comptroller General or City representatives and such representatives shall be granted access to the foregoing documents and information during reasonable business hours and until the latter of five (5) years after the final payment under the Agreement or expiration of the applicable statute of limitations. When conducting an audit of this Agreement, the City Auditor shall be subject to government auditing standards issued by the United States Government Accountability Office by the Comptroller General of the United States, including with respect to disclosure of information acquired

during the course of an audit. No examination of records and audit pursuant to this paragraph shall require Parties to make disclosures in violation of state or federal privacy laws. Parties shall at all times comply with D.R.M.C. 20-276.

B. The Contractor acknowledges that it is subject to any and all applicable regulations or guidance of the United States Office of Management and Budget.

C. The Contractor shall keep true and complete records, and shall annually furnish an accurate statement for the preceding calendar year, of all business transactions under this Agreement, which statement shall be certified by an authorized representative of the Contractor to be correct. The Contractor agrees to establish and maintain a system of bookkeeping satisfactory to the federal government or the City's Auditor and to give any authorized representatives of the federal government or the City access during reasonable hours to such books and records. Any representative of the federal government or the City's Auditor shall have the right at any time, and from time to time, to audit all of the books of account, bank statements, documents, records, tax returns, papers and files of the Contractor, related to this Agreement, whether prepared manually or electronic, and the Contractor, upon request, shall make all such matters available for such examination. If said records exist in electronic form, the Contractor shall maintain a means of transferring said records to hardcopy form. The Contractor's obligation to retain the above records shall expire five (5) years after the Contractor's statement for any period has been delivered to the City.

D. The Contractor is subject to the audit requirements contained in the Single Audit Act Amendments of 1996 (31 USC §§ 751-7507), Office of Management and Budget Guidance (2 C.F.R. Part 200, Subpart F), and Department of Health and Human Services Audit Requirements (45 C.F.R. Part 75, Subpart F), with audits required for all contractors receiving $750,000 or more per year in federal grants. Based on criteria established by the grantee, sub grantees or sub-recipients of RW funds that are small programs (i.e. receive less than $750,000 per year in federal grants) may be subject to audit as a major program (i.e. a program that receives more than $750,000 in aggregate federal funding). Selection of auditor is based on policies and procedures established by the Board of Directors (if nonprofit).

8. WHEN RIGHTS AND REMEDIES NOT WAIVED: In no event shall any action by the City hereunder constitute or be construed to be a waiver by the City of any breach of covenant or default which may then exist on the part of the Contractor, and the City's action or inaction when any such breach or default shall exist shall not impair or prejudice any right or remedy available to the City with respect to such breach or default; and no assent, expressed or implied, to any breach of any one or more covenants, provisions or conditions of this Agreement shall be deemed or taken to be a waiver of any other breach.

9. INSURANCE:

A. General Conditions: Contractor agrees to secure, at or before the time of execution of this Agreement, the following insurance covering all operations, goods or services provided pursuant to this Agreement. Contractor shall keep the required insurance coverage in force at all times during the term of the Agreement, or any extension thereof, during any warranty period, and for three (3) years after termination of the Agreement. The required insurance shall be underwritten by an insurer licensed or authorized to do business in Colorado and rated by A.M. Best Company as "A-"VIII or better. Each policy shall contain a valid provision or endorsement

requiring notification to the City in the event any of the required policies be canceled or non-renewed before the expiration date thereof. Such written notice shall be sent to the parties identified in the Notices section of this Agreement. Such notice shall reference the City contract number listed on the signature page of this Agreement. Said notice shall be sent thirty (30) days prior to such cancellation or non-renewal unless due to non-payment of premiums for which notice shall be sent ten (10) days prior. If such written notice is unavailable from the insurer, contractor shall provide written notice of cancellation, non-renewal and any reduction in coverage to the parties identified in the Notices section by certified mail, return receipt requested within three (3) business days of such notice by its insurer(s) and referencing the City's contract number. If any policy is in excess of a deductible or self-insured retention, the City must be notified by the Contractor. Contractor shall be responsible for the payment of any deductible or self-insured retention. The insurance coverages specified in this Agreement are the minimum requirements, and these requirements do not lessen or limit the liability of the Contractor. The Contractor shall maintain, at its own expense, any additional kinds or amounts of insurance that it may deem necessary to cover its obligations and liabilities under this Agreement.

B. Proof of Insurance: Contractor shall provide a copy of this Agreement to its insurance agent or broker. Contractor may not commence services or work relating to the Agreement prior to placement of coverage. Contractor certifies that the certificate of insurance attached as **Exhibit D**, preferably an ACORD certificate, complies with all insurance requirements of this Agreement. The City requests that the City's contract number be referenced on the Certificate. The City's acceptance of a certificate of insurance or other proof of insurance that does not comply with all insurance requirements set forth in this Agreement shall not act as a waiver of Contractor's breach of this Agreement or of any of the City's rights or remedies under this Agreement. The City's Risk Management Office may require additional proof of insurance, including but not limited to policies and endorsements.

C. Additional Insured: For Commercial General Liability, Auto Liability and Excess Liability/Umbrella, Contractor and subcontractor's insurer(s) shall name the City and County of Denver, its elected and appointed officials, employees and volunteers as additional insured.

D. Waiver of Subrogation: For all coverage's, with the exception of Professional Liability, Contractor's insurer shall waive subrogation rights against the City.

E. Subcontractors and Subconsultants: All sub-consultants, subcontractors, independent contractors, suppliers or other entities providing goods or services required by this Agreement shall be subject to all of the requirements herein. Contractor shall require all of its subcontractors and sub consultants to provide insurance coverage in types and amounts required by the Contractor, but in amounts of at least $1,000,000 Commercial General Liability, statutory Workers' Compensation coverage, and $1,000,000 professional liability for any subcontractor performing legal, medical, or mental health related work. Contractor agrees to provide proof of insurance for all such subcontractors, subconsultants, independent contractors or other entities upon request by the City.

F. Workers' Compensation/Employer's Liability Insurance: Contractor shall maintain the coverage as required by statute for each work location and shall maintain Employer's Liability insurance with limits of $100,000 per occurrence for each bodily injury

claim, $100,000 per occurrence for each bodily injury caused by disease claim, and $500,000 aggregate for all bodily injuries caused by disease claims. Contractor expressly represents to the City, as a material representation upon which the City is relying in entering into this Agreement, that none of the Contractor's officers or employees who may be eligible under any statute or law to reject Workers' Compensation Insurance shall effect such rejection during any part of the term of this Agreement, and that any such rejections previously effected, have been revoked as of the date Contractor executes this Agreement.

G. Commercial General Liability: Contractor shall maintain a Commercial General Liability insurance policy with limits of $1,000,000 for each occurrence, $1,000,000 for each personal and advertising injury claim, $2,000,000 products and completed operations aggregate, and $2,000,000 policy aggregate.

H. Business Automobile Liability: Contractor shall maintain Business Automobile Liability with limits of $1,000,000 combined single limit applicable to all owned, hired and non-owned vehicles used in performing services under this Agreement.

I. Professional Liability (Errors & Omissions): Contractor shall maintain minimum limits of $1,000,000 per claim and $1,000,000 policy aggregate limit. The policy shall be kept in force, or a Tail policy placed, for three (3) years for all contracts except construction contracts for which the policy or Tail shall be kept in place for eight (8) years.

J. Cyber Liability: Contractor shall maintain Cyber Liability coverage with minimum limits of $1,000,000 per occurrence and $1,000,000 policy aggregate covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. If Claims Made, the policy shall be kept in force, or a Tail policy placed, for three (3) years.

K. Additional Provisions:

(1) For Commercial General Liability and Excess Liability, the policies must provide the following:

- **(i)** That this Agreement is an Insured Contract under the policy;
- **(ii)** Defense costs are in excess of policy limits;
- **(iii)** A severability of interests or separation of insureds provision (no insured vs. insured exclusion);
- **(iv)** A provision that coverage is primary and non-contributory with other coverage or self-insurance maintained by the City; and
- **(v)** No exclusion for sexual abuse or molestation.

(2) For claims-made coverage:

- **(i)** The retroactive date must be on or before the contract date or the first date when any goods or services were provided to the City, whichever is earlier.

(3) Contractor shall advise the City in the event any general aggregate or other aggregate limits are reduced below the required per occurrence limits. At their own expense, and where such general aggregate or other aggregate limits have been reduced below the required per occurrence limit, the Contractor will procure such per occurrence limits and furnish a new certificate of insurance showing such coverage is in force.

10. DEFENSE AND INDEMNIFICATION:

A. Contractor hereby agrees to defend, indemnify, reimburse and hold harmless City, its appointed and elected officials, agents and employees for, from and against all liabilities, claims, judgments, suits or demands for damages to persons or property arising out of, resulting from, or relating to the work performed under this Agreement ("Claims"), unless such Claims have been specifically determined by the trier of fact to be the sole negligence or willful misconduct of the City. This indemnity shall be interpreted in the broadest possible manner to indemnify City for any acts or omissions of Contractor or its subcontractors either passive or active, irrespective of fault, including City's concurrent negligence whether active or passive, except for the sole negligence or willful misconduct of City.

B. Contractor's duty to defend and indemnify City shall arise at the time written notice of the Claim is first provided to City regardless of whether Claimant has filed suit on the Claim. Contractor's duty to defend and indemnify City shall arise even if City is the only party sued by claimant and/or claimant alleges that City's negligence or willful misconduct was the sole cause of claimant's damages.

C. Contractor will defend any and all Claims which may be brought or threatened against City and will pay on behalf of City any expenses incurred by reason of such Claims including, but not limited to, court costs and attorney fees incurred in defending and investigating such Claims or seeking to enforce this indemnity obligation. Such payments on behalf of City shall be in addition to any other legal remedies available to City and shall not be considered City's exclusive remedy.

D. Insurance coverage requirements specified in this Agreement shall in no way lessen or limit the liability of the Contractor under the terms of this indemnification obligation. The Contractor shall obtain, at its own expense, any additional insurance that it deems necessary for the City's protection.

E. This defense and indemnification obligation shall survive the expiration or termination of this Agreement.

11. COLORADO GOVERNMENTAL IMMUNITY ACT: In relation to the Agreement, the City is relying upon and has not waived the monetary limitations and all other rights, immunities and protection provided by the Colorado Governmental Act, C.R.S. § 24-10-101, *et seq*.

12. TAXES, LATE CHARGES, AND PERMITS: The City is not liable for the payment of taxes, late charges or penalties of any nature, except for any additional amounts that the City may be required to pay under the City's prompt payment ordinance D.R.M.C. § 20-107, *et seq*. The Contractor shall promptly pay when due, all taxes, bills, debts and obligations it incurs

performing the services under the Agreement and shall not allow any lien, mortgage, judgment or execution to be filed against City property, including to land, facilities, improvements, or equipment.

13. ASSIGNMENT AND SUBCONTRACTING: The Contractor shall not voluntarily or involuntarily assign any of its rights or obligations under the Agreement or subcontract performance obligations without obtaining the Executive Director's prior written consent. Any attempt by the Contractor to assign its rights or obligations or subcontract performance obligations without the Executive Director's prior written consent will be void and, at the Executive Director's option, automatically terminate the Agreement. The Executive Director has sole and absolute discretion whether to consent to any assignment of rights or obligations and subcontracting of performance obligations under the Agreement. In the event of any subcontracting or unauthorized assignment: (i) the Contractor shall remain responsible to the City; and (ii) it shall not create a contractual relationship between the City and sub-consultant or subcontractor or assignee.

14. NO THIRD PARTY BENEFICIARY: Enforcement of the terms of the Agreement and all rights of action relating to enforcement are strictly reserved to the parties. Nothing contained in the Agreement gives or allows any claim or right of action to any third person or entity. Any person or entity other than the City or the Contractor receiving services or benefits pursuant to the Agreement is an incidental beneficiary only.

15. NO AUTHORITY TO BIND CITY TO CONTRACTS: The Contractor lacks any authority to bind the City on any contractual matters. Final approval of all contractual matters that purport to obligate the City must be executed by the City in accordance with the City's Charter and the D.R.M.C.

16. AGREEMENT AS COMPLETE INTEGRATION-AMENDMENTS: The Agreement is the complete integration of all understandings between the parties as to the subject matter of the Agreement. No prior or contemporaneous addition, deletion, or other modification has any force or effect, unless embodied in the Agreement in writing. No subsequent novation, renewal, addition, deletion, or other amendment will have any force or effect unless embodied in a written amendment to the Agreement properly executed by the parties. No oral representation by any officer or employee of the City at variance with the terms of the Agreement or any written amendment to the Agreement will have any force or effect or bind the City. The Agreement is, and any amendments thereto will, be binding upon the parties and their successors and assigns. Amendments to this Agreement will become effective when approved by both parties and executed in the same manner as this Agreement.

17. SEVERABILITY: Except for the provisions of the Agreement requiring appropriation of funds and limiting the total amount payable by the City, if a court of competent jurisdiction finds any provision of the Agreement or any portion thereof to be invalid, illegal, or unenforceable, the validity of the remaining portions or provisions will not be affected, if the intent of the parties can be fulfilled.

18. CONFLICT OF INTEREST:

A. No employee of the City shall have any personal or beneficial interest in the services or property described in the Agreement; and the Contractor shall not hire, or contract for

services with, any employee or officer of the City in violation of the City's Code of Ethics, D.R.M.C. §2-51, et seq. or the Charter §§ 1.2.8, 1.2.9, and 1.2.12.

B. The Contractor shall not engage in any transaction, activity or conduct that would result in a conflict of interest under the Agreement. The Contractor represents that it has disclosed any and all current or potential conflicts of interest which shall include transactions, activities or conduct that would affect the judgment, actions or work of the Contractor by placing the Contractor's own interests, or the interests of any party with whom the Contractor has a contractual arrangement, in conflict with those of the City. The City, in its sole discretion, will determine the existence of a conflict of interest and may terminate the Agreement in the event it determines a conflict exists, after it has given the Contractor written notice describing the conflict.

19. NOTICES: Notices concerning termination of the Agreement, alleged or actual violations of the terms of the Agreement, and matters of similar importance must be hand delivered, sent by overnight courier service, mailed by certified mail, return receipt requested, or mailed via United States mail, postage prepaid, if to Contractor at the address first above written, and if to the City at:

By Contractor to: Executive Director, Department of Public Health & Environment
City and County of Denver
101 W. Colfax Avenue
Suite 800
Denver, Colorado 80202

With a copy to: Program Manager
Denver Office of HIV Resources
Department of Public Health and Environment
101 W. Colfax Avenue
Suite 800
Denver, Colorado 80202

Notices hand delivered or sent by overnight courier are effective upon delivery; notices sent by certified mail are effective upon receipt; and notices sent by mail are effective upon deposit with the US Postal Service. The parties may designate substitute addresses where or persons to whom notices are to be mailed or delivered; however, these substitutions will not become effective until actual receipt of written notification.

20. DISPUTES: All disputes of whatsoever nature between the City and the Contractor regarding this Agreement shall be resolved by administrative hearings pursuant to the procedure established by Denver Revised Municipal Code, § 56-106(b), *et seq*. For the purposes of that procedure, the City official rendering a final determination shall be the City representative identified in paragraph 1 hereof.

21. GOVERNING LAW; VENUE: The Agreement will be construed and enforced in accordance with applicable federal law, the laws of the State of Colorado, the Charter and Revised Municipal Code of the City and County of Denver, and the ordinances, regulations and Executive Orders enacted or promulgated pursuant to the Charter and Code. The Charter, Revised Municipal Code and Executive Orders of the City and County of Denver are expressly

incorporated into the Agreement. Venue for any legal action relating to the Agreement will be in the District Court of the State of Colorado Second Judicial District.

22. COMPLIANCE WITH APPLICABLE LAWS: The Contractor will comply with all applicable Federal, State and City laws, ordinances, codes, regulations, rules, executive orders, and policies whether or not specifically referenced herein. Any references to specific federal, state, or local laws or other requirements incorporated into this Agreement are not intended to constitute an exhaustive list of federal, state, and City requirements applicable to this Agreement. Applicable statutes, regulations and other documents pertaining to administration or enforcement of the services referenced in this Agreement and all other applicable provisions of federal, state or local law are deemed to be incorporated herein by reference. Compliance with all such statutes, regulations and other documents is the responsibility of the Contractor. In particular, and not by way of limitation, the services shall be performed in strict compliance with all laws, executive orders, ordinances, rules, regulations, policies and procedures prescribed by the City and the United States Government, and the following additional federal requirements:

A. Ryan White Part A Programs: This Agreement is subject to the provisions of the Ryan White Comprehensive AIDS Resources Emergency Act, as amended by the Ryan White HIV/AIDS Extension Act of 2009 (Ryan White Act) pertaining to the HIV emergency relief grants program and the U.S. Department of Health and Human Services' (HHS) implementing regulations.

B. Federal Grant Award: This Agreement is subject to all of the terms and conditions of the Ryan White Part A Grant between the City and HHS for the fiscal year covered by this Agreement and to any subsequent Ryan White Part A Grant whether or not any such terms or conditions are set forth in the text of this Agreement. The terms and conditions of the said Ryan White Part A grant are incorporated herein by reference.

C. HIPAA and HITECH Act: Contractor shall be required to comply with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act"), and their implementing regulations at 45 CFR Parts 160 and 164 ("The HIPAA Regulations"), which are outlined in **Exhibit C**, and incorporated into this Agreement by reference.

D. Program Guidance: All information, circulars, memoranda, program guidance, instructions or other written documentation issued by the federal government concerning the Ryan White Part A program or the expenditure of other federal funds provided under this Agreement.

E. OMB Uniform Guidance and HHS Requirements: The applicable terms and conditions of OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards/Funds, 2 C.F.R. Part 200, and the applicable terms and condition of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 C.F.R. Part 75.

F. Grievance Policy: The parties desire to ensure that clients are being adequately informed over pending actions concerning their continued participation in the program or activity provided by the Contractor. Also, clients must be allowed adequate opportunity to

communicate dissatisfaction with the facilities or services offered by the Contractor. In order to satisfy this requirement, the Contractor agrees to provide a written "Grievance Policy" and related procedures as a mechanism to provide opportunities for the City and its clients to meaningfully communicate problems, dissatisfaction, and concerns and to establish procedures for resolution of grievances. The policy must be communicated to clients upon their initial receipt of services. Failure to provide an acceptable Grievance Policy shall constitute a material breach of this Agreement.

G. Debarment: The Contractor is subject to the prohibitions on contracting with a debarred organization pursuant to U.S. Executive Orders 12549 and 12689, Debarment and Suspension, and implementing federal regulations codified at 2 C.F.R. Part 180 and 2 C.F.R. Part 376. By its signature below, the Contractor assures and certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. The Contractor shall provide immediate written notice to the Executive Director if at any time it learns that its certification to enter into this Agreement was erroneous when submitted or has become erroneous by reason of changed circumstances. If the Contractor is unable to certify to any of the statements in the certification contained in this Article, the Contractor shall provide a written explanation to the City within thirty (30) calendar days of the date of execution of this Agreement. Furthermore, if the Contractor is unable to certify to any of the statements in the certification contained in this Article, the City may pursue any and all available remedies available to the City, including but not limited to terminating this Agreement immediately, upon written notice to the Contractor.

The Contractor shall include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction" in all covered transactions associated with this Agreement. The Contractor is responsible for determining the method and frequency of its determination of compliance with Executive Orders 12549 and 12689 and their implementing regulations.

H. No Discrimination in Program Participation: The Contractor will comply with any and all applicable federal, state, and local laws that prohibit discrimination in programs and activities funded by this Agreement on the basis of race, color, national origin, sex, disability, and age including but not limited to Title VI of the Civil Rights Act of 1964 (Title VI), Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990 (ADA), Title IX of the Education Amendments of 1972, Title VII of the Civil Rights Act of 1964 (Title VII), the Age Discrimination in Employment Act (ADEA), the antidiscrimination provision of the Immigration Reform and Control Act of 1986 (IRCA), and the Equal Pay Act (EPA). Violations may be subject to any penalties set forth in said applicable laws and the Contractor agrees to indemnify and hold the City harmless from any and all claims, losses, or demands that arise under this Article.

I. Access to Services for Persons with Limited English Proficiency: As clarified by Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting federal agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with Title VI, Contractor must take reasonable steps to ensure that LEP persons have meaningful access to Contractor's programs, services and activities.

J. Prohibited Transactions:

(1) Interest of Contractor: The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required to be performed under this Agreement. The Contractor further covenants that in the performance of this Agreement, no person having any such interest will be employed.

(2) Members of Congress: No member of or delegate to the Congress of the United States of America shall be admitted to any share or part hereof or to any benefit to arise from this Agreement.

(3) City Employees: No officer or employee of either the City or the Contractor shall derive any unlawful personal gain, either by salary, fee payment or personal allowance, from his or her association with the other party to this Agreement. Any contractual provision that contravenes the provisions of this section shall be null and void. This section shall not prohibit an officer or administrator of one party to this Agreement from being reimbursed by the other party for actual, out-of-pocket expenses incurred on behalf of the other party.

(4) No Political Activity: Without limiting the foregoing, the Contractor agrees that political activities are prohibited under this Agreement and agrees that no funds paid to it by the City hereunder will be used to provide transportation for any persons to polling places or to provide any other services in connection with elections.

K. Byrd Anti-Lobbying: If the **Maximum Contract Amount** exceeds $100,000, the Contractor must complete and submit to the City a required certification form provided by the City certifying that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress in connection with obtaining any Federal contract grant of any other award covered by 31 U.S.C. 1352. Contractor must also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award.

L. Mandatory Disclosures: Contractor must disclose, in a timely manner, in writing to the City all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the work to be performed under this Agreement. Failure to make required disclosures can result in the City taking any of the remedies described in 2 C.F.R. §200.339.

23. NO EMPLOYMENT OF ILLEGAL ALIENS TO PERFORM WORK UNDER THE AGREEMENT:

A. This Agreement is subject to Division 5 of Article IV of Chapter 20 of the Denver Revised Municipal Code, and any amendments (the "Certification Ordinance").

B. The Contractor certifies that it will participate in the E-Verify Program, as defined in § 8-17.5-101(3.7), C.R.S., to confirm the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement.

C. The Contractor also agrees and represents that:

(1) It shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

(2) It shall not enter into a contract with a subconsultant or subcontractor that fails to certify to the Contractor that it shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

(3) It has confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement, through participation in the E-Verify Program.

(4) It is prohibited from using the E-Verify Program procedures to undertake pre-employment screening of job applicants while performing its obligations under the Agreement, and that otherwise requires the Contractor to comply with any and all federal requirements related to use of the E-Verify Program including, by way of example, all program requirements related to employee notification and preservation of employee rights.

(5) If it obtains actual knowledge that a subconsultant or subcontractor performing work under the Agreement knowingly employs or contracts with an illegal alien, it will notify such subconsultant or subcontractor and the City within three (3) days. The Contractor will also then terminate such subconsultant or subcontractor if within three (3) days after such notice the subconsultant or subcontractor does not stop employing or contracting with the illegal alien, unless during such three-day period the subconsultant or subcontractor provides information to establish that the subconsultant or subcontractor has not knowingly employed or contracted with an illegal alien.

(6) It will comply with any reasonable request made in the course of an investigation by the Colorado Department of Labor and Employment under authority of § 8-17.5-102(5), C.R.S, or the City Auditor, under authority of D.R.M.C. 20-90.3.

D. The Contractor is liable for any violations as provided in the Certification Ordinance. If Contractor violates any provision of this section or the Certification Ordinance, the City may terminate this Agreement for a breach of the Agreement. If the Agreement is so terminated, the Contractor shall be liable for actual and consequential damages to the City. Any such termination of a contract due to a violation of this section or the Certification Ordinance may also, at the discretion of the City, constitute grounds for disqualifying Contractor from submitting bids or proposals for future contracts with the City.

24. NO DISCRIMINATION IN EMPLOYMENT: In connection with the performance of work under this Agreement, the Contractor agrees not to refuse to hire, nor to discharge, promote or demote, nor to discriminate in matters of compensation against any person otherwise qualified, solely because of race, color, religion, national origin, gender, age, military status, sexual orientation, gender identity or gender expression, marital status, or physical or mental disability; and further agrees to insert the foregoing provision in all subcontracts hereunder.

25. USE, POSSESSION OR SALE OF ALCOHOL OR DRUGS: The Contractor shall cooperate and comply with the provisions of Executive Order 94 and Attachment A thereto concerning the use, possession or sale of alcohol or drugs. Violation of these provisions or refusal

to cooperate with implementation of the policy can result in the City barring the Contractor from City facilities or participating in City operations.

26. CONFIDENTIAL INFORMATION; OPEN RECORDS:

A. Confidential Information: The Contractor acknowledges and accepts that, in the performance of all work under the terms of this Agreement, the Contractor will or may have access to the following types of information: (1) City Proprietary Data or confidential information that may be owned or controlled by the City ("City Proprietary Data"); (2) confidential information pertaining to persons receiving services from the Agency ("Client Data"), or (3) confidential proprietary information owned by third parties ("Third Party Proprietary Data"). For purposes of this Agreement, City Proprietary Data, Client Data, and Third Party Proprietary Data shall be referred to collectively as "Confidential Information". The Contractor agrees that all Confidential Information provided or otherwise disclosed by the City to the Contractor or as otherwise acquired by the Contractor during its performance under this Agreement shall be held in confidence and used only in the performance of its obligations under this Agreement. The Contractor shall limit access to any and all Confidential Information to only those employees who have a need to know such information in order to provide services under this Agreement. The Contractor shall exercise the same standard of care to protect any and all Confidential Information as a reasonably prudent contractor or Contractor would to protect its own proprietary or confidential data. Contractor acknowledges that Confidential Information may be in hardcopy, printed, digital or electronic format. The City reserves the right to restrict at any time Contractor's access to electronic Confidential Information to "read-only" access or "limited" access as such terms are designated by the Executive Director.

The Contractor agrees to comply with all applicable state and federal laws protecting the privacy or confidentiality of any and all Client Data, including protected health information, or other protected information, and to comply with all requirements contained in the attached **Exhibit C**.

(1) Use of Confidential Information: Except as expressly provided by the terms of this Agreement, the Contractor agrees that it shall not disseminate, transmit, license, sublicense, assign, lease, release, publish, post on the internet, transfer, sell, permit access to, distribute, allow interactive rights to, or otherwise make available any Confidential Information or any part thereof to any other person, party or entity in any form or media for any purpose other than performing its obligations under this Agreement. The Contractor further acknowledges that by providing access to Confidential Information, the City is not granting to the Contractor any right or license to use such data except as provided in this Agreement. The Contractor further agrees not to reveal, publish, disclose, or distribute to any other party, in whole or in part, in any way whatsoever, any Confidential Information without prior written authorization from the Executive Director.

(2) City Methods: The Contractor agrees that any ideas, concepts, know-how, computer programs, or data processing techniques developed by the Contractor or provided by the City in connection with this Agreement shall be deemed to be the sole property of the City and all rights, including copyright, shall be reserved to the City. The Contractor agrees, with respect to Confidential Information, that: (a) the Contractor shall not copy, recreate, reverse, engineer or decompile such data, in whole or in part, unless authorized in writing by the Executive Director; (b) the Contractor shall retain no copies, recreations, compilations, or decompilations, in

whole or in part, of such data; (c) the Contractor shall, upon the expiration or earlier termination of the Agreement, destroy (and, in writing, certify destruction) or return all such data or work products incorporating such data or information to the City.

(3) Employees and Subcontractors: The requirements of this provision shall be binding on the Contractor's employees, agents, officers and assigns. The Contractor warrants that all of its employees, agents, and officers who designated to provide services under this Agreement will be advised of this provision. All requirements and obligations of the Contractor under this Agreement shall survive the expiration or earlier termination of this Agreement.

(4) Disclaimer: Notwithstanding any other provision of this Agreement, the City is furnishing Confidential Information on an "as is" basis, without any support whatsoever, and without representation, warranty or guarantee, including, but not in any manner limited to, fitness, merchantability, accuracy and completeness of the Confidential Information. The Contractor acknowledges and understands that Confidential Information may not be completely free of errors. The City assumes no liability for any errors or omissions in any Confidential Information. Specifically, the City is not responsible for any costs including, but not limited to, those incurred as a result of lost revenues, loss of use of data, the costs of recovering such programs or data, the cost of any substitute program, claims by third parties, or for similar costs. If discrepancies are found, the Contractor agrees to contact the City immediately.

B. Open Records: The parties understand that all the material provided or produced under this Agreement may be subject to the Colorado Open Records Act, C.R.S. § 24-72-200.1–205.5 (2019), and that in the event of a request to the City for disclosure of such information, the City shall advise the Contractor of such request in order to give the Contractor the opportunity to object to the disclosure of any of its proprietary or confidential material. In the event of the filing of a lawsuit to compel such disclosure, the City will tender all such material to the court for judicial determination of the issue of disclosure and the Contractor agrees to intervene in such lawsuit to protect and assert its claims of privilege and against disclosure of such material or waive the same. The Contractor further agrees to defend, indemnify and save and hold harmless the City, its officers, agents and employees, from any claims, damages, expenses, losses or costs arising out of the Contractor's intervention to protect and assert its claim of privilege against disclosure under this Article including, but not limited to, prompt reimbursement to the City of all reasonable attorney fees, costs and damages that the City may incur directly or may be ordered to pay by such court.

27. INTELLECTUAL PROPERTY RIGHTS: The City and the Contractor intend that all property rights to any and all materials, text, logos, documents, booklets, manuals, references, guides, brochures, advertisements, music, sketches, plans, drawings, prints, photographs, specifications, software, data, products, ideas, inventions, and any other work or recorded information created by the Contractor and paid for by the City pursuant to this Agreement, in preliminary or final forms and on any media whatsoever (collectively, "Materials"), shall belong to the City. The Contractor shall disclose all such items to the City. To the extent permitted by the U.S. Copyright Act, 17 USC § 101, *et seq*., the Materials are a "work made for hire" and all ownership of copyright in the Materials shall vest in the City at the time the Materials are created. To the extent that the Materials are not a "work made for hire," the Contractor hereby

sells, assigns and transfers all right, title and interest in and to the Materials to the City, including the right to secure copyright, patent, trademark, and other intellectual property rights throughout the world and to have and to hold such copyright, patent, trademark and other intellectual property rights in perpetuity.

28. LEGAL AUTHORITY: Contractor represents and warrants that it possesses the legal authority, pursuant to any proper, appropriate and official motion, resolution or action passed or taken, to enter into the Agreement. Each person signing and executing the Agreement on behalf of Contractor represents and warrants that he has been fully authorized by Contractor to execute the Agreement on behalf of Contractor and to validly and legally bind Contractor to all the terms, performances and provisions of the Agreement. The City shall have the right, in its sole discretion, to either temporarily suspend or permanently terminate the Agreement if there is a dispute as to the legal authority of either Contractor or the person signing the Agreement to enter into the Agreement.

29. NO CONSTRUCTION AGAINST DRAFTING PARTY: The parties and their respective counsel have had the opportunity to review the Agreement, and the Agreement will not be construed against any party merely because the Agreement or any provisions thereof were prepared by a particular party.

30. SURVIVAL OF CERTAIN PROVISIONS: The terms of the Agreement and any exhibits and attachments that by reasonable implication contemplate continued performance, rights, or compliance beyond expiration or termination of the Agreement survive the Agreement and will continue to be enforceable. Without limiting the generality of this provision, the Contractor's obligations to provide insurance and to indemnify the City will survive for a period equal to any and all relevant statutes of limitation, plus the time necessary to fully resolve any claims, matters, or actions begun within that period.

31. INUREMENT: The rights and obligations of the parties to the Agreement inure to the benefit of and shall be binding upon the parties and their respective successors and assigns, provided assignments are consented to in accordance with the terms of the Agreement.

32. TIME IS OF THE ESSENCE: The parties agree that in the performance of the terms, conditions, and requirements of this Agreement, time is of the essence.

33. PARAGRAPH HEADINGS: The captions and headings set forth herein are for convenience of reference only, and shall not be construed so as to define or limit the terms and provisions hereof.

34. CITY EXECUTION OF AGREEMENT: This Agreement is expressly subject to, and shall not be or become effective or binding on the City until it has been fully executed by all signatories of the City and County of Denver.

35. CONTRACT DOCUMENTS; ORDER OF PRECEDENCE: In the event of any conflicts between the language of the Agreement and the exhibits, the language of the Agreement controls.

36. ELECTRONIC SIGNATURES AND ELECTRONIC RECORDS: Contractor consents to the use of electronic signatures by the City. The Agreement, and any other documents requiring a signature hereunder, may be signed electronically by the City in the manner specified by the City. The Parties agree not to deny the legal effect or enforceability of the Agreement solely because it is in electronic form or because an electronic record was used in its formation. The Parties agree not to object to the admissibility of the Agreement in the form of an electronic record, or a paper copy of an electronic document, or a paper copy of a document bearing an electronic signature, on the ground that it is an electronic record or electronic signature or that it is not in its original form or is not an original.

END

Exhibits List:

Exhibit A	Scope of Work
Exhibit B	Budget
Exhibit C	HIPAA and HITECH
Exhibit D	Proof of Insurance
Exhibit E	Financial Administration
Exhibit F	Service Standards
Exhibit G	CQM Plan Template
Exhibit H	CQM Summary Template
Exhibit I	Self-Attestation Form

SIGNATURE PAGES AND EXHIBITS FOLLOW THIS PAGE

Contract Control Number: ENVHL-202158736-00
Contractor Name: COLORADO HEALTH NETWORK, INC.

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of:

SEAL

CITY AND COUNTY OF DENVER:

ATTEST:

By: _____

_____

APPROVED AS TO FORM:

Attorney for the City and County of Denver

By: _____

REGISTERED AND COUNTERSIGNED:

By: _____

By: _____

Contract Control Number: ENVHL-202158736-00
Contractor Name: COLORADO HEALTH NETWORK, INC.

By: DocuSigned by: Darrell Vigil F026B8BCAFB94E3...

Darrell Vigil
Name: _____
(please print)

Chief Executive Officer
Title: _____
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

EXHIBIT A

SCOPE OF WORK

DENVER PUBLIC HEALTH & ENVIRONMENT

SCOPE OF WORK

I. Purpose of Agreement

The purpose of this contract is to establish an agreement and Scope of Services between the Denver Department of Public Health & Environment (DDPHE), Denver HIV Resources (DHR) and **Colorado Health Network, Inc.**

Colorado Health Network, Inc. has been awarded the following amounts in Ryan White Part A funds:

- Maximum of **$2,301,779.00** in Fiscal Year (FY) 2021 (March 1, 2021 – February 28, 2022)

II. Services and Conditions

A. The Denver Ryan White Part A HIV AIDS Program Service Standards are the minimum requirements that subrecipients are expected to meet when providing HIV care and support services funded by the Denver Ryan White HIV/AIDS Part A grant. All subrecipients **must** follow the Universal Standards in the Service Standards. Subrecipients are also responsible for meeting the standards outlined for each service category for which they receive funding. Denver HIV Resources (DHR) evaluates program adherence to Service Standards during site visits. Subrecipients may exceed the requirements of the Service Standards, though this is not required and will not be evaluated during site visits. It is important that subrecipients are familiar with the Service Standards that apply to them. Denver HIV Resources Planning Council (DHRPC) initiatives and DHR programmatic updates may result in adjustments to the Service Standards during the Fiscal Year. DHR will inform subrecipients when changes are implemented and will provide subrecipients with an updated version of the Service Standards. The Service Standards for fiscal year 2021 is attached as **Exhibit F**

B. Colorado Health Network, Inc. is to provide the following services to individuals living with HIV/AIDS in the Denver Transitional Grant Area (TGA), which includes and is limited to, Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson counties, in accordance with the Service Standards for the following service categories:

SERVICE CATEGORY	FUNDING SOURCE	FY 2021 AWARD AMOUNT
Emergency Financial Assistance	RW Part A	$352,734
Food Bank/Home Delivered Meals	RW Part A	$131,779
Housing Services	RW Part A	$352,734
Medical Case Management	RW Part A	$560,583
Mental Health Services	RW Part A	$33,946
Medical Transportation Services	RW Part A	$99,900
Outpatient/Ambulatory Health Services	RW Part A	$134,195
Oral Health Care	RW Part A	$510,085
Oral Health Fund	RW Part A	$54,823
Psychosocial Support Services	RW Part A	$40,259
Substance Abuse Outpatient Care	RW Part A	$30,741
FY 2021 MAXIMUM REIMBURSABLE AMOUNT:		**$2,301,779**

DENVER PUBLIC HEALTH & ENVIRONMENT

SCOPE OF WORK

III. Process and Outcome Measures

Colorado Health Network, Inc. will provide:

SERVICE CATEGORY	UNDUPLICATED CLIENTS	SERVICE UNITS DELIVERED
Emergency Financial Assistance	350	350
Food Bank/Home Delivered Meals	600	30,000
Housing Services	300	300
Medical Case Management	1,000	12,000
Mental Health Services	58	1,044
Medical Transportation Services	500	17,500
Outpatient/Ambulatory Health Services	98	335
Oral Health Care	848	2,544
Oral Health Fund	21	21
Psychosocial Support Services	20	30
Substance Abuse Outpatient Care	53	954

IV. Clinical Quality Management Program

A. Clinical Quality Management Plan

1. Contractor will be required to submit a FY 2021 Clinical Quality Management Plan. **Clinical Quality Management Plans will be due on May 28, 2021.** Quality Management Plans must follow the *Clinical Quality Management Plan Template* attached as **Exhibit G.**

2. Contractor will be required to submit two Clinical Quality Management Plan summaries for check-in **due on August 27, 2021 and November 26,2021 respectively. The final summary is due on February 25, 2022.** The Clinical Quality Management Plan summaries must follow the *Clinical Quality Management Plan Summary Template* attached as **Exhibit H**

B. Clinical Quality Management Activities

1. Contractor will be required to document at least one quality improvement activity in the Fiscal Year

2. Quality Improvement activities should be related to the Clinical Quality Management Plan and impact the sub-recipients identified annual quality goals

3. Contractor will hold Quality Committee meetings quarterly at a minimum.

V. Clinical Quality Management Infrastructure and Capacity Building

Contractor will be required to identify one contact person for all Quality Management related deliverables

Contractor will be required to have two staff members participate in both DHR hosted, Clinical Quality Management Trainings **on April 27,2021 and on September 28, 2021**

VI. Schedule of Payments for Services

A. After the contract is executed, invoices for all service months completed before the execution date are due immediately. Subsequent invoices shall follow the Contractor invoicing schedule outlined below:

B. Three or more occurrences of a late invoice shall be considered a contract compliance issue.

C. The Contractor is required to submit a complete invoice package monthly using required DDPHE HIV Resources invoice forms. A complete invoice package will include the following:

Item 1: a complete monthly invoice package for the service month

Item 2: supporting documentation for all expenses

Contractor invoicing schedule is as follows:

SERVICE MONTH	INVOICE PACKAGE DUE BY	INVOICE PACKAGE INCLUDES:
March 2021	May 15, 2021	Items 1 and 2
April 2021	June 15, 2021	Items 1 and 2
May 2021	July 15, 2021	Items 1 and 2
June 2021	August 17, 2021	Items 1 and 2
July 2021	September 15, 2021	Items 1, 2, and 3
August 2021	October 15, 2021	Items 1 and 2
September 2021	November 16, 2021	Items 1 and 2
October 2021	December 15, 2021	Items 1, 2, and 3
November 2021	January 15, 2022	Items 1 and 2
December 2021	February 15, 2022	Items 1 and 2
January 2022	March 15, 2022	Items 1, 2, and 3
February 2022	April 15, 2022	Items 1, 2, and 3

VII. Disallowances and Review of Reports

The City and County of Denver may review the budget, management, financial and audit reports, and any other materials or information the City and County of Denver may consider appropriate to assess whether any expenditures by the Contractor are disallowed by the City and County of Denver. **Exhibit E** attached as the Subrecipient Financial Administration describes expenditures that will be disallowed by The City and County of Denver. The City and County of Denver may disallow reimbursement for services or expenditures that were

not provided or approved in accordance with the terms of this Agreement. The Contractor shall not unreasonably refuse to provide expenditure information related to this Agreement that the City and County of Denver may reasonably require.

These disallowances will be deducted from any payments due the Contractor, or if disallowed after contract termination, the Contractor shall remit the disallowed reimbursement to the City and County of Denver according to a schedule to be determined by the City and County of Denver at its sole discretion. Despite the City and County of Denver's approval of expenditures, if a review or an audit conducted by the City, State or federal governments results in final disallowances of expenditures, the Contractor shall remit the amount of those disallowances to the City and County of Denver according to a schedule to be determined by the City and County of Denver at its sole discretion following written notice of disallowances to the Contractor. This Section survives termination or expiration of this Agreement.

VIII. Administrative Cost Limit

The Contractor's total administrative costs cannot exceed **10%** of the maximum reimbursable amount. Administrative costs are defined as the costs incurred for usual and recognized overhead, including established indirect cost, management and oversight of specific programs funded under this contract and other types of program support such as quality assurance, quality control, and related activities. Examples of administrative costs include:

- Salaries and related fringe benefits for accounting, secretarial, and management staff, including those individuals who produce, review and sign monthly program and fiscal reports
- Consultants who perform administrative, non-service delivery functions
- General office supplies
- Travel costs for administrative and management staff
- General office printing and photocopying
- General liability insurance and
- Audit fees.

IX. Invoices

Complete invoice packages are due to DDPHE HIV Resources at HIVInvoiceIntake@denvergov.org by the 15th calendar day of the second month following the month of service provision. Invoice requests for reimbursement of costs should be submitted on a regular and timely basis in accordance with policies established in the Subrecipient Financial Administration document attached as **Exhibit E**.

X. Budget

Contractor shall submit a complete budget package using required DDPHE HIV Resources budget forms. The budget for this agreement is attached as **Exhibit B**.

XI. Budget Modifications

Contractor may submit budget modifications for review and approval based on policies established in the Subrecipient Financial Administration attached as **Exhibit E**. Approval of such request is based on the discretion of the Executive Director or his/her designee.

XII. Performance Management and Reporting

DENVER PUBLIC HEALTH & ENVIRONMENT

SCOPE OF WORK

A. Performance Management

Monitoring may be performed by the DDPHE HIV Resources staff. Contractor may be reviewed for:

1. **Clinical Quality Management Monitoring:** Review contractor Clinical Quality Management program inclusive of performance data, health outcomes, and satisfaction surveys.
2. **Program Monitoring*:** Review and analysis of current program information to determine the extent to which contractors are achieving established contractual goals.
3. **Fiscal Monitoring*:** Review financial systems and billings to ensure that contract funds are allocated and expended in accordance with the terms of the agreement.
4. **Program Income.** DDPHE may require subrecipients to report program income directly generated by a supported activity earned as a result of this grant. Program income includes but is not limited to income from fees for services performed, e.g. direct payment or reimbursements received from Medicaid, Medicare, and third-party insurance. Program income does not include rebates, credits, discounts, and interest earned on any of these.
5. **Administrative Monitoring*:** Monitoring to ensure that the requirements of the contract document, Federal, State and City and County regulations, and DDPHE policies are being met.

*DDPHE HIV Resources *may provide regular performance monitoring and reporting.* DDPHE HIV Resources and/or its designee*, may manage any performance issues and may develop interventions that will resolve concerns.*

B. Reporting

The following reports shall be developed and delivered to the City as stated in this section.

Report # and Name	Description	Due Date	Reports to be sent to:
1). CAREWare Reporting	Contractor is required to enter client-level data monthly into CAREWare for all funded services including: 1. All client-level information required by HRSA: https://targethiv.org/sites/default/files/media/documents/2020-12/2020_RSR_Manual_Final_12_04_2020_508.pdf and/or requirements subject to change by HRSA 2. Contractor may enter client- level data into CAREWare using two	Manual Data Entry Provider: 15th of each month PDI: 25th of each month	Into CAREWare system

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	different methodologies: Direct manual data entry via the CAREWare interface; or Provider Data Import (PDI).		
2). Ryan White Part A Service Report (RSR)	Includes, but is not limited to: • Data input throughout the calendar year • Run provider RSR reports to clean existing data and/or input missing data with technical assistance from DHR • Review finalized RSR report with DHR • Generate client-level XML file and upload into the HRSA Web Application (per HRSA requirement) Submit RSR report into HRSA Web Application	TBD by HRSA, March 2022	Into CAREWare system for data entry Into HRSA Web Application for RSR final reporting
3).1st Quarter report	Report shall: • Review and verify the # of clients served, the number of service units, the amount of funding expended • Provide an update on changes to staff including vacancies and new staff	July 15, 2021	DHR Data Analyst: Kylie Mason Kylie.mason@denvergov.org
4). 3rd Quarter Report	Report shall: • Review and verify the # of clients served, the number of service units, the amount of funding expended • Provide an update on changes to staff including vacancies and new staff	January 19, 2022	DHR Data Analyst: Kylie Mason Kylie.mason@denvergov.org
5). CARES Act: COVID-19 Reporting	Subrecipients shall complete and/or assist Denver HIV Resources in the completion of monthly COVID-19 Data Reports (CDR). The timeframe for this data reporting is from March 15, 2021 – June 31, 2021.The CDR includes data pertinent to your agency's overall telehealth capacity for client services, any/all COVID-19 testing data for Ryan White Part A Clients given at your agency site, items procured using CARES Act funding, and CARES Act funded	COVID-19 Data Report in Google Form: 10th of every Month starting in March 15, 2021 COVID-19 Data Report in HRSA Electronic Handbook:	Data Administrator: Nick Roth Nicholas.roth@denvergov.org

DENVER PUBLIC HEALTH & ENVIRONMENT

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	service utilization data. The CDR Manual can be found here: https://targethiv.org/sites/default/files/file-upload/resources/2020-CDR-Instruction-Manual_DRAFT05272020.pdf	due 15th of every month starting March 15, 2021	
6). Other reports, data or processes as reasonably requested by the City	To be determined (TBD)	TBD	TBD

XIII. CAREWare System Use

A. Contractor shall have active user access and system utilization of CAREWare application by agency staff.

B. Contractor shall manually enter new client eligibility data into CAREWare at their soonest opportunity, but at least weekly, to reduce barriers to care for newly enrolled Ryan White Part A clients, including uploading any/all eligibility documentation for said clients.

C. Contractor shall utilize Shared Eligibility data and AIDS Drug Assistance Program (ADAP) surrogate data eligibility whenever said data is available in CAREWare to reduce barriers to care for Ryan White Part A clients.

D. Contractor shall utilize client referral features in CAREWare when said feature is implemented in CAREWare to reduce barriers to care for Ryan White Part A clients.

XIV. Self-Attestation/No Change Form

A. Contractor is required to complete the Self-Attestation/No Change Form **(Exhibit I)** for the semiannual eligibility recertification if the client's income, residency, household size, or health insurance status have not changed in the previous six (6) months.

B. If another contractor has already completed the form for the client's semiannual eligibility recertification, the contractor does not need to complete the form again but does need to confirm this verification in CAREWare.

XV. Required Acknowledgement and Disclaimer Language

A. HRSA requires subrecipients to use the following acknowledgement and disclaimer on all products produced by HRSA grant funds:

"This [project/publication/program/website, etc.] [is/was] supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $XX with XX percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov."

B. Subrecipients are required to use this language when issuing statements, press releases, requests for proposals, bid solicitations, and other HRSA supported publications and

forums describing projects or programs funded in whole or in part with HRSA funding.

- Examples of HRSA supported publications include, but are not limited to, manuals, toolkits, resources guides, case studies, and issues briefs.

XVI. Other

Contractor shall submit updated documents which are directly related to the delivery of services.

EXHIBIT B

BUDGET

DDPHE HIV RESOURCES BUDGET SUBMISSION PACKAGE

CONTRACT SUMMARY DATA
SUBRECIPIENT INFORMATION

SUBRECIPIENT: Colorado Health Network, Inc.

DATE OF SUBMISSION: 10/30/2020 **CONTRACT AMOUNT:** $2,301,779.00

Check One: ☑ First Submission or ☐ Resubmission

FUNDING SOURCE: Select One

EFFECTIVE DATES: 03/01/2021 to 02/28/2022

SUBRECIPIENT CORPORATION INFORMATION

NOTE: This name and address will appear on City Contractor Agreement.

FEDERAL TAX ID#: 84-0961159 **DUNS#:** 14955331

EXACT CORPORATE NAME: Colorado Health Network, Inc.

CORPORATE ADDRESS: 6260 East Colfax Ave
Address Line 1

Address Line 2

Denver | CO | 80220
City | State | Zipcode

CORPORATE WEBSITE: www.coloradohealthnetwork.org

AGENCY TYPE: Community-Based Organization

OWNERSHIP TYPE: Private, Nonprofit

FAITH-BASED: No

I CERTIFY THAT COSTS HAVE BEEN DETERMINED ALLOWABLE ACCORDING TO CITY AND APPROPRIATE FEDERAL PRINCIPLES AND STANDARDS AS LISTED ON FORM A-2. I FURTHER CERTIFY THAT THERE ARE NO MATHEMATICAL ERRORS IN THIS BUDGET. PLEASE SIGN ON DESIGNATED LINE BELOW.

AGENCY HEAD:

Printed Name	Phone	Email
Darrell Vigil	303-962-5310	Darrell.Vigil@coloradohealthnetwork.c

SENIOR ADMINISTRATOR:

Printed Name	Phone	Email
Randy Vessell	303-962-5312	Randy.Vessell@coloradohealthnetwor

BOARD PRESIDENT:

Printed Name	Phone	Email
Bill Mead	719-636-8088	meadman2@aol.com

CONTRACT SIGNATORY:

Printed Name	Phone	Email
Darrell Vigil	303-962-5310	Darrell.Vigil@coloradohealthnetwork.c

CONTRACT CONTACT INFORMATION

PROGRAM CONTACT: Maria Lopez (Name) | Director of Client Services (Title)

Telephone	Fax	Email
303-962-4487		Maria.Lopez@coloradohealthnetwork.org

FISCAL CONTACT: Randy Vessell (Name) | Chief Financial Officer (Title)

Telephone	Fax	Email
303-962-5312		Randy.Vessell@coloradohealthnetwork.org

DATA CONTACT: Bonnie Brown (Name) | Database Administrator (Title)

Telephone	Fax	Email
303-960-4223		Bonnie.Brown@coloradohealthnetwork.org

QUALITY CONTACT:	Jamie Villalobos		Program Quality Officer
	Name		Title
303-962-4492		Jamie.Villalobos@coloradohealthnetwork.org	
Telephone	Fax	Email	
PAYMENT ADDRESS:			
	Address Line 1		
NOTE: Only complete if Payment Address is different than Corporate Address.			
	Address Line 2		
	City	State	Zipcode

SUBRECIPIENT: **Colorado Health Network, Inc.**

BUDGET CATEGORY	EFA	FBM	HS	MCM-A	MHS-A	MTS	OAH	OHC	OHF	PSS-A	SAO-A	TOTAL
PERSONNEL	$ 18,883.00	$ 92,712.78	$ 18,883.00	$ 417,722.06	$ 24,475.41	$ 13,023.92	$ 96,000.37	$ 377,182.49	$ -	$ 28,639.42	$ 22,000.30	$ 1,109,522.75
FRINGE BENEFITS	$ 4,154.26	$ 20,396.81	$ 4,154.26	$ 91,898.85	$ 5,384.59	$ 2,865.26	$ 21,120.08	$ 82,980.15	$ -	$ 6,300.67	$ 4,840.07	$ 244,095.00
TRAVEL	$ -	$ 523.50	$ -	$ -	$ -	$ -	$ -	$ 51.00	$ -	$ 134.00	$ 106.00	$ 814.50
EQUIPMENTS	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SUPPLIES	$ -	$ 6,166.00	$ -	$ -	$ -	$ -	$ 500.00	$ 3,500.00	$ -	$ -	$ -	$ 10,166.00
SUBCONTRACT COST	$ -	$ -	$ -	$ -	$ 1,000.00	$ -	$ 2,500.00	$ -	$ -	$ 1,525.00	$ 1,000.00	$ 6,025.00
SUBTOTAL OTHER	$ 297,630.01	$ -	$ 297,630.01	$ -	$ -	$ 74,929.00	$ 1,875.00	$ -	$ 49,839.09	$ -	$ -	$ 721,903.11
SUBTOTAL OPERATING COST	$ 297,630.01	$ 6,689.50	$ 297,630.01	$ -	$ 1,000.00	$ 74,929.00	$ 4,875.00	$ 3,551.00	$ 49,839.09	$ 1,659.00	$ 1,106.00	$ 738,908.61
TOTAL DIRECT COST	$ 320,667.27	$ 119,799.09	$ 320,667.27	$ 509,620.91	$ 30,860.00	$ 90,818.18	$ 121,995.45	$ 463,713.64	$ 49,839.09	$ 36,599.09	$ 27,946.37	$ 2,092,526.36
INDIRECT COST	$ 32,066.73	$ 11,979.91	$ 32,066.73	$ 50,962.09	$ 3,086.00	$ 9,081.82	$ 12,199.55	$ 46,371.36	$ 4,983.91	$ 3,659.91	$ 2,794.64	$ 209,252.64
TOTAL BUDGETED COST	$ 352,734.00	$ 131,779.00	$ 352,734.00	$ 560,583.00	$ 33,946.00	$ 99,900.00	$ 134,195.00	$ 510,085.00	$ 54,823.00	$ 40,259.00	$ 30,741.00	$ 2,301,779.00

SUBRECIPIENT: Colorado Health Network, Inc.

PERIOD OF	BEGIN DATE	04/01/2020	04/01/2020	07/01/2020	06/01/2020		07/01/2020	Various	01/01/2020	10/01/2020	
FUNDING:	END DATE	03/31/2021	03/31/2021	06/30/2021	05/31/2021		06/30/2021	Various	12/31/2021	09/30/2021	
BUDGET CATEGORY	RYAN WHITE PART A (DDPHE)	RYAN WHITE PART B (CDPHE)	CDPHE HIV Core and Support Services	RYAN WHITE PART F (Univ CO)	HUD	CDC (CDPHE)	HOPWA CHAMP (State of CO)	CDPHE OTHER SOURCES	HOPWA	GENERAL OPERATION/ PRIVATE	TOTAL BUDGET
PERSONNEL	$ 1,109,522.75	$ 1,047,779.00	$ 686,697.00	$ 85,881.00	$ 105,821.00		$ 133,194.00	$ 1,741,038.00	$ 474,094.00	$ 1,063,917.00	$ 6,447,943.75
FRINGE BENEFITS	$ 244,095.00	$ 295,527.00	$ 193,684.00	$ 18,894.00	$ 29,847.00		$ 25,306.00	$ 409,310.00	$ 89,013.00	$ 198,678.00	$ 1,504,354.00
TRAVEL	$ 814.50	$ 13,332.00	$ 17,914.00	$ 2,000.00	$ 1,857.00		$ 2,000.00	$ 22,612.00	$ 2,256.00	$ 12,474.00	$ 75,259.50
EQUIPMENTS	$ -	$ 12,000.00	$ 5,000.00		$ 4,100.00		$ -	$ 47,200.00	$ 3,605.00	$ 24,500.00	$ 96,405.00
SUPPLIES	$ 10,166.00	$ 62,800.00	$ 89,000.00	$ 28,325.00	$ 8,000.00		$ 45,365.36	$ 127,600.00	$ 4,000.00	$ 54,243.00	$ 429,499.36
SUBCONTRACT COST	$ 6,025.00	$ 37,816.00	$ 62,500.00	$ 11,278.00	$ 5,647.00		$ 10,800.00	$ 1,980,097.00	$ 16,032.00	$ 148,890.00	$ 2,279,085.00
SUBTOTAL OTHER	$ 721,903.11	$ 3,091,134.00	$ 196,870.00		$ 2,925.00		$ 538,100.00	$ 5,926,607.00	$ 1,636,283.00	$ 364,161.00	$ 12,477,983.11
SUBTOTAL OPERATING COST	$ 738,908.61										$ 738,908.61
TOTAL DIRECT COST	$ 2,092,526.36	$ 4,560,388.00	$ 1,251,665.00	$ 146,378.00	$ 158,197.00	$ -	$ 754,765.36	$ 10,254,464.00	$ 2,225,283.00	$ 1,866,863.00	$ 23,310,529.72
INDIRECT COST	$ 209,252.64	$ 440,413.00	$ 124,093.00	$ 12,468.00	$ 11,907.00		$ 52,833.58	$ 898,372.00	$ 105,904.00		$ 1,855,243.21
TOTAL BUDGETED COST	$ 2,301,779.00	$ 5,000,801.00	$ 1,375,758.00	$ 158,846.00	$ 170,104.00	$ -	$ 807,598.94	$ 11,152,836.00	$ 2,331,187.00	$ 1,866,863.00	$ 25,165,772.93

EXHIBIT C

BUSINESS ASSOCIATE AGREEMENT
HIPAA/HITECH

1. GENERAL PROVISIONS AND RECITALS.

1.01 The parties agree that the terms used, but not otherwise defined below, shall have the same meaning given to such terms under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and their implementing regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations") as they exist or may hereafter be amended.

1.02 The parties agree that a business associate relationship (as described in 45 CFR §160.103) under HIPAA, the HITECH Act, and the HIPAA regulations arises between the CONTRACTOR and the CITY to the extent that CONTRACTOR performs, or delegates to subcontractors to perform, functions or activities on behalf of CITY.

1.03 CITY wishes to disclose to CONTRACTOR certain information, some of which may constitute Protected Health Information ("PHI") as defined below, to be used or disclosed in the course of providing services and activities.

1.04 The parties intend to protect the privacy and provide for the security of PHI that may be created, received, maintained, transmitted, used, or disclosed pursuant to the Agreement in compliance with the applicable standards, implementation specifications, and requirements of HIPAA, the HITECH Act, and the HIPAA regulations as they exist or may hereafter be amended.

1.05 The parties understand and acknowledge that HIPAA, the HITECH Act, and the HIPAA regulations do not pre-empt any state statutes, rules, or regulations that impose more stringent requirements with respect to privacy of PHI.

1.06 The parties understand that the HIPAA Privacy and Security rules apply to the CONTRACTOR in the same manner as they apply to a covered entity. CONTRACTOR agrees to comply at all times with the terms of this Agreement and the applicable standards, implementation specifications, and requirements of the Privacy and the Security rules, as they exist or may hereafter be amended, with respect to PHI.

2. DEFINITIONS.

2.01 "Administrative Safeguards" are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic PHI and to manage the conduct of CONTRACTOR's workforce in relation to the protection of that information.

2.02 "Agreement" means the attached Agreement and its exhibits to which these additional terms are incorporated by reference.

2.03 "Breach" means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the PHI.

2.03.1 Breach excludes:

1. Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of CONTRACTOR or CITY, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.

2. Any inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI, or organized health care arrangement in which CITY participates, and the information received as a result of such disclosure is not further used or disclosed in a manner disallowed under the HIPAA Privacy Rule.

3. A disclosure of PHI where CONTRACTOR or CITY has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

2.03.2 Except as provided in paragraph (a) of this definition, an acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule is presumed to be a breach unless CONTRACTOR demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

1. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

2. The unauthorized person who used the PHI or to whom the disclosure was made;

3. Whether the PHI was actually acquired or viewed; and

4. The extent to which the risk to the PHI has been mitigated.

2.04 "CONTRACTOR" shall have the same meaning as in the attached Agreement, to which these Business Associate terms are incorporated by reference.

2.05 "CITY" shall have the same meaning as in the attached Agreement, to which these Business Associate terms are incorporated by reference.

2.06 "Data Aggregation" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR §164.501.

2.07 "Designated Record Set" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR §164.501.

2.08 "Disclosure" shall have the meaning given to such term under the HIPAA regulations in 45 CFR §160.103.

2.09 "Health Care Operations" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR §164.501.

2.10 "Immediately" where used here shall mean within 24 hours of discovery.

2.11 "Individual" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR §160.l03 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

2.12 "Parties" shall mean "CONTRACTOR" and "CITY", collectively.

2.13 "Physical Safeguards" are physical measures, policies, and procedures to protect CONTRACTOR's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

2.14 "The HIPAA Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

2.15 "Protected Health Information" or "PHI" shall have the meaning given to such term under the HIPAA regulations at 45 CFR §160.103.

2.16 "Required by Law" shall have the meaning given to such term under the HIPAA Privacy Rule at 45 CFR §164.103.

2.17 "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

2.18 "Security Incident" means attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. "Security incident" does not include trivial incidents that occur on a daily basis, such as scans, "pings", or unsuccessful attempts to penetrate computer networks or servers maintained by CONTRACTOR.

2.19 "The HIPAA Security Rule" shall mean the Security Standards for the Protection of electronic PHI at 45 CFR Part 160, Part 162, and Part 164, Subparts A and C.

2.20 "Subcontractor" shall have the meaning given to such term under the HIPAA regulations at 45 CFR §160.103.

2.21 "Technical safeguards" means the technology and the policy and procedures for its use that protect electronic PHI and control access to it.

2.22 "Unsecured PHI" or "PHI that is unsecured" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or

methodology specified by the Secretary of Health and Human Services ("HHS") in the guidance issued on the HHS Web site.

2.23 "Use" shall have the meaning given to such term under the HIPAA regulations at 45 CFR §160.103.

3. OBLIGATIONS AND ACTIVITIES OF CONTRACTOR AS BUSINESS ASSOCIATE.

3.01 CONTRACTOR agrees not to use or further disclose PHI that CITY discloses to CONTRACTOR except as permitted or required by this Agreement or by law.

3.02 CONTRACTOR agrees to use appropriate safeguards, as provided for in this Agreement, to prevent use or disclosure of PHI that CITY discloses to CONTRACTOR or that CONTRACTOR creates, receives, maintains, or transmits, on behalf of CITY, except as provided for by this Contract.

3.03 CONTRACTOR agrees to comply with the HIPAA Security Rule, at Subpart C of 45 CFR Part 164, with respect to electronic PHI that CITY discloses to CONTRACTOR or that CONTRACTOR creates, receives, maintains, or transmits, on behalf of CITY.

3.04 CONTRACTOR agrees to mitigate, to the extent practicable, any harmful effect of a Use or Disclosure of PHI by CONTRACTOR in violation of the requirements of this Agreement that becomes known to CONTRACTOR.

3.05 CONTRACTOR agrees to immediately report to CITY any Use or Disclosure of PHI not provided for by this Agreement that CONTRACTOR becomes aware of. CONTRACTOR must report Breaches of Unsecured PHI in accordance with 45 CFR §164.410.

3.06 CONTRACTOR agrees to ensure that any of its subcontractors that create, receive, maintain, or transmit, PHI on behalf of CONTRACTOR agree to comply with the applicable requirements of Section 164 Part C by entering into a contract or other arrangement.

3.07 To comply with the requirements of 45 CFR §164.524, CONTRACTOR agrees to provide access to CITY, or to an individual as directed by CITY, to PHI in a Designated Record Set within fifteen (15) calendar days of receipt of a written request by CITY.

3.08 CONTRACTOR agrees to make amendment(s) to PHI in a Designated Record Set that CITY directs or agrees to, pursuant to 45 CFR §164.526, at the request of CITY or an Individual, within thirty (30) calendar days of receipt of the request by CITY. CONTRACTOR agrees to notify CITY in writing no later than ten (10) calendar days after the amendment is completed.

3.09 CONTRACTOR agrees to make internal practices, books, and records, including policies and procedures, relating to the use and disclosure of PHI received from, or created or received by CONTRACTOR on behalf of CITY, available to CITY and the Secretary in a time and manner as determined by CITY, or as designated by the Secretary, for purposes of the Secretary determining CITY'S compliance with the HIPAA Privacy Rule.

3.10 CONTRACTOR agrees to document any Disclosures of PHI that CITY discloses to CONTRACTOR or that CONTRACTOR creates, receives, maintains, or transmits on behalf of CITY, and to make information related to such Disclosures available as would be required for CITY to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 CFR §164.528.

3.11 CONTRACTOR agrees to provide CITY information in a time and manner to be determined by CITY in order to permit CITY to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 CFR §164.528.

3.12 CONTRACTOR agrees that, to the extent CONTRACTOR carries out CITY's obligation(s) under the HIPAA Privacy and/or Security rules, CONTRACTOR will comply with the requirements of 45 CFR Part 164 that apply to CITY in the performance of such obligation(s).

3.13 CONTRACTOR shall work with CITY upon notification by CONTRACTOR to CITY of a Breach to properly determine if any Breach exclusions exist as defined below.

4. SECURITY RULE.

4.01 CONTRACTOR shall comply with the requirements of 45 CFR § 164.306 and establish and maintain appropriate Administrative, Physical and Technical Safeguards in accordance with 45 CFR §164.308, §164.310, §164.312, §164.314 and §164.316 with respect to electronic PHI that CITY discloses to CONTRACTOR or that CONTRACTOR creates, receives, maintains, or transmits on behalf of CITY. CONTRACTOR shall follow generally accepted system security principles and the requirements of the HIPAA Security Rule pertaining to the security of electronic PHI.

4.02 CONTRACTOR shall ensure that any subcontractors that create, receive, maintain, or transmit electronic PHI on behalf of CONTRACTOR agree through a contract with CONTRACTOR to the same restrictions and requirements contained here.

4.03 CONTRACTOR shall immediately report to CITY any Security Incident of which it becomes aware. CONTRACTOR shall report Breaches of Unsecured PHI as described in 5. BREACH DISCOVERY AND NOTIFICATION below and as required by 45 CFR §164.410.

5. BREACH DISCOVERY AND NOTIFICATION.

5.01 Following the discovery of a Breach of Unsecured PHI, CONTRACTOR shall notify CITY of such Breach, however, both parties may agree to a delay in the notification if so advised by a law enforcement official pursuant to 45 CFR §164.412.

5.01.1 A Breach shall be treated as discovered by CONTRACTOR as of the first day on which such Breach is known to CONTRACTOR or, by exercising reasonable diligence, would have been known to CONTRACTOR.

5.01.2 CONTRACTOR shall be deemed to have knowledge of a Breach, if the Breach is known, or by exercising reasonable diligence would have been known, to any person

who is an employee, officer, or other agent of CONTRACTOR, as determined by the federal common law of agency.

5.02 CONTRACTOR shall provide the notification of the Breach immediately to the CITY DEH Executive Director or other designee.

5.02.1 CONTRACTOR'S initial notification may be oral, but shall be followed by written notification within 24 hours of the oral notification.

5.03 CONTRACTOR'S notification shall include, to the extent possible:

5.03.1 The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by CONTRACTOR to have been, accessed, acquired, used, or disclosed during the Breach;

5.03.2 Any other information that CITY is required to include in the notification to each Individual under 45 CFR §164.404 (c) at the time CONTRACTOR is required to notify CITY, or promptly thereafter as this information becomes available, even after the regulatory sixty (60) day period set forth in 45 CFR §164.410 (b) has elapsed, including:

1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

2. A description of the types of Unsecured PHI that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

3. Any steps Individuals should take to protect themselves from potential harm resulting from the Breach;

4. A brief description of what CONTRACTOR is doing to investigate the Breach, to mitigate harm to Individuals, and to protect against any future Breaches; and

5. Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

5.04 CITY may require CONTRACTOR to provide notice to the Individual as required in 45 CFR §164.404, if at the sole discretion of the CITY, it is reasonable to do so under the circumstances.

5.05 In the event that CONTRACTOR is responsible for a Breach of Unsecured PHI in violation of the HIPAA Privacy Rule, CONTRACTOR shall have the burden of demonstrating that CONTRACTOR made all required notifications to CITY, and as required by the Breach notification regulations, or, in the alternative, that the acquisition, access, use, or disclosure of PHI did not constitute a Breach.

5.06 CONTRACTOR shall maintain documentation of all required notifications of a Breach or its risk assessment under 45 CFR §164.402 to demonstrate that a Breach did not occur.

5.07 CONTRACTOR shall provide to CITY all specific and pertinent information about the Breach, including the information listed above, if not yet provided, to permit CITY to meet its notification obligations under Subpart D of 45 CFR Part 164 as soon as practicable, but in no event later than fifteen (15) calendar days after CONTRACTOR's initial report of the Breach to CITY.

5.08 CONTRACTOR shall continue to provide all additional pertinent information about the Breach to CITY as it becomes available, in reporting increments of five (5) business days after the prior report to CITY. CONTRACTOR shall also respond in good faith to all reasonable requests for further information, or follow-up information, after report to CITY, when such request is made by CITY.

5.09 In addition to the provisions in the body of the Agreement, CONTRACTOR shall also bear all expense or other costs associated with the Breach and shall reimburse CITY for all expenses CITY incurs in addressing the Breach and consequences thereof, including costs of investigation, notification, remediation, documentation or other costs or expenses associated with addressing the Breach.

6. PERMITTED USES AND DISCLOSURES BY CONTRACTOR.

6.01 CONTRACTOR may use or further disclose PHI that CITY discloses to CONTRACTOR as necessary to perform functions, activities, or services for, or on behalf of, CITY as specified in the Agreement, provided that such use or Disclosure would not violate the HIPAA Privacy Rule if done by CITY.

6.02 CONTRACTOR may use PHI that CITY discloses to CONTRACTOR, if necessary, for the proper management and administration of the Agreement.

6.03 CONTRACTOR may disclose PHI that CITY discloses to CONTRACTOR to carry out the legal responsibilities of CONTRACTOR, if:

6.03.1 The Disclosure is required by law; or

6.03.2 CONTRACTOR obtains reasonable assurances from the person or entity to whom/which the PHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person or entity and the person or entity immediately notifies CONTRACTOR of any instance of which it is aware in which the confidentiality of the information has been breached.

6.04 CONTRACTOR may use or further disclose PHI that CITY discloses to CONTRACTOR to provide Data Aggregation services relating to the Health Care Operations of CONTRACTOR.

6.05 CONTRACTOR may use and disclose PHI that CITY discloses to CONTRACTOR consistent with the minimum necessary policies and procedures of CITY.

7. OBLIGATIONS OF CITY.

7.01 CITY shall notify CONTRACTOR of any limitation(s) in CITY'S notice of privacy practices in accordance with 45 CFR §164.520, to the extent that such limitation may affect CONTRACTOR'S Use or Disclosure of PHI.

7.02 CITY shall notify CONTRACTOR of any changes in, or revocation of, the permission by an Individual to use or disclose his or her PHI, to the extent that such changes may affect CONTRACTOR'S Use or Disclosure of PHI.

7.03 CITY shall notify CONTRACTOR of any restriction to the Use or Disclosure of PHI that CITY has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect CONTRACTOR'S use or disclosure of PHI.

7.04 CITY shall not request CONTRACTOR to use or disclose PHI in any manner that would not be permissible under the HIPAA Privacy Rule if done by CITY.

8. BUSINESS ASSOCIATE TERMINATION.

8.01 Upon CITY'S knowledge of a material breach or violation by CONTRACTOR of the requirements of this Contract, CITY shall:

8.01.1 Provide an opportunity for CONTRACTOR to cure the material breach or end the violation within thirty (30) business days; or

8.01.2 Immediately terminate the Agreement, if CONTRACTOR is unwilling or unable to cure the material breach or end the violation within (30) days, provided termination of the Agreement is feasible.

8.02 Upon termination of the Agreement, CONTRACTOR shall either destroy or return to CITY all PHI CONTRACTOR received from CITY and any and all PHI that CONTRACTOR created, maintained, or received on behalf of CITY in conformity with the HIPAA Privacy Rule.

8.02.1 This provision shall apply to all PHI that is in the possession of subcontractors or agents of CONTRACTOR.

8.02.2 CONTRACTOR shall retain no copies of the PHI.

8.02.3 In the event that CONTRACTOR determines that returning or destroying the PHI is not feasible, CONTRACTOR shall provide to CITY notification of the conditions that make return or destruction infeasible. Upon determination by CITY that return or destruction of PHI is infeasible, CONTRACTOR shall extend the protections of this Agreement to the PHI and limit further Uses and Disclosures of the PHI to those purposes that make the return or destruction infeasible, for as long as CONTRACTOR maintains the PHI.

8.03 The obligations of this Agreement shall survive the termination of the Agreement.

EXHIBIT D

PROOF OF CERTIFICATE OF INSURANCE

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/20/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
CCIG
155 Inverness Drive West
Englewood CO 80112

License#: 45339

CONTACT NAME: Michelle Devore
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INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Pinnacol Assurance	41190
INSURER B : Zurich American Ins. Company	16535
INSURER C : Columbia Casualty Ins. Co.	31127
INSURER D : Berkley Insurance Company	
INSURER E : Continental Casualty Co	20443
INSURER F :	

INSURED
Colorado Health Network, Inc.
6260 E. Colfax
Denver CO 80220

COLOAID-01

COVERAGES **CERTIFICATE NUMBER:** 2131526103 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
C	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT X LOC OTHER:	Y		HMA6075837911	10/28/2020	10/28/2021	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 50,000 $ 10,000 $ 1,000,000 $ 3,000,000 $ 3,000,000
D	**AUTOMOBILE LIABILITY** X ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS X HIRED AUTOS ONLY / X NON-OWNED AUTOS ONLY		Y	852565715	10/28/2020	10/28/2021	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
C D	X **UMBRELLA LIAB** X OCCUR X **EXCESS LIAB** CLAIMS-MADE DED X RETENTION $ 0	Y	Y	HMC6075643346 852565715	10/28/2020 10/28/2020	10/28/2021 10/28/2021	EACH OCCURRENCE AGGREGATE	$ 1,000,000 $ 1,000,000
A B	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N: Y **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A	Y	1761322 WC298318801	8/1/2020 8/1/2020	8/1/2021 8/1/2021	X PER STATUTE / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 500,000 $ 500,000 $ 500,000
E C	Cyber Liability Professional Liability	Y Y	Y Y	652290826 HMA6075837911	12/1/2020 10/28/2020	12/1/2021 10/28/2021	Ntwrk sec / Priv liab Claims Made / Agg	$1M each claim $1M / $1M

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Excess coverage via policy #852565715 with Berkley goes over the Auto Liability coverage.
As required by written contract, the City and County of Denver, its Elected and Appointed Officials, Employees and Volunteers are included as Additional Insured for ongoing operations under General Liability on a primary and non-contributory basis and Additional Insured under Umbrella Liability. As required by written contract or written agreement, a Waiver of Subrogation in favor of the Certificate Holder applies to General Liability, Auto Liability, Umbrella Liability and Workers' Compensation. Umbrella coverage is Follow Form to General Liability, Automobile Liability, Workers Compensation Employers Liability.

CERTIFICATE HOLDER

City and County of Denver
Department of Public Health and Environment
101 W. Colfax Avenue
Suite 800
Denver CO 80202

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

BUSINESS AUTO BROADENING ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies and is subject to the insurance provided under the following:

BUSINESS AUTO COVERAGE FORM

The following is only a summary of the additional coverages provided by this endorsement and is provided only for your reference and convenience. For the Limits of Insurance and the additional coverages provided by this endorsement, read the provisions on the following pages and the Coverage Form, which this endorsement modifies. The deductibles specified on your "auto" declarations page are applicable to these coverages unless a different deductible is indicated.

If one or more of these coverages is provided by a specific endorsement, then the specific endorsement will apply.

SUBJECTS OF INSURANCE

Who Is An Insured

1. Broad Form Named Insured
2. Employees As Insureds
3. Volunteers As Insureds
4. Employee Hired Auto

Broadened Liability Supplementary Payments

1. Bail Bonds - $3,000
2. Reasonable Expenses Incurred - $300 per day

Physical Damage Coverage Amendments

1. Towing
2. Coverage Extensions
   a) Transportation Expenses
   b) Loss of Use Expenses
   c) Auto Loan/Lease Gap Coverage
   d) Personal Property Coverage
   e) Airbag Discharge
3. Hired Car Physical Damage
4. Rental Reimbursement Coverage
5. Audio, Visual and Data Electronic Equipment
6. Deductible Amendments
   a) 2 or more Autos
   b) Glass Deductible

Business Auto Conditions Amendments

1. Knowledge of Occurrence
2. Blanket Waiver of Subrogation

General Condition Amendment

Unintentional Errors and Omissions

The coverages listed in this endorsement are provided as extensions or additions to your insurance program.

BUSINESS AUTO BROADENING ENDORSEMENT

1. Broad Form Named Insured

The following is added to Section II – Liability Coverage, Paragraph A. 1. **Who Is An Insured** provision:

d. Any organization you newly acquire or form, other than a partnership, joint venture or limited liability company, and over which you maintain ownership or majority interest, will qualify as a Named Insured if there is no other similar insurance available to that organization. However:

Coverage under this provision is afforded only until the 180th day after you acquire or form the organization or the end of the policy period, whichever is earlier.

e. Your Board Members (or their spouses) are an "insured" while operating an "auto" hired or rented under a contract or agreement in that Board Member's or spouses name, with your permission, while performing duties related to the conduct of your business.

2. Employees As Insureds

The following is added to Section II – Liability Coverage, Paragraph A. 1. **Who Is An Insured** provision:

f. Any "employee" of yours is an "insured" while using a covered "auto" you don't own, hire or borrow while performing duties related to the conduct of your business.

3. Volunteers As Insureds

The following is added to Section II – Liability Coverage, Paragraph A. 1. **Who Is An Insured** provision:

g. Anyone volunteering services to you is an "insured" while using a covered "auto" you don't own, hire or borrow to transport your clients or other persons in activities necessary to your business. Anyone else who furnishes that "auto" is also an "insured".

4. Employee As Insured

The following is added to Section II – Liability Coverage, Paragraph A. 1. **Who Is An Insured** provision:

h. An "employee" of yours is an "insured" while operating an "auto" hired or rented under a contract or agreement in that "employee's" name, with your permission, while performing duties related to the conduct of your business.

5. Broadened Liability Supplementary Payments

The following replaces Section II – Liability Coverage, Paragraph A.2. Coverage Extensions, a. Supplementary Payments (2) and (4):

(2) Up to $3000 for cost of bail bonds (including bonds for related traffic law violations) required because of an "accident" we cover. We do not have to furnish these bonds.

(4) All reasonable expenses incurred by the "insured" at our request, including actual "loss" of earnings up to $300 a day because of time off from work.

6. Towing

The following replaces Section III – Physical Damage Coverage, A. Coverage, Paragraph 2. Towing:

We will pay up to $ 75 for towing and labor costs incurred each time a covered "auto" is disabled. However, the labor must be performed at the place of disablement.

No deductible applies to this coverage.

7. Transportation Expenses

The following replaces Section III – Physical Damage Coverage, 4. Coverage Extensions, a. Transportation Expenses:

We will pay up to $50 per day to a maximum of $1500 for temporary transportation expense incurred by you because of the total theft of a covered "auto" of the private passenger type. We will pay only for those covered "autos" for which you carry either Comprehensive or Specified Causes of Loss Coverage. We will pay for temporary transportation expenses incurred during the policy period and ending, regardless of the policy's expiration, when the covered "auto" is returned to use or we pay for its "loss".

BUSINESS AUTO BROADENING ENDORSEMENT

8. Loss Of Use Expenses

The following replaces Section III – Physical Damage Coverage, A. Coverage, 4. Coverage Extensions, b. Loss of Use Expenses:

For Hired Auto Physical Damage, we will pay expense for which an "insured" becomes legally responsible to pay for "loss" of use of a vehicle rented or hired without a driver, under a written rental contract or agreement. We will pay for "loss" of use expenses if caused by:

(1) Other than collision only if the Declarations indicate that Comprehensive Coverage is provided for any covered "auto";

(2) Specified Causes Of Loss only if the Declarations indicate that Specified Causes Of Loss Coverage is provided for any covered "auto"; or

(3) Collision only if the Declarations indicate that Collision Coverage is provided for any covered "auto".

However, the most we will pay for any expenses for loss of use is $80 per day, to a maximum of $800.

9. Auto Loan/Lease Gap Coverage

The following is added to the Section III – Physical Damage Coverage, Paragraph 4. Coverage Extensions:

c. Auto Loan/Lease Gap Coverage

In the event of a total "loss" to a covered "auto" shown in the Schedule or Declarations, we will pay any unpaid amount due on the lease or loan for a covered "auto", less:

(1) The amount paid under the Physical Damage Coverage Section of the policy; and

(2) Any:

(a) Overdue lease/loan payments at the time of the "loss";
(b) Financial penalties imposed under a lease;
(c) Security deposits not returned by the lessor;
(d) Costs for extended warranties, Credit Life Insurance, Health, Accident or Disability Insurance purchased with the loan or lease; and
(e) Carry-over balances from previous loans or leases.

10. Personal Property Coverage

The following is added to Section III – Physical Damage Coverage, A. Coverage, 4. Coverage Extensions.

d. Personal Property Coverage

We will pay up to $500 for loss to any personal property which is:

(1) owned by an "insured"; and

(2) in or on your covered "auto".

This coverage is applicable only in the event of a total theft of a covered "auto".

No deductible applies to this coverage.

11. Airbag Discharge

The following is added to Section III – Physical Damage Coverage, A. Coverage, 4. Coverage Extensions.

e. Airbag Discharge

If there is an accidental discharge of an airbag in your covered "auto", we will pay to have the airbag replaced. This extension is excess over any other collectible insurance or warranty.

No deductible applies to this coverage.

12. Hired Car Physical Damage

If this policy provides Comprehensive, Specified Causes of Loss or Collision Coverage, that coverage may be extended to hired "autos". The coverage available to a hired "auto" will be equal to the broadest coverage shown on the Declarations available to any covered "auto".

The most we will pay for any one "accident" or "loss" is:

(1) $40,000; or

(2) The actual cash value or cost of repair of the damaged or stolen property.

Paragraph 5.b. of the Other Insurance Condition in the Business Auto Coverage Form is replaced by the following:

b. For Hired Auto Physical Damage Coverage, the following are deemed to be covered "autos" you own:

(1) Any covered "auto" you lease, hire, rent or borrow; and

(2) Any covered "auto" hired or rented by your "employee" under a contract in that individual "employee's" name, with your permission, while performing duties related to the conduct of your business.

(3) Any covered "auto" hired or rented by your Board Members (or their spouses) under a contract in that individual Board Member's (or spouses') name, with your permission, while performing duties related to the conduct of your business.

However, any "auto" that is leased, hired, rented or borrowed with a driver is not a covered auto.

13. Rental Reimbursement Coverage

a. We will pay for rental reimbursement expenses incurred by you for the rental of an auto because of "loss" to a covered "auto". Payment applies in addition to the otherwise applicable amount of each coverage you have on a covered "auto". No deductibles apply to this coverage.

b. We will pay only for those expenses incurred during the policy period and ending, regardless of the policy's expiration, with the lesser of the following number of days.

(1) The number of days reasonably required to repair or replace the covered "auto". If loss is caused by theft, this number of days is added to the number of days it takes to locate the covered "auto" and return it to you.

(2) 30 days.

c. Our payment is limited to the lesser of the following amounts:

(1) Necessary and actual expenses incurred.

(2) $50 per day.

d. This coverage does not apply while there are spare or reserve autos available to you for your operations.

e. If "loss" results from the total theft of a covered "auto" of the private passenger type, we will pay under this coverage only that amount of your rental reimbursement expenses which is not already provided for under Section III – Physical Damage Coverage, 4. Coverage Extensions, a. Transportation Expenses.

14. Audio, Visual And Data Electronic Equipment

We will pay with respect to a covered "auto" for "loss" to any electronic equipment that receives or transmits audio, visual or data signals and that is not designed solely for the reproduction of sound. This coverage applies only if the equipment is permanently installed in the covered auto at the time of the loss or the equipment is removable from a housing unit which is permanently installed in the covered "auto" at the time of the "loss", and such equipment is designed to be solely operated by use of the power from the "auto" electrical system, in or upon the covered "auto".

The most we will pay for "loss" to audio, visual or data electronic equipment as a result of any one "accident" is the lessor of:

a. The actual cash value of the damaged or stolen property as of the time of the "loss";

b. The cost of repairing or replacing the damaged or stolen property with other property of like kind and quality; or

c. $400.

This coverage does not apply if there is other coverage provided under this policy for the above described audio, visual and data electronic equipment. We will pay any deductible, up to $400, that is applicable to the other coverage.

BUSINESS AUTO BROADENING ENDORSEMENT

No deductible applies to this coverage.

15. Deductible Amendment

The following is added to Section III – Physical Damage Coverage, A. Coverage, Paragraph D. Deductible.

In the event that a "loss" from one "accident" involves two or more covered "autos", only the largest applicable deductible for Comprehensive, Specified Causes Of Loss, or Collision coverage will apply. This provision applies only to those "autos" designated in the Schedule or Declarations to have Comprehensive, Specified Causes Of Loss, or Collision coverage.

16. Glass Deductible

The following is added to Section III – Physical Damage Coverage, Paragraph D. Deductible.

No deductible applies to "loss" to glass used in the windshield, doors or windows of a covered "auto".

17. Knowledge Of Occurrence

The following replaces Section IV – Business Auto Conditions, A. Loss Conditions, 2. Duties In The Event Of Accident, Claim, Suit Or Loss, a.

a. In the event of "accident", "claim", "suit" or "loss", you must give us or our authorized representative prompt notice of the "accident" or "loss". Include:

   (1) How, when and where the "accident" or "loss" occurred;

   (2) The "insured's" name and address; and

   (3) To the extent possible, the names and addresses of any injured persons and witnesses.

   Your obligation to provide prompt notice to us is satisfied if you send us notice as soon as practicable after:

   (1) You, if you are an individual;

   (2) A partner, if you are a partnership;

   (3) An executive officer or insurance manager, if you are a corporation;

   (4) Your members, managers or insurance manager, if you are a limited liability company;

   (5) Your elected or appointed officials, trustees, board members, or your insurance manager, if you are an organization other than a partnership, joint venture, or limited liability company;

   becomes aware of, or should have become aware of such "accident", "claim", "suit" or "loss".

18. Blanket Waiver Of Subrogation

The following is added to Section IV – Business Auto Conditions, A. Loss Conditions.

6. If required by written insured contract, we waive any right of recovery we may have against any person or organization because of payments we make for "bodily injury" or "property damage" caused by an "accident" and resulting from the ownership, maintenance or use of a covered "auto".

19. Unintentional Errors And Omissions

The following is added to Section IV – Business Auto Conditions, B. General Condition, 2. Concealment, Misrepresentation Or Fraud.

However, if you should unintentionally misrepresent or conceal information to us at any time, we will not deny coverage under this policy based on this unintentional error or omission.

This provision does not affect our right to cancel or non-renew your coverage or collect additional premium for any added exposures.

THIS ENDORSEMENT MUST BE ATTACHED TO A CHANGE ENDORSEMENT WHEN ISSUED AFTER THE POLICY IS WRITTEN.

EXHIBIT E

SUBRECIPIENT FINANCIAL ADMINISTRATION

SUBRECIPIENT FINANCIAL ADMINISTRATION

1.1 Invoice Policies

i. A complete Invoice package must be submitted monthly. Complete Invoice packages are due to Denver Department of Public Health and Environment (DDPHE) HIV Resources by the 15th calendar day of the second month following the month of service provision. For example, services provided in the month of March will be invoiced by May 15.

ii. The final complete Invoice package for the contract period is due no later than 45 days following the close of the contract period and must be clearly marked "Final Invoice". The City and County of Denver shall not be obligated to pay any invoice submitted after 45 days following the close of the contract period. For example, if the contract period ends February 28, the "Final Invoice" will be due by April 15.

iii. Invoices must only include amounts for actual direct costs expenditures.

iv. If underspending is anticipated, subrecipients must inform DDPHE HIV Resources immediately. DDPHE HIV Resources reserves the right to reallocate funds to expend all funding and to provide services at adequate levels.

v. Do not revise any previously submitted invoice. Make necessary adjustments on the next monthly invoice within the same contract year.

1.2 Supporting Documentation

i. Personnel – Include all salaries and allowances paid to staff directly contributing to the activities of the service category. Time sheets or payroll reports FTE certification effort or activities.
ii. Personnel Benefits – Schedule of benefits with list of actual expenditures. Documentation can be provided by employee or in the aggregate for all employees. When using percentages of salary, the subrecipient must provide a worksheet that shows the allocation.
iii. Consultants – Consultant invoice that reflects the job performed, rate, and hours.
iv. Contractual Expenses – Invoice that meets the payment arrangements specified in the agreement and that are properly approved.
v. Supplies/Other Direct Costs – Copies of vendor invoices for all supply purchases.
vi. Equipment/Supplies – Copies of invoices for all purchases of equipment or for all other special purchases.
vii. Travel – Supporting documentation will consist of properly approved invoices and should include airfare, ground transportation, accommodation, meals/per diem, etc. For airfare, economy class must always be used. International travel is never permitted. This is only allowed for indirect cost.
viii. All other budgeted items – Properly approved vendor invoices.

1.3 Unallowable Costs

A. Below is a summary of unallowable costs; it is not intended to be a complete or definitive listing. Subrecipients are responsible for referring to the documents referenced below for complete guidelines.

i. Payment for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service (a) under any state compensation program,

under an insurance policy, or under any federal or state health benefits program; or (b) by an entity that provides health services on a prepaid basis [section 2605(a)(4)], consequently, program activities that are revenue generating may not be included in the budget.

ii. Funds may not be used to pay an individual's base salary in excess of $199,300
iii. Administrative costs that exceed 10% of your total budget [section 2604(e)]
iv. Purchase and/or improvement of land [section 2604(h)]
v. Purchase, construction, or permanent improvement of any building or other facility [section 2604(h)]
vi. Clinical trials [HRSA policy 97-02.3]
vii. Syringe exchange [section 2678 & HRSA letter 1/6/12]
viii. The use of client incentives is not allowable unless pre-approved by DDPHE; incentives may not be in the form of cash and gift cards may not be in the form of a pre-paid credit card or redeemable for cash; recipients must not use gift card incentives to purchase alcohol, tobacco, illegal drugs or firearms.

Note: The use of gift cards as incentive for clients may be allowable with advance DDPHE approval.

ix. Costs associated with obtaining professional licensure or meeting program licensure requirements (e.g. Attorney Registration Fee, Notary Public License Fees, etc.) [HRSA policy notice 11 04]
x. Legal services for criminal defense, or class action suits unrelated to access to services eligible for funding [HRSA policy notice 10-02.11]
xi. Maintenance expense (tires, repairs, etc.) of a privately-owned vehicle or other costs associated with the vehicle, such as lease, or loan payment, insurance or license and registration fees [HRSA policy notice 10-02.12]

B. The following costs are <u>not permitted</u> under the Health and Human Services (HHS) Grants Policy Statement, HRSA National Monitoring Standards, Code of Federal Regulations 45 Part 75, and the Office of Management and Budget (OMB):

i. Local or state personal property taxes (residential property, private automobile, or any other personal property against which taxes may be levied)
ii. Cash payments to clients
iii. Cash payments to clients; funeral, burial, cremation and related expenses
iv. Staff training - service-specific capacity development dollars in excess of 5% of the dollars contracted to provide the service
v. Vocational, employment or employment-readiness services
vi. Clothing
vii. Pet foods or other non-essential products
viii. Household appliances
ix. Pre-exposure prophylaxis
x. Post-exposure prophylaxis
xi. Basic household items such as sheets, towels, blankets and kitchen utensils
Exceptions: kitchen cooking utensils allowable for Food Bank and Home-Delivered Meals Programs
xii. Off-premises recreational and social activities or payment for a client's gym
xiii. Non-targeted marketing promotions or advertising about HIV services that target the general public
xiv. Development of materials to promote or encourage injection drug use or sexual activity
xv. Outreach activities that have HIV prevention education as their exclusive focus
xvi. Bad debts
xvii. Capital improvements
xviii. Contingency provisions
xix. Contributions and/or donations to others
xx. Depreciation expenses as a direct cost and as related to federally funded equipment
xxi. Entertainment costs

xxii. Alcoholic beverages
xxiii. Selling and Marketing Costs
xxiv. Fines, penalties, damages and other settlements
xxv. Foreign travel
xxvi. Interest expense
xxvii. Lobbying costs
xxviii. Refreshments
xxix. Stipends
xxx. Taxes for which exemptions are available to the organization
xxxi. Vehicles, without written Grants Management Officer approval

C. Health and Human Services (HHS) expressly prohibits client meals. HHS permits reasonable food costs associated with advisory board meetings as an administrative cost as follows:

- A modest meal or lunch costing no more than $13.50 per person; **or**
- Light refreshments consisting of breakfast or snack foods costing no more than $8.50 per person may be provided.

In all other instances, nutritious snacks (e.g. granola bars, fruit, etc.) of negligible value (no more than $3.50 per client) may be considered program supplies.

D. Limitation on Uses of Part A: The Contractor must adhere to a 10% limit on proportion of federal funds spent on administrative costs in any given grant year.

i. The Contractor shall prepare a project budget and track expenses, including administrative expenses, with sufficient detail. Expenditures are reported by line item within service category, with sufficient detail, and identify administrative expenses.

ii. The Contractor may use indirect costs as part or all their 10 percent administration costs. To do so, the Contractor must include indirect costs (capped at 10 percent) only where the DDPHE has a certified DHHS negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certificate of Indirect Costs, which has been reviewed by the HRSA/HAB Project Officer. If the Contractor chooses to use indirect cost as part or all their 10 percent administration costs, they must obtain and keep on file a federally approved DHHS-negotiated Certificate of Cost Allocation Plan or Certificate of Indirect Costs. The contractor must submit a current copy of the certificate to DDPHE.

iii. The Contractor must ensure that budgets do not include unallowable costs. The Contractor will provide budgets and financial expense reports to DDPHE with sufficient detail to document that they do not include unallowable costs.

1.4 Budget Modification Requests

i. The Denver Department of Public Health and Environment (DDPHE) may, at its option, restrict the transfer of funds among line items, programs, functions, or activities at its discretion as deemed appropriate by the Executive Director or his/her designee.

ii. Minor modifications to the services provided by the Contractor or changes to each line item budget equal to or less than a ten percent (10%) threshold, which do not increase the total funding to the Contractor, will require notification to DDPHE program staff and upon approval may be submitted

with the next monthly draw. Minor modifications to the services provided by Contractor, or changes to each line item budget in excess of the ten percent (10%) threshold, which do not increase the total funding to Contractor, may be made only with prior written approval by the Executive Director or his/her designee. Such budget and service modifications will require submittal by Contractor of written justification and new budget documents. All other contract modifications will require an amendment to this Agreement executed in the same manner as the original Agreement.

iii. The Contractor understands that any budget modification requests under this Agreement must be submitted to DDPHE prior to the last Quarter of the Contract Period, unless waived in writing by the Executive Director or his/her designee.

1.5 Procurement

i. The Contractor shall follow the City Procurement Policy to the extent that it requires that at least three (3) documented quotations be secured for all purchases or services (including insurance) supplies, or other property that costs more than five thousand dollars ($5,000) in the aggregate.

ii. The Contractor will maintain records sufficient to detail the significant history of procurement. These records will include but are not limited to the following: rationale for the method of procurement, selection of contract type, contractor selection or rejection, and the basis for the contract price.

iii. If there is a residual inventory of unused supplies exceeding five thousand dollars ($5,000) in total aggregate upon termination or completion of award, and if the supplies are not needed for any other federally sponsored programs or projects the Contractor will compensate the awarding agency for its share.

1.6 Income from Fee-for-Services

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section C. Please reference this document for more detailed requirements.

i. The Contractor must document the use of Part A and third-party funds to maximize program income from third party sources and ensure that Ryan White is the payer of last resort. Third party funding sources include: Medicaid, Children's Health Insurance Programs, Medicare (including the Part D prescription drug benefit), and private insurance.

ii. The Contractor will document billing and collection from third party payers, including Medicare and Medicaid, so that payer of last resort requirements are met.

iii. If the Contractor receives funding in Medicaid eligible service categories, they will document participation in Medicaid and certification to receive Medicaid payments, unless waived by the Secretary of Health and Human Services.

iv. The Contractor must document retention of program income derived from Ryan White funded services and use of such funds in one or more of the following ways: funds added to resources committed to the project or program, and used to further eligible project or program objectives; and funds used to cover program costs.

1.7 Imposition & Assessment of Client Charges

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section D. Please reference this document for more detailed requirements.

i. The Contractor will have policies and procedures for a publicly posted schedule of charges (e.g. sliding fee scale) to clients for services, which may include a documented decision to impose only a nominal charge.

ii. The Contractor will not impose charges on clients with incomes below 100% Federal Poverty Level (FPL).

iii. Charges to clients with incomes greater than 100% of poverty are determined by the schedule of charges. Annual limitation on amounts of charge (i.e. caps on charges) for Ryan White services are based on the percent of client's annual income, as follows: 5% for clients with incomes between 100% and 200% of FPL; 7% for clients with incomes between 200% and 300% of FPL; and 10% for clients with incomes greater than 300% of FPL.

1.8 Fiscal Management

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section E and F. Please reference this document for more detailed requirements.

i. The Contractor must comply with all the established standards in the Code of Federal Regulations (CFR) for nonprofit organizations, hospitals, institutions of higher education, and state and local governments.

ii. The Contractor budgets and reports with sufficient detail to account for Ryan White funds by service category, subgrantee, administrative costs, and (75/25 rule) core medical and support services rules, and to delineate between multiple funding sources and show program income.

iii. The Contractor will submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services. The budget should include at least four category columns; Administrative, Clinical Quality Management (CQM), HIV Services, Minority AIDS Initiative (MAI).

iv. The Contractor will document all request for approval of budget revisions.

v. The Contractor must track and report on tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part A funds and having: a useful life of more than one year; and an acquisition cost of $5,000 or more per unit (lower limits may be established, consistent with DDPHE policies).

vi. The Contractor shall develop and maintain a current, complete, and accurate supply and medication inventory list and make the list available to DDPHE upon request. Title to supplies to be vested in DDPHE upon acquisition, with the provision that if there is a residual inventory of unused supplies exceeding $5,000 in total aggregate value upon termination or completion of the program, and the supplies are not needed for any other federally-sponsored program, DDPHE shall retain the supplies

for use on non-federally sponsored activities or sell them and compensate the federal government for its share contributed to purchase of supplies.

1.9 Cost Principles

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section G. Please reference this document for more detailed requirements.

i. The Contractor will develop and maintain documentation that services are cost based. The Contractor will ensure that budgets and expenses conform to federal cost principles and that fiscal staff are familiar with applicable federal regulations.

ii. The Contractor must have written procedures for determining the reasonableness of costs, the process for allocations, and policies for allowable costs in accordance with provisions of applicable Federal cost principles and the terms and conditions of the award. Costs are reasonable when they do not exceed what would be incurred by a prudent person under circumstances prevailing at the time the decision was made to incur the costs.

iii. Requirements to be met in determining the unit cost of a service are; unit cost not to exceed the actual cost of providing the service, unit cost to include only expenses that are allowable under Ryan White requirements, and calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided.

2.0 Matching or Cost Sharing Funds

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section I. Please reference this document for more detailed requirements.

i. If the Contractor provides matching or cost sharing funds, they must report these funds to DDPHE and meet the verification process to ensure that non-federal contributions: are verifiable in provider records; are not used as matching for another federal program; are necessary for program objectives and outcomes; are allowable; are not part of another federal award contribution (unless authorized); are part of the approved budget; are part of unrecovered indirect cost (if applicable); are apportioned in accordance with appropriate federal cost principles; include volunteer services, if used, are an integral and necessary part of the program, with volunteer time allocated value similar to amounts paid for similar work in the provider organization; value services of contractors at the employees' regular rate of pay plus reasonable, allowable and allocable fringe benefits; assign value to donated supplies that are reasonable and do not exceed the fair market value; value donated equipment, buildings, and land differently according to the purpose of the award; and value donated property in accordance with the usual accounting policies of the recipient (not to exceed fair market value).

2.1 Fiscal Procedures

Below are requirements from the HRSA National Monitoring Standards, Fiscal Requirements for Part A, Section K. Please reference this document for more detailed requirements.

i. The Contractor will have policies and procedures for handling revenues from the Ryan White grant, including program income. The Contractor will prepare a detailed chart of accounts and general ledger that provide for the tracking of Part A revenue and will make this available to DDPHE upon request.

ii. The Contractor has policies and procedures that allow DDPHE prompt and full access to financial, program, and management records and documents as needed for program and fiscal monitoring and oversight and will make this available to DDPHE upon request.

iii. The Contractor will grant access to payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White funds.

iv. The Contractor will provide timely, properly documented invoices to assist DDPHE to periodically track the accounts payable process from date of receipt of invoices to date the checks are deposited.

v. The Contractor will document employee time and effort, with charges for the salaries and wages of hourly employees. The Contractor will maintain payroll records for specified employees and will establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources. The Contractor will make payroll records and allocation methodology available to DDPHE upon request.

vi. The Contractor's fiscal staff have responsibility to ensure adequate reporting, reconciliation, and tracking of program expenditures, coordinate fiscal activities with program activities (e.g., the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, formula and supplemental unobligated balances, and program income), and have an organizational and communications chart for the fiscal department.

EXHIBIT F

RYAN WHITE PART A SERVICE STANDARDS

HIV RESOURCES
DENVER PUBLIC HEALTH & ENVIRONMENT

DENVER HIV RESOURCES PLANNING COUNCIL

Part A Service Standards

Denver TGA Ryan White HIV/AIDS Program

Revised: March 2021

Finalized: April 1, 2021

Approved by the DHRPC: April 1, 2021

Table of Contents

Introduction

This Service Standards document was prepared by Denver HIV Resources with opportunities for community input and is regularly reviewed by the Denver HIV Resources Planning Council in order to guide the delivery of high-quality services for people living with HIV and AIDS. This document was established to:

- Define service standards and quality management indicators for Part A-funded services.
- Provide DHR with a basis to evaluate services funded through Part A.

Service Standards are the minimum requirements that programs are expected to meet when providing HIV care and support services funded by the Ryan White Denver TGA. Programs may exceed these standards. Service Standards are tied to multiple processes throughout the Part A system and changes reverberate throughout the entire system.

Definitions and Descriptions

Service Standards: The minimum level or service standard that agencies must follow in the provision of Part A funded services.

Unit Cost of Service: Define how many service units are delivered to a client for billing and documentation purposes.

Quality Management Indicator: A measure to determine, over time, an organization's performance of a particular element of care.

Active Referral: A referral in the which the client is provided assistance by the program to complete the referral and receive the needed services.

Passive Referral: A referral in which the program does not track the success of the referral.

Acronyms

ACCI	American Consortium of Certified Interpreters
ADA	Americans with Disabilities Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
AND	Aid to the Needy Disabled
ART	Antiretroviral Therapy
CAB	Community Advisory Board
CARE Act	Comprehensive AIDS Resources Emergency Act
CARES Act	Coronavirus Aid, Relief and Economic Security Act
CBC	Complete Blood Count
CD4	Cluster of differentiation 4
CDI	Certified Deaf Interpreter
CFR	Code of Federal Regulations
CM	Case Manager
DHHS	Department of Health and Human Services
DHRPC	Denver HIV Resources Planning Council

DHR	Denver HIV Resources
DORA	Department of Regulatory Agencies
EFA	Emergency Financial Assistance
EIS	Early Intervention Services
FPL	Federal Poverty Level
HAB	HIV/AIDS Bureau
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HRSA	Health Resources and Service Administration
LTC	Linkage to Care
MCM	Medical Case Management
MH	Mental Health
MSM	Men who have sex with men
NADI	National Association of Deaf Interpreters
OBH	Office of Behavioral Health
OMB	Office of Management and Budget
PDSA	Plan, Do, Study, Act
PVD	Peripheral Vascular Disease
RID	Registry of Interpreters for the Deaf
RSR	Ryan White Services Report
RTD	Regional Transportation District
RW	Ryan White
RWHAP	Ryan White HIV/AIDS Program
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SS	Service Standards
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STI	Sexually Transmitted Infection
TB	Tuberculosis
TGA	Transitional Grant Area
VA	Veteran's Administration

Universal Standards

I. Documentation and Eligibility Screening

Programs must have systems in place that meet the requirements outlined in HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A (April 2013) – Section B. The following information should be in all client charts and will be checked during site visits. Agencies should not use client self-report for any required documentation.

STANDARD	MEASURE	DATA SOURCE
A. Programs will ensure appropriate screening and reassessment (every six months) of all clients to determine eligibility.	**A.1.** Verification of the client's HIV status should be from a medical program (i.e. lab work results, a letter on letterhead signed by medical staff personnel, or a current ADAP card or confirmation of application/renewal).	**Client's file** contains confirmation of HIV status. This must be confirmed at initiation of services.
	A.2. Client must qualify as low income; a household income of less than or equal to 500 percent of FPL. Household income is what the client defines as their household. People who meet the following criteria should be included when computing the household size of the client: • A legal spouse with whom the client resides; • The client's child with whom the client resides, including children related to the client biologically or through legal adoption; • Other children for whom the client pays child support, whether or not the children reside with the client. Early Intervention Services (EIS) may be provided to clients of any income level, however, client's above the eligible income level may not receive Ryan White Part A service once linkage is complete.	**Client's file** contains paycheck or stub, bank statement, current ADAP card, confirmation of ADAP application/renewal, AND/SSI/SSDI award letter or TPQY, electronic confirmation of Medicaid eligibility (Medifax, DentaQuest, etc.) or other adequate proof. If the client is reporting no income, then the program must document how the client is subsisting. This must be confirmed every six months.

	A.3. Client must demonstrate insurance status including: • Uninsured or underinsured status. • Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare. • For underinsured, document the client's ineligibility for service. • Veterans receiving VA health benefits are considered uninsured, thus exempting these veterans from the "payer of last resort" requirement.	**Client's file** contains proof of insurance, underinsured, or documentation of ineligibility for third party insurance including Medicaid and Medicare. Documentation may include copy of dated insurance card or statement of coverage, current ADAP card or confirmation of ADAP application/renewal, AND/SSI award letter or TPQY, SSDI award if after the 2-year waiting period, electronic confirmation of Medicaid eligibility (Medifax, DentaQuest, etc.). If client has no insurance, the TGA Insurance Screening Template or other tool can be used to sign/attest that the person has no insurance. This must be confirmed every six months
	A.4. Client must demonstrate residence within the Denver TGA. The Denver TGA is comprised of Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson Counties.	**Client's file** contains any of the following documents with current, valid Denver TGA address and client's name including: • An unexpired Colorado driver's license or state-issued identification card with a current valid Colorado address; • A lease mortgage, rent receipts, hotel receipts, or other evidence that the client has obtained and/or paid for housing in Colorado; • A utility bill with a Colorado service address in the client's name; • Another form of government-issued identification with a valid Colorado residential address. • Medicaid card (with proof of residence in the Denver TGA) • ADAP enrollment verification; • Ramsell face sheet; • Medication and Medical Copay Assistance Identification Card. In certain instances, a client may be unable to produce one of the preferred forms of documentation of Colorado residency due to homelessness, undocumented status, or other barriers.

		In such instances, acceptable forms of documentation are: • A signed letter from a person with whom the client resides or who otherwise provides housing for the applicant, verifying the clients' residence in Colorado. This letter should include contact information and a case manager should follow up to confirm statements made in the letter. • A signed letter from a case manager, social worker or other professional explaining why the client's claim of Colorado residency is supportable (for example, the case manager has visited the client's home or the client has presented evidence of continual employment in a position that requires local residency). It is not necessary to be a U.S. citizen to receive Ryan White Program services. Applicants do not have to document citizenship or immigration status in order to be eligible for services.
	A.5. Document that all staff involved with eligibility determination have participated in a comprehensive, internal or external training in eligibility determination requirements.	**Personnel file** of all staff involved with eligibility determination demonstrates that the staff member has completed a comprehensive, internal or external training in eligibility determination requirements.
	A.6. Ensure program's client level data reporting is consistent with funding requirements, and demonstrates that eligible clients are receiving allowable services.	**Client's file and CAREWare data** demonstrate that client receives only allowable services.
B. Every client's legal name will be documented and used in the creation of the eURN in CAREWare**.**	**B.1.** Programs are to use the client's legal name attained from a government issued document in data entry in CAREWare.	**Client's file** contains copy of a government issued document showing legal name (e.g. driver's license, social security card, matricula card, and passport). This must be confirmed at initiation of services.

C. Every program must have the ability to screen clients for RW Part A eligibility.	**C.1.** Programs must have an eligibility screening procedure.	**Program's Policies and Procedures** include a procedure on eligibility screening process.
	C.2. Programs must have the necessary staff and systems for screening procedure.	**Program's Policies and Procedures** demonstrate the necessary staff and systems for screening procedure.
D. Program will provide timely and responsive services to clients.	**D.1.** Program must maintain a maximum response time of 3 business days, best practice being 1 business day, when providing phone assistance to clients and phone access for setting appointments, answering questions, and resolving problems. Program must respond to internet or email inquiries within 3 business day, best practice being 1 business day.	**Program's Policies and Procedures** demonstrate process for responding to clients within 1 business day.
	D.2. Program shall cancel less than 10 percent of all client appointments. All cancelled appointments receive active follow up, including the offer of a new appointment within 10 business days.	**Client's file** shows cancellation and rescheduling rates within the established limits. **Program's Policies and Procedures** demonstrate a policy for following up with clients if the program cancels an appointment.

II. Staff and Volunteer Requirements and Training

The program's staff have sufficient education, experience, and skills to competently serve the HIV client population.

STANDARD	MEASURE	DATA SOURCE
A. Staff members and volunteers will have a clear understanding of their job definition and responsibilities.	**A.1.** Written job descriptions will be on file and signed by the staff or volunteers.	**Personnel/Volunteer file** contains signed job description**.**

B. Staff members will receive structured supervision from qualified supervisors.	**B.1.** Every employee working directly with clients will receive supervision on both clinical and job performance issues. Programs should complete a standardized performance evaluation for each staff member at least annually.	**Personnel file** contains clinical and/or job performance evaluations for employees who have been with the program for a year or more**.**
C. Staff and supervisors are qualified to provide the necessary services to clients.	**C.1.** Staff and Supervisors have the appropriate licensure, education and experience.	**Personnel file** has proof of licensure and/or education appropriate for the specific position**.**
D. Initial orientation and training shall be given to new direct service staff.	**D.1** Newly hired staff are oriented within 6 months of employment on the following: • Cultural mindfulness • Basic HIV information including medical and support services • Ryan White (RW) Care Act Part A services and other funding sources • Program's policy and procedures • Other government and community programs • Behavioral health services and support • Denver TGA Part A service standards and requirements Training can be internal and external to the organization.	**Personnel File** demonstrates the type, amount (minutes or hours), and date of orientation and training that each staff receives both internally and externally.
E. Staff should receive the following training annually.	**E.1.** Every staff handling confidential information will receive an annual training concerning HIPAA and confidentiality.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.
	E.2. Every staff receives annual training on Occupational Safety Health Administration regulations and universal precautions.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.
	E.3. Every direct care staff receives 20 hours of job specific professional development training annually.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.

F. Each program has a volunteer training program appropriate to support each volunteer position.	**F.1.** Initial orientation and training for volunteers working directly with clients must be completed prior to working directly with clients and should include, at a minimum, the following: • Cultural mindfulness • Basic HIV information • Basic client contact skills • HIPAA and confidentiality • Program's policy and procedures Training can be internal and external to the organization.	**Volunteer file** demonstrates the type and amount of orientation the volunteer received.
G. Staff or volunteers working with clients are to be screened in accordance with state and local laws.	**G.1.** Background checks must be obtained as required by state and local laws.	**Personnel or Volunteer file** contains background checks.
H. Staff or volunteers transporting clients will have a valid Colorado driver's license and proof of insurance.	**H.1.** Programs will ensure that they have a current valid driver's license and current insurance information for each staff or volunteer who transports clients.	**Personnel or Volunteer File** contains a copy of a valid driver's license for those staff or volunteer who transport clients.

I. Clinical Quality Management

Programs are responsible for ongoing clinical quality management programs to improve funded programs, as well as to offer regular feedback to staff to help promote performance.

STANDARD	MEASURE	DATA SOURCE
A. Each program will have written policies on Quality Management, including how data will be used to improve each funded program.	**A.1.** Each program will collect client level data to support CAREWare reporting and other data reports as indicated.	**Reports from Denver HIV Resources** will be completed accurately and on time.
	A.2. Each program will adopt a quality improvement system (Chronic Care Model, PDSA Cycle, or other) to guide work plans and other clinical quality management activities.	**Program's Reports** documents the use of a quality improvement system.
B. Each agency will have 1 quality plan (using the DHR Quality Plan Template) including all initiatives for required performance	**B.1.** Each program will have a quality plan to assess the quality of care provided, to ensure that deficiencies	**Program's Reports** documents the use of a quality plan.

measures (core and support). If agency is also MAI funded a separate quality plan is permitted.	are identified and addressed, and to identify areas for improvement.	
	B.2. Quality plan is updated annually**.**	**Program's Reports** document quality plan revisions.
C. Program will document clinical quality management activities, including at least one quality improvement project focused on evaluating or improving HIV program services.	**C.1.** Quality improvement projects must be focused on improvement of health outcomes along the HIV Care Continuum.	**Program's files and reports** document quality management activities.
	C.2. QI projects are not administrative in nature for the purposes of the CQM Plan.	
	C.3. Programs will use a Plan Do Study Act (PDSA) model for improvement for reporting projects to Denver HIV Resources.	
D. Program will assure compliance with relevant service category definitions and Denver transitional grant area (TGA) service standards.	**D.1.** Program will conduct quality assurance activities as needed to comply with Denver TGA service standards.	**Program's files and reports** document quality assurance activities.
E. Program will implement structured and ongoing efforts to obtain input from clients regarding the design and delivery of services.	**E.1.** Program will maintain visible suggestion box or other client input mechanism.	**Site visit** inspection of program facility.
	E.2. Program will implement client satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented annually.	**Program's Files** demonstrate implementation of satisfaction survey tool, focus groups, and/or public meetings including analysis and use of results.

II. Confidentiality

Programs must have systems in place to protect confidentiality according to best practices and applicable regulations.

STANDARD	MEASURE	DATA SOURCE
A. Programs shall have written policies and procedures addressing client confidentiality which are compliant with HIPAA.	**A.1.** Policies and procedures should address HIV-related confidentiality and program procedures, including those limiting access to passwords, electronic files, medical records, faxes, and release of client information.	**Program's Policies and Procedures** on confidentiality.

	A.2. Policies and Procedures are signed and dated by staff during orientation.	**Personnel file** has a signed statement by each staff that the staff has read and understood the program's policies and procedures regarding confidentiality.
	A.3. Major changes in policies and procedures are presented to all the staff they impact.	**Personnel file** indicates that staff have been trained on any major changes to policies and procedures.
B. All hard copy materials and records shall be securely maintained by the Program.	**B.1.** Records and hard copy materials are maintained under double lock (in locked files and in locked areas); secure from public access.	**Site Visit** observation**.**
	B.2. Each computer is password protected and staff/volunteers must change passwords at least every 120 days.	**Program's Policies and Procedures** on confidentiality demonstrate compliance.
C. There should be no release of client information without a signed, dated client release.	**C.1.** Clients must be informed of the release of information form and under what circumstances client information can be released.	**Client's File** contains a signed release of information form with all required elements appropriate to the services provided and information needed.
	C.2. There should be a signed, dated release of information form specific to HIV, TB, STI, substance misuse, mental health and any other confidential information prior to the release or exchange of any information.	**Client's File** contains a signed release of information form with all required elements appropriate to the services provided and information needed.
D. Program must have a private space or appropriate accommodations to conduct confidential client meetings.	**D.1.** The program will make accommodations that ensure confidential client meetings in which others cannot hear the conversation (i.e. room with floor to ceiling walls and a door, white noise machine, etc.)	**Site Visit** inspection of program's facility**.**

III. Culturally Mindful and Linguistically Appropriate Service Delivery

Programs will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs, practices, and experience, preferred languages, health literacy, and other communication needs. Interpretation services refer to oral and visual services and translation services refer to written services.

Standard	Measure	Data Source

A. Programs will ensure that clients receive from all staff members effective, equitable, understandable, respectful and quality care that is provided in a manner compatible with the client's cultural beliefs, practices, and experience.	**A.1.** All staff members receive appropriate cultural mindfulness training within the first year of employment and at least annually thereafter.	**Program's Policies and Procedures** contain requirements for culturally mindful training for all staff members. **Personnel files** demonstrate the type, amount (minutes or hours), and date of training that each staff receives both internally and externally.
	A.2 Programs shall adopt and implement the National Standards for Culturally and Linguistically Appropriate Services (CLAS) as relevant to their program.	
B. Programs recruit, retain, and promote a diverse staff and leadership that reflects the cultural and linguistic diversity of the community.	**B.1.** Programs have a strategy on file to recruit, retain, and promote qualified, diverse, and linguistically and culturally mindful administrative, clinical, and support staff who are trained and qualified to address the needs of people living with HIV.	**Program's Policies and Procedures** contain strategies to recruit, retain, and promote a diverse staff and leadership that reflects the cultural and linguistic diversity of the community.
C. Programs assess the cultural and linguistic needs, resources, and assets of its service area and focused population(s).	**C.1.** Programs collect and use demographic, epidemiological, and service utilization data in planning for focused population(s).	**Program's Policies and Procedures** contain strategies to assess the cultural and linguistic needs, resources, and assets of its service area.

D. Programs ensure access to services for clients with limited English proficiency.	**D.1.** Programs ensure access in one of the following ways (listed in order of preference):
	• Bilingual staff who can communicate directly with clients in their preferred language
	• Face-to-face interpretations provided by:
	  ○ Qualified staff, contract interpreters, or volunteer interpreters;
	  ○ Telephone interpreter services; or
	  ○ Video interpreter services.
	• Referral to programs with bilingual/bicultural clinical, administrative, and support staff and/or interpretation services by a qualified bilingual/bicultural interpreter.
		Personnel file includes relevant certifications for interpreters and/or bilingual staff or volunteers and documentation of skills.
		
		Program's Policies and Procedures cover how the program provides services for patients with limited English proficiency, including a directory of telephone interpreter services and a listing of programs that provide bilingual/bicultural services.
		
		Client's File contains documentation of preferred language.

	D.2. Family and friends are not considered adequate substitutes for interpreters because of confidentiality, privacy, and medical terminology issues. If a client chooses to have a family member or friend as their interpreter, the provider must obtain a written and signed consent in the client's preferred language. Family member or friend must be over the age of 18.	**Client's File** contains signed consent form that requests family member or friend to provide interpretation services.
E. Interpretation services are provided by properly trained and certified staff.	**E.1.** Individuals providing interpretation services will have completed a medical interpreter training that includes: • Proficient interpretation skills; • Information on healthcare (and HIV care preferred); • Cultural mindfulness; and • Communication skills for advocacy.	**Personnel file** demonstrates the type, amount (minutes or hours), and date of training that each staff member receives both internally and externally.
	E.2. Sign language interpreters should be certified by the Registry of Interpreters for the Deaf (RID) at a minimum level of Certified Deaf Interpreter (CDI), by the American Consortium of Certified Interpreters (ACCI) at a minimum level IV (Above Average Performance), the National Association of Deaf Interpreters (NAD) at a minimum of Level IV, or have relevant experience.	**Personnel File** has proof of certification/ licensure for the position.

IV. Client Rights and Responsibilities

Informing clients of their rights and responsibilities encourages them to be active clients in their own healthcare, and ensures that services are accessible to eligible clients.

STANDARD	MEASURE	DATA SOURCE
A. Programs shall have an established grievance policy and procedure in place that allows clients to express concerns and/or	**A.1.** Clients must read and sign a form outlining the grievance policy and procedure.	**Client's File** contains a copy of a signed and dated grievance form.

file complaints if they are dissatisfied with the services provided. Clients must be informed of this policy.	**A.2.** Programs must review the grievance policy and procedure annually and update as appropriate.	**Program's Policies and Procedures** include a grievance policy and procedure.
	A.3. Programs are responsible for notifying DHR of any formal grievance filed against the program by a Ryan White funded client. Grievances must be reported at a minimum on quarterly narratives submitted to DHR with confidential information deducted as applicable.	**Program's Reports** document grievances.
B. Program provides each client a copy of a client rights and responsibilities form that informs client of what they are allowed and what is required of them.	**B.1.** Client Rights and Responsibilities includes, at a minimum: • the program's expectations of the client as a participant of services • the client's right to file a grievance; • the client's right to receive no-cost interpreter services; • The reasons for which a client's case may be closed/inactivated from services, including due process for involuntary closure/inactivation.	**Program's Policies and Procedures** contains Client Rights and Responsibilities form
	B.2. Clients must read and sign a copy of the Client Rights and Responsibilities form	**Client's File** contains copy of signed and dated form.
C. Clients have the right to access their file.	**C.1.** Program has a policy on client file access that is sensitive to the client's concerns according to clinical best practice guidelines.	**Program's Policies and Procedures** contains a policy on client file access
	C.2. Client's files are retained for at least 7 years after the last day that the client accessed services	**Program's Policies and Procedures** contains a policy on file retention and destruction.

V. Access to Services

Programs must have systems in place that meet the requirements outlined in HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A (April 2013) – Section A. Clients should be supported in having system-wide access to services and barriers to service should be eliminated.

STANDARD	MEASURE	DATA SOURCE

A. Programs shall eliminate barriers to service and ensure provision of services in a setting accessible to low-income individuals with HIV.	**A.1**. Medical care, pharmaceuticals, case management, and home health care shall provide accessible hours for service delivery.	**DHR Contract** will include the Scope of Service description, and the hours of service will be posted in a prominent place within the program.
	A.2. Program will comply with Americans with Disabilities Act (ADA) requirements.	**Program's files** will document ADA complaints and grievances, with documentation of complaint review and decision reached.
	A.3. Appropriate accommodations shall be made to meet language or other needs such as illiteracy, visual or hearing impairment.	**Program's Policies and Procedures** demonstrate how they provide services to those needing special accommodations.
	A.4. Program will ensure that the facility is accessible by public transportation or provides for transportation.	**Site visit** inspection of program facility.
	A.5. Programs will document efforts to inform low-income individuals of the availability of HIV-related services and how to access them. Program will maintain file documenting program activities for the promotion of HIV services to low-income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements.	**Program's Files** will document program activities for the promotion of HIV services to low-income individuals.
B. Program shall allow for the provision of services regardless of an individual's ability to pay for the service.	**B.1.** Program will have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services regardless of the client's ability to pay. See imposition of client charges policies and procedures.	**Program's Policies and Procedures** document their billing, collection, co-pay and sliding fee policies and that they do not act as a barrier to providing services regardless of the client's ability to pay.
	B.2. Program will maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients, with documentation of complaint review and decision reached.	**Program's files** will document individuals refused services with reasons for refusal specified; included in file are any complaints from clients, with documentation of complaint review and decision reached.

C. Programs will ensure provision of services regardless of the current or past health condition of the individual to be served.	**C.1.** Eligibility Policies and Procedures state that services are provided regardless of pre-existing conditions.	**Program's Policies and Procedures** will document that services are provided regardless of pre-existing conditions.
	C.2. Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients, with documentation of complaint review and decision reached.	**Program's files** will document individuals refused services with reasons for refusal specified; included in file are any complaints from clients, with documentation of complaint review and decision reached.
D. Programs will have a full range of service referrals available and will actively or passively direct clients to additional services appropriate to client situation, preference, and need.	**D.1.** To establish this base of referrals, programs need to network with other AIDS service organizations and prevention programs as well as city, state, and private organizations providing similar or complimentary services in the community.	**Program's policies and procedures** demonstrate that the program has established a full range of service referrals and maintains effective referral relationships with other programs.
	D.2. Programs may make an active referral or a passive referral based on the client's situation, preference, and need.	**Program's policies and procedures** demonstrate that the program has processes for making active and passive referrals.
E. Program will make HIPAA-compliant virtual services available to all RWHAP Part A clients.	**E.1.** Program will ensure that clients have the option to receive services via HIPAA- compliant virtual platforms, if a service can be provided online.	**Program's policies and procedures** demonstrate that tele-health services are offered to clients, when applicable.
	E.2. Program will have procedures in place that give clients the right to accept tele-health services or deny tele-health services and request meeting with a provider in person.	**Program's policies and procedures** show that clients have a right to accept or deny tele-health services and to see a provider in person upon request.

VI. Transition and Closure

Programs must have systems in place to ensure that client cases are closed fairly and with due process.

STANDARD	MEASURE	DATA SOURCE

A. The program has a comprehensive transition and closure procedure in place that is implemented for clients leaving services.	**A.1.** Policy includes that a client case may be closed if: • the client dies; • the client requests closure; • the client's needs change and they would be better served through services at another provider agency; • the client's actions put the agency, service provider, or other clients at risk; • the client sells or exchanges emergency assistance, child care, or transportation vouchers for cash or other resource for which the assistance is not intended; • the client moves/relocates out of the service area; or • the program is unable to reach a client after at least 3 attempts over a period of 3 months.	**Program's Policies and Procedures** outlines closure procedures. **Client's File** indicates reason for closure of client case.
B. Program has a due process policy in place for involuntary closure of client cases from services.	**B.1.** Policy covers the steps taken before involuntarily closing a client case, including numerous verbal and written warnings before final notice and closure.	**Program's Policies and Procedures** outline the necessary steps before a client case is closed. **Client's file** details all contact attempts made.
C. Program has a process for maintaining communication with clients who are active and identifying those who are inactive.	**C.1.** Clients are considered inactive if the program is unable to reach a client after at least 3 attempts over a period of 3 months. All communication attempts are documented.	**Client's File** contains details of communication attempts.
D. At the time of transition or closure, the program will make referrals to services and/or programs based on the requests and preferences of the client.	**D.1.** Referrals to programs and/or services at the time of transition or closure will be made in a timely manner and documented.	**Client's File** contains documentation of any referrals.

Service Category Service Standards

Early Intervention Services

An EIS program is a package of services designed to identify and link a newly diagnosed person to Outpatient/Ambulatory Health Services (OAHS), Medical Case Management (MCM), and Substance Use Outpatient Services (SAO), if indicated (see "Linked" definition below). The package of services is defined below, and includes screening for barriers and needs, creating a plan to address client needs, and health education and literacy. Once a client has been successfully linked to OAHS or SAO, the EIS engagement is complete. If a client needs ongoing support, the support would happen in MCM Services.

Early Intervention Services (EIS) for Part A may include targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV; referral services to improve HIV care and treatment services at key points of entry; access and linkage to HIV care and treatment services such as OAHS, MCM, and SAO. If an EIS program provides targeted testing, the program will coordinate testing services with other HIV prevention and testing programs to avoid duplication of efforts and ensure that HIV testing paid for by EIS does not supplant testing efforts paid for by other sources.

Definitions and Descriptions

The following indicates that the client has been "Linked":

- Client followed through on first HIV care appointments: and
- CD4 test and/or viral load test was completed: and
- If appropriate, referral to medical case management was made

Active referral process given to clients should include, at a minimum, referral to a named program, and release of information form (if refused by client this must be documented and communicated upon referral).

Targeted HIV testing is a focused effort for people who are unaware of their HIV status who may have increased chance of HIV exposure.

Acronyms	
AIDS	Acquired Immunodeficiency Syndrome
DHR	Denver HIV Resources
DHRPC	Denver HIV Resource Planning Council
EIS	Early Intervention Services
HIV	Human Immunodeficiency Virus
MCM	Medical Case Management
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
ROI	Release of Information
RWHAP	Ryan White HIV/AIDS Program
SS	Service Standards

Units of Service

1 unit = 30 minutes

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Programs funded for EIS Linkage services may provide targeted HIV testing services to vulnerable populations.	**A.1.** Programs providing HIV testing services must create a targeted testing plan.	**Program's policies and procedures** will contain an approved targeted HIV testing plan.
	A. 2. Protocols are in place documenting the connection between testing and linkage services, including clear roles, responsibilities, and processes.	**Program's policies and procedures** will contain the protocol detailing the connection between testing and linkage services, including clear roles, responsibilities, and processes
	A.3. Testing services must coordinate with other HIV prevention and testing programs to avoid duplication of effort.	**Provider's policies and procedures** will document that relationships will be maintained with other programs and documented via MOA, MOU, letter of support, or another source.
	A.4. Ryan White Part A is the payer of last resort and HIV testing covered by EIS under RWHAP cannot replace testing efforts paid for by other sources.	**Provider's policies and procedures** will document that RWHAP is the payer of last resort and testing services covered by EIS under RWHAP cannot replace testing efforts paid for by other sources.
B. EIS Services will be utilized to link individuals who are newly diagnosed with HIV or are aware of their status and currently not in care.	**B.1.** Clients eligible for EIS are individuals newly diagnosed with HIV or are aware of their status and currently not in care.	**Client's file** contains the date of a client's HIV diagnosis.
	B.2. EIS is a brief service to ensure linkage to medical care and other needed services. EIS services may be as short as one interaction, or last up to 90 days. If additional time is needed, the reason must be clearly documented.	**Client's file** documents the dates of service and reflect that services lasted no longer than 90 days. If additional time is needed the reason is documented and includes a timeline for expected completion of services.
	B.3. If at any time during this process a Linkage Referral is made to another EIS Linkage Provider	**Client's file** will contain the Linkage Referral and documentation confirming

	(for example a referral for confirmatory testing), the responsibility for linking the client to an HIV medical provider, and/or MCM services will transition to the new EIS Provider. The referral to the new EIS Provider should be documented following the Linkage Referral guidance defined above.	the client connected to the new EIS Provider.
C. EIS client will be assessed utilizing an approved screening tool to identify needs and barriers to services. This screening will be used to develop a Linkage Plan.	**C.1.** EIS provider will schedule an EIS screening session within three business days of HIV diagnosis.	**Client's file** will contain documentation regarding contact with the client, documentation that the client was scheduled to be screened within 3 business days of a new diagnosis and an identified need for EIS.
	C.2. The approved screening tool will include but is not limited to the assessment of: • Barriers to medical care; • Client's behavioral health; • Substance use; • Financial situation; • Housing situation; • Payer source for medical care; and • Health education, risk reduction, and health literacy needs.	**Client's file** contains a completed EIS screening that includes the date of diagnosis, date of the screening, and the identified priority need areas.
D. EIS program will link client to a HIV medical provider within 30 days and not to exceed 90 days of entry into EIS.	**D.1.** Clients will be referred to a HIV medical provider. A release of information will be established between the EIS program and the medical provider.	**Client's file** documents the date of the linkage referral release of information between EIS program and the medical provider. If the ROI is refused by client, this is documented in the file.
	D.2. EIS program will confirm client has linked to a HIV medical provider within 30 days and not to exceed 90 days of entry into EIS.	**Client's file** documents the date of the confirmed medical appointment, and labs (CD4 and/or Viral Load) reflecting that it was within 30 and did not

		exceed 90 days of entry into EIS.
E. EIS providers will make a linkage referral to a Medical Case Management program within 30 days of entry if MCM services are needed and if the client agrees.	**E.1.** If the EIS screening indicates MCM services are needed, and the client agrees, a linkage referral will be made to an MCM program. If the client does not agree, they will be offered information about available MCM programs.	**Client's file** will contain documentation of referral and if the client accepted the referral. If the client does not accept the referral, the EIS program will document the information that was provided.
	E.2. Linkage referrals to MCM services will occur within 30 days of entering EIS not to exceed 90 days.	**Client's file** documents the date of linkage referral reflecting that it was within 30 days of entry into EIS and did not exceed 90 days.
	E.3. A release of information will be established between the EIS provider and the MCM program.	**Client's file** documents the date of the linkage referral release of information between the EIS program and the MCM program.
F. All EIS clients must have a Linkage Plan.	**F.1.** The Linkage Plan will document a plan to address the needs identified in the EIS screening. The plan will contain goals, objectives, action steps, and outcomes.	**Client's file** contains a Linkage Plan.
	F. 2. The Linkage Plan will be created at the time of screening, or within one week of the EIS screening.	**Client's file** contains a Linkage Plan that identifies the date of when the plan was created.
	F. 3. The linkage plan will document when EIS services have been completed.	**Client's file** contains a Linkage Plan that identifies the date when the plan was completed.
	F. 4. If at the end of 90 days there continue to be barriers to accessing care, a new Linkage Plan will be established.	**Client's file** contains a new Linkage Plan that identifies the barriers and actions to alleviate those barriers with a timeline for service completion.
G. Progress notes will be completed after every contact with the client and every contact related to the client that lasts at	**G.1.** Progress notes demonstrate that the Linkage Plan is being implemented and followed or revised to meet the client's needs.	**Client's file** contains progress notes.

least 15 minutes or is significant to care.		

Emergency Financial Assistance

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist a RWHAP Part A 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.

The Denver Part A RWHAP currently funds Medical Transportation, Housing Services, and Food Bank / Home-delivered Meals service categories.

Acronyms

ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
DHR	Denver HIV Resources
DSS	Division of Service Systems
EFA	Emergency Financial Assistance
FPL	Federal Poverty Line
HIV	Human Immunodeficiency Virus
PLWH	Person(s) Living With HIV
RWHAP	Ryan White HIV/AIDS Program

Units of Service

1 unit = any assistance request (including denied requests)

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Client eligibility is based on income level. **Clients between 0 - 500 percent of Federal Poverty Level (FPL)** are eligible for emergency financial assistance not to exceed $1,000 for the current fiscal year.	**A.1.** Payments may be made for the following services, and may include past due charges, but do not include items in collections: **- Phone & Internet:** Payment for cable is not allowable. **- Water** **- Trash** **- Utilities:** Payments may be made for electric, gas, and sewer. **- HIV-related medication** not covered by	**Client's file** contains documentation, such as a bill that documents the reason for the request, dollars needed, and the vendor to be paid. Documentation shows that client is at 500% FPL, or below.

EFA funds may not be used for clothing, or direct cash payments	ADAP (single occurrence or short duration) - **Food and essential household supplies**, if there is no separate food bank at the provider. - **Transportation**, if there is no separate medical transportation service available - **Medical and Insurance:** Payments may be made for medical premiums, medical copayments, and pharmacy copayments secondary to ADAP. Utilization of ADAP must be ruled out first. Includes past due charges, however charges may not be in collections. Payments cannot be made to a current Ryan White Part A Program. **Optical:** Payments may be made for copayments, prescription eye wear, but not the exam. Payments cannot be made to a current Ryan White Part A Program. - **ID Cards** - **Colorado Bureau of Investigation (CBI) background investigation fees** - **Housing Related Application Fees** - **Child Care Services:** Payments can be made to provide intermittent child care through a licensed child care provider that will enable an HIV positive adult or child to secure needed medical, or support services, or to participate in Ryan White HIV/AIDS program-related activities.	
	A.2. In some circumstances clients with extensive medical needs may appeal to DHR for a medical waiver of the limitation on amount if the cap would cause immediate devastating medical harm. To be approved for a medical waiver an individual must: • Submit a waiver request to DHR demonstrating that the limitation on	**Client's file** contains complete and signed medical waiver, if applicable.

	amount guidelines would cause immediate devastating medical harm. • Submit verification from a licensed physician who is providing current medical care for the client, explaining why the limitation on amount guidelines would cause immediate devastating medical harm.	
B. Programs will have procedures for clients to gain EFA assistance, deny EFA requests, and handle inappropriate use of funds. Eligibility criteria will be applied equally to all clients regardless of program.	**B.1.** The client and program will meet in a way that allows client participation (i.e. in person, virtually, by email, or by phone) to process the housing request.	**Client's file** contains documentation of client participation in the process**.**
	B. 2. A client can be suspended from EFA for up to three months, for misrepresentation of expenses, income or other policy violations. If a client is suspended from accessing EFA, the program will notify the client and the single payer within three business days of the suspension effective date and the client will be made aware of how to appeal the suspension.	**Client's file** documents verbal or written communication to the client and the single payer regarding the misrepresentation of expenses, income, or other policy violations that led to subsequent suspension, as well as communication on how the client can appeal the suspension. **Program's policies and procedures** demonstrates a process for notifying the client and the single payer of the suspension.
C. Single payer will respond to check requests in a timely manner and maintain payment records.	**C.1.** Checks for EFA will be issued by the contracted single payer program.	**Single payer records** contain check information.
	C. 2. Checks will be sent to the vendor address listed on the request. Checks cannot be payable or issued to clients.	**Single payer records** demonstrate that checks will be sent to the vendor.
	C. 3. The single payer will maintain electronic records of checks related to EFA.	**Single payer records** contain check information.
	C. 4. Approved check request will be completed within three business days of the request date.	**Single payer records** demonstrate that check requests were completed in a timely manner.

Food Bank and Home-Delivered Meals

Food bank and home-delivered meals involves the provision of actual food items or prepared meals. This includes the provision of both frozen and hot meals. It does not include finances to purchase food or meals but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items, household cleaning supplies, and water filtration/purification systems in communities where issues of water safety exist should be included in this item.

Definitions and Descriptions

Food Services include home delivered meals, food bank services, food vouchers and essential hygiene items, household cleaning supplies, and water filtration/ purification systems in communities where issues with water purity exist.

Registered Dietitian Nutritionist is an expert in food or nutrition who has completed the following:

- A Bachelor's, Master's or Doctorate degree in nutrition and related sciences;
- A supervised dietetic internship or equivalent; and
- A national exam which credentials her/him as an RD by the Commission on Dietetic Registration.

Food Banks are distribution centers that warehouse food and related grocery items including nutritional supplements and other miscellaneous items.

Home-delivered Meals is the provision of prepared meals that meet the client's nutritional and dietary requirements. This includes the provision of frozen, cold and hot meals.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ASO	AIDS Services Organization
CBO	Community Based Organization
DHR	Denver HIV Resources
DTR	Dietetic Technician Registered
HIV	Human Immunodeficiency Virus
RD	Registered Dietitian

Units of Service

Service units of Food Bank/Home Delivered Meals services are defined as the number of meals or bags of groceries provided to eligible clients.

1 unit = 1 meal

1 unit = 1 bag of groceries

Service Components

STANDARD	MEASURE	DATA SOURCE

A. Staff and volunteers have appropriate skills, relevant training, and knowledge about HIV and safe food handling.	**A.1.** Staff or volunteers involved in food preparation and/or food distribution will complete a food safety class equivalent to State of Colorado standards.	**Personnel files** document staff and volunteer training hours.
	A.2. Supervisory staff will stay current with the latest information on HIV and nutrition by attending trainings on an annual basis.	**Personnel file** will document topic specific training.
B. Funding for Food Bank/Home-delivered Meals will cover HRSA-approved food items and essential non-food items.	**B.1.** Allowable costs include: Food items: • The provision of actual food items; • Provision of frozen, cold, or hot meals; and • A voucher program to purchase food. Essential non-food items: • Personal hygiene products; • Household cleaning supplies; and • Water filtration/ purification systems in communities where issues with water purity exist.	**Program's policies and procedures** will document allowable costs under RWHAP.
	B.2. Unallowable costs include: • Household appliances; • Pet foods; • Permanent water filtration systems for water entering the house; and • Other non-essential products.	**Provider's policies and procedures** will document un-allowable costs under RWHAP.
	B.3. Documentation that: • Services supported are limited to food bank, home- delivered meals, and/or food voucher program; • Types of non-food items provided are allowable; and • If water filtration/ purification systems are provided, community has water purity issues.	**Program's policies and procedures** document allowable and unallowable costs under RWHAP.
C. Food services will comply with current food safety guidelines.	**C.1.** Food services will comply with Colorado food safety regulations, USDA dietary guidelines for Americans, FDA food safety guidelines, Office of Disease Prevention and Health Promotion guidelines.	**Documentation** that agency has participated in an annual food safety inspection.

D. If the program has a waitlist, the waitlist is appropriately managed.	**D.1.** If a provider is ever faced with the need to create a waiting list, the program must provide documentation explaining the need for a wait list.	**Program's policies and procedures** demonstrate how waiting lists and referrals are managed.
	D.2. The program will maintain referral relationships with other Food Bank/Home delivered meal programs in the area.	**Program's policies and procedures** details networking strategy and list of referral relationships.
	D.3. The wait list is managed in an equitable manner. If growth restrictions become inevitable, then programs will serve those most in need based on overall health.	**Policies and procedures** demonstrate how waiting lists are managed.

I. Food Bank Service Components

Food banks are distribution centers that warehouse food and related grocery items including nutritional supplements and other miscellaneous items. They are required to ensure services are convenient for and accessible to participants through removing barriers to service or developing an innovative approach to ensure access.

STANDARD	MEASURE	DATA SOURCE
A. Food banks will make sure their services are accessible for clients.	**A.1.** Food bank hours will be accessible to participants with variable schedules and must include operating hours that are outside of 9am-5pm Monday-Friday.	**Program's Policies and Procedures** document accessible food bank hours.
	A.2. Program should be accessible via public transportation.	**Program's Policies and Procedures** document program accessibility via public transportation.

II. Home-Delivered Meals Service Components

Home delivered meals is the provision of prepared meals that meet the client's nutritional and dietary requirements. This includes the provision of frozen, cold, and hot meals. Home delivered meals are provided for clients experiencing physical or emotional difficulties related to HIV that render them incapable of preparing nutritional meals for themselves.

STANDARD	MEASURE	DATA SOURCE
A. Home delivered meals will be provided in a manner convenient to the client and will meet the client's nutritional needs.	**A.1.** Participants will be given a delivery time period within which they can expect to receive their meals.	**Provider's policies and procedures** address communication and standards around delivery of food.

	A.2. Meals will have caloric and nutritional content to meet the individual participant's dietary needs.	**Program's Menus** demonstrate each meal's average caloric and nutritional content.
	A.3. Menus will be made in conjunction with RD to ensure it meets the participants' nutritional needs.	**Program's Policies and Procedures** contain documentation that registered dietitian signed off on the menu.
B. Home delivered meal services will follow accepted standards of practice of the Academy of Nutrition and Dietetics and HIV/AIDS Evidence-Based Nutrition Practice Guidelines.	**B.1.** Home delivered meals services will follow accepted standards of practice of the Academy of Nutrition and Dietetics, and HIV/AIDS Evidence-Based Nutrition Practice Guidelines.	**Program's Policies and** Procedures contain documentation that program is following accepted nutrition standards.
C. Program must assess needs of each client receiving home-delivered meals at least once a year to assure compliance with service requirements.	**C.1** Provider assesses client needs and status at least once a year and includes: • Dietary and cultural food needs; • Food preferences; and • Client's ability to access services.	**Client's file** show annual assessment of need.

Housing Services

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Acronyms

AIDS	**Acquired Immunodeficiency Syndrome**
DHR	Denver HIV Resources
FPL	Federal Poverty Level
HIV	Human Immunodeficiency Virus
PLWH	People Living With HIV

Units of Service

1 unit = any assistance request (including denied requests)

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Client eligibility is based on income level. Clients between 0-500 percent of FPL are eligible for housing assistance not to exceed $1,200 for the current fiscal year. Housing services funds may not be used for rental deposits or mortgage payments. Clients who receive a housing subsidy are eligible for housing assistance not to exceed $600 for the current fiscal year.	**A.1.** Payments may be made for the following services, and may include past due charges, but do not include items in collections: **Rental Assistance**: Payments may be made for rent assistance. **Hotel/Motel:** Payments may be made for a hotel, or motel.	**Client's file** contains documentation including a lease, letter, or other proof of dollars needed and vendor to be paid. If it is a sublease, the vendor must be the property owner. A family member may be the vendor if they are the property owner. If property owner is an individual, not a company, owner must be verified using the County assessor's website(s). For clients who receive a housing subsidy, documentation of the housing subsidy should be included when requesting housing assistance.
	A.2. In some circumstances clients with extensive medical needs may appeal to DHR for a medical waiver of the limitation on amount if the cap would cause immediate devastating medical harm. To be approved for a medical waiver an individual must: • Submit a waiver request to DHR demonstrating that the limitation on amount guidelines would cause immediate devastating	**Client's file** contains complete and signed medical waiver, if applicable.

	medical harm. • Submit verification from a licensed physician who is providing current medical care for the client, explaining why the limitation on amount guidelines would cause immediate devastating medical harm.	
B. Programs will have procedures for clients to gain housing assistance, deny housing requests, and handle inappropriate use of funds. Eligibility criteria will be applied equally to all clients regardless of program.	**B.1.** The client and program will meet in a way that allows client participation (i.e. in person, virtually, by email, or by phone) to process the housing request.	**Client's file** contains documentation of client participation in the process**.**
	B.2. The client and the program will develop a complete plan, including a short, and long term housing plan, applying for available benefits and subsidies, and creating a plausible budget. The program will give the client a list of financial planning resources when creating a plan.	**Client's file** contains a copy of the financial plan or a program specific planning tool.
	B. 3. A client can be suspended from housing services for up to three months, for misrepresentation of expenses, income or other policy violations. If a client is suspended from accessing housing services, the program will notify the client and the single payer within three business days of the suspension effective date and the client will be made aware of how to appeal the suspension.	**Client's file** documents verbal or written communication to the client and the single payer regarding the misrepresentation of expenses, income, or other policy violations that led to subsequent suspension, as well as communication on how the client can appeal the suspension. **Program's policies and procedures** demonstrates a process for notifying the client and the single payer of the suspension.
C. Single payer will respond to check requests in a timely manner and maintain payment records.	**C.1.** Checks for housing services will be issued by the contracted single payer program.	**Single payer records** contain check information.
	C. 2. Checks will be sent to the vendor address listed on in the request. Checks will not be payable or issued to clients.	**Single payer records** demonstrate that checks will be sent to the vendor.

	C. 3. The single payer will maintain electronic records of checks related to housing services.	**Single payer records** contain check information.
	C. 4. Approved check request will be completed within three business days of the request date.	**Single payer records** demonstrate that check requests were completed in a timely manner.

Medical Case Management

Medical Case Management is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services in order to improve health outcomes in support of the HIV care continuum. MCM provides coordination, guidance, active and passive referrals, and assistance in accessing medical, social, community, legal, financial, income related activities, and/or other needed services. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g. face-to-face, phone contact, and any other forms of communication). The primary goal of MCM is to improve client health care outcomes by helping clients address barriers directly affecting their abilities to adhere to medical advice. MCM's hallmark characteristic is having the case manager work directly with the client's HIV medical providers to address these issues. Whereas, the services provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Key activities include:

- Initial assessment of service needs;
- Development of a comprehensive, individualized care plan;
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care;
- Continuous client monitoring to assess the efficacy of the care plan;
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems;
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments;
- Client-specific advocacy and/or review of utilization of services; and
- Coordination with medical providers.

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Acronyms

AIDS	**Acquired Immunodeficiency Syndrome**

MCM	Medical Case Management
DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
DHRPC	Denver HIV Resources Planning council

Units of Service

1 unit = 15 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
A. The program will initiate screenings within one week of initial contact with client. If the program has a waitlist, the program will appropriately manage the waitlist to mitigate wait times for clients.	**A.1.** The program will schedule the eligibility screening and admissions process within one week of the initial contact or be placed on a waiting list and filtered into a caseload as soon as a space becomes available. If the client has urgent needs, services or referrals will be provided immediately.	**Program's Policies and Procedures** demonstrate their intake process, per the regulations, and how waiting lists are managed.
	A.2. If the program is ever faced with the need to create a waiting list, the program must provide documentation explaining the need for a wait list, and an accurate assessment of how long it takes to receive care once placed on the wait list.	**Program's policies and procedures** demonstrate how waiting lists and referrals are managed.
	A.3. The program will maintain referral relationships with other case management programs in the area and make referrals when appropriate to mitigate wait times for clients.	**Program's policies and procedures** details networking strategy, list of referral relationships, and documentation of referrals when they are made.
B. The program will conduct an intake interview and needs assessment following assignment to a medical case manager.	**B.1.** The program will schedule an intake appointment within two weeks of assignment to a medical case manager.	**Client's file** will demonstrate an intake interview was conducted within two weeks of assignment.
	B.2. A needs assessment will be completed within three appointments of the intake interview which will include, but is not limited to, an assessment of: • Client's functional and cognitive capacity; • Health; • Strengths; • Abilities; • Mental health;	**Client's file** has initial assessment with all necessary information completed within the one-month period.

	• Substance use; • Resources; and • Needs.	
C. An Acuity Assessment shall be completed for each client to determine level of MCM.	**C.1.** Every client will be assessed for acuity at intake or within 30 days of initiating MCM services, utilizing the TGA MCM Acuity Assessment Tool, or other tool approved by DHR.	**Client's file** documents assessment was administered at intake or within 30 days of initiating MCM.
	C.2. Every client should be re-assessed for acuity, as life changes indicate, or at a minimum based on the acuity level: • Intensive Level: every three to six months; • Moderate Level: every six months; and • Monitoring Level: annually.	**Client's file** documents appropriate re-assessment.
D. The program will assess client for adherence to their HIV medication at least annually utilizing an approved tool.	**D.1.** Every client should be assessed for adherence to their HIV medication at least annually, utilizing an approved tool.	**Client's file** will contain an annual assessment of adherence to their HIV medication.
	D.2. If an adherence barrier is identified during the adherence assessment, the case manager should provide adherence counseling and/or make a referral to a medical provider or pharmacist to ensure adherence counseling is provided to the client.	**Client's file** documents date and content of adherence discussion or referral.
E. Every client will have an Individual Service Plan which guides their care.	**E.1.** Development of an Individual Service Plan is based on the initial and ongoing acuity assessment and meets the client's needs and preferences. The plan will be completed within two weeks of the assessment.	**Client's file** contains Individual Service Plan which demonstrates connections to medical care.
	E.2. The Individual Service Plan will demonstrate that the client will get medical care at least once every six months, or as medically indicated. This includes addressing barriers to care and establishing plans for engagement.	**Client's file** contains Individual Service Plan that is completed within the required timeframe.
	E.3. The Individual Service Plan demonstrates that the client is linked to all appropriate services needed.	**Client's file** documents all referrals.
	E.4. The Individual Service Plan contains objectives for each goal, stating how the client will reach the goals. Objectives are measurable and achievable.	**Client's file** contains Individual Service Plan with measurable and updated objectives.

	E.5. Each client's needs are reassessed as life changes indicate, or at a minimum based on the MCM Level determined by the MCM Acuity Assessment: • Intensive Level: every three to six months; • Moderate Level: every six months; and • Monitoring Level: annually. This reassessment is documented in updates to the Individual Service Plan.	**Client's file** documents that the Individual Service Plan is updated as required by MCM Level.
F. Progress notes will be completed after every contact with the client that relates to the client's care.	**F. 1.** Progress notes demonstrate that the Individual Service Plan is being implemented and followed or revised to meet the client's changing needs.	**Client's file** contains progress notes related to the Individual Service Plan.
G. The program will collaborate and coordinate with medical providers.	**G.1.** The case manager will coordinate and collaborate with the HIV medical care team based on the MCM level determined by the MCM Acuity Assessment at a minimum: • Intensive Level: coordination and collaboration required at least once annually, and can include case conferencing; • Moderate Level: coordination and collaboration recommended; • Monitoring Level: coordination and collaboration recommended on an "as needed basis." Coordination may take the form of shared service planning, acuity assessment, phone and secure email communication, and case conferences.	**Client's file** documents compliance.
H. Case closure shall be documented, and proper referrals made if applicable.	**H.1.** MCM case closure will be completed at the request of the client, the program, or at death; using pre-established guidelines and criteria. Clients should be referred to appropriate providers upon closure when appropriate. For more guidance on case closure, please refer to section VIII of the Universal Standards.	**Client's file** states the reason for closure and that proper referrals are made.
I. Caseload size will be determined by individual programs and based on acuity of clients.	**I.1.** The following guidance should be utilized in consultation with DHR. • Intensive level: 40-60 clients; • Moderate Level: 60-100 clients; • Monitoring Level: 100-200 clients.	**Program's policies and procedures** will document how caseloads are managed.

	Caseloads may have mixed levels of acuity and may not fall neatly in these categories. Caseload sizes shall be routinely assessed by supervisor.	

Medical Transportation Services

Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Medical transportation is classified as a support service and is used to provide transportation for eligible RW HIV/AIDS Program clients to core medical services and support services. Medical transportation must be reported as a support services in all cases, regardless of whether the client transported to a medical core service or to a support service.

Definitions and Descriptions

Rideshare: a service where a passenger pays for travel in a private vehicle driven by its owner for a fee, usually arranged by a website or app. Ex: Uber or Lyft.

Acronyms

DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
RTD	Regional Transportation District-Denver
RW	Ryan White

Units of Service

1 unit = 1 bus trip (bus trip = one ticket)
1 unit = cab voucher (1 one-way voucher)
1 unit = 1 vehicle mileage reimbursement
1 unit = 1 one-way rideshare trip

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Transportation allows clients to connect to HIV-related health and support services who do not have the means to access them on their own or need vehicle mileage reimbursement assistance.	**A. 1.** Transportation funds will be used in a manner that is most cost effective and appropriate for the client.	**Program's Policies and Procedures** demonstrate how transportation funds are delivered and how they ensure cost effectiveness.
	A. 2. Transportation services will be delivered to clients with transportation barriers to access HIV-related health and support services.	**Client's file** documents barriers and how transportation funds are

		used to access HIV-related health and support services.

	A. 3. Distribution of transportation service must document:
	• Client name or other identifier
	• Type of distribution:
	  ○ cab voucher;
	  ○ mileage reimbursement;
	  ○ bus ticket; or
	  ○ rideshare trip.
	• Units distributed
	• Date
	• Purpose
	• Type of distribution:
	  ○ Bus ticket
	  ○ Cab voucher: must include origin and destination
	  ○ Mileage reimbursement: must include 1) trip origin and destination, 2) Google Maps, Map Quest, etc. documentation of trip distance, 3) signed certification by destination HIV-related service provider confirming destination, and 4) amount of reimbursement provided
	  ○ Rideshare: must include 1) trip origin and destination, and 2) a receipt from rideshare trip that is signed by service provider.
		Client's file documents the distribution of the transportation service.

B. The program will provide mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical and other support services.	**B. 1.** The program has a system for providing mileage reimbursement (through a non-cash system) that does not exceed the federal per-mile reimbursement rate for the current calendar year.	**Program's Policies and Procedures** document that vehicle mileage is reimbursed *after the trip* at the federal per-mile reimbursement rate.
C. The program utilizes RTD discount purchase programs when possible.	**C. 1.** Transportation services will be purchased at a discount rate from RTD when possible.	**Program's Policies and Procedures** show that transportation services are purchased at a discounted rate when possible.
D. Rideshare services can be provided by the program, or the client can be reimbursed	**D.1.** If the program uses its own account to provide transportation via rideshare, the rideshare program used	**Program's Policies and Procedures** detail which rideshare services the

through a non-cash system for using a personal rideshare account.	must be HIPAA compliant, for example Uber Health and Lyft Business.	program partners with, and evidence of HIPAA compliance.
	D.2. If the program reimburses clients for rideshare trips where the client uses a personal account, then reimbursement can operate like mileage reimbursement (through a non-cash system) for use of a personal vehicle. However, reimbursement for a rideshare trip can only cover the established rate for federal programs and may not cover the full amount the client paid for the trip.	**Client's File** contains a receipt (email, screenshot, etc.) of the client's rideshare trip, and the amount reimbursed based on the federal mileage rate.

Mental Health Services

Mental health services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

In some cases, a client may be seen for a brief intervention. A brief intervention, also known as a brief conversation, occurs in various settings, such as a primary healthcare setting and lasts a short duration with anticipation that each session could be the last session. In contrast, ongoing mental health services take place when there is the expectation that an individual will receive ongoing care and treatment. The standards that apply to both brief interventions and ongoing care are listed first under "All Mental Health Services Components," the standards that apply to only ongoing care are listed under "Ongoing Mental Health Services Components," and the standards that apply only to brief interventions are listed under "Brief Intervention Service Components."

Definitions and Descriptions

Measurable – Using methods including but not limited to the who, what, when, where, why, how, and how often method or the SMART method.

Acronyms	
DHR	Denver HIV Resources
DORA	Department of Regulatory Agencies
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
MHS	Mental Health Services
OBH	Office of Behavioral Health, Colorado Dept. of Human Services
RW	Ryan White

Units of Service

1 unit = 30 minutes or less

All Mental Health Services Components

STANDARD	MEASURE	DATA SOURCE
A. Providers of mental health services must have the proper qualification and expertise to deliver services.	**A.1.** Mental health services can be provided by a: • Psychiatrist; • Licensed Psychologist; • Licensed Psychiatric Nurse Practitioner; • Licensed Marriage and Family Therapist; • Licensed Professional Counselor; • Licensed Clinical Social Worker; • Licensed Behavioral Health Specialist;	**Personnel File** has proof of certification/ Licensure for the position.
	A.2. Mental health services can be provided by unlicensed registered clinicians or graduate level student interns with appropriate supervision per licensure or internship regulations and in compliance with Colorado Mental Health statutes found at https://sehd.ucdenver.edu/cpce-internships/files/2010/08/Statute.pdf.	**Personnel File** clearly designates a supervisor.

B. Providers of mental health services will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**B.1.** Therapeutic disclosure will be reviewed and signed by all clients and must be compliant with Colorado Mental Health statutes: https://sehd.ucdenver.edu/cpce-internships/files/2010/08/Statute.pdf. At a minimum, the disclosure must include: • Therapist's name; • Degrees, credentials, certifications, and licenses; • Business address and business phone; • DORA description and contact information; • Treatment methods and techniques • Option for second opinion; • Option to terminate therapy at any time; • Statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to DORA; and • Information about confidentiality and the legal limitations of confidentiality.	**Client's file** contains a copy of the therapeutic disclosure, signed and dated by both client and therapist.
C. Referrals made to services related to the service plan shall be made and documented in a timely manner.	**C.1.** Referrals to qualified practitioners and/or services will occur if clinically indicated. If the client is in immediate crisis, they will be seen immediately or proper referrals will be made.	**Client's File** will contain documentation of referrals.
D. Progress notes shall be completed after every contact with the client.	**D.1.** Progress notes should: • Be a written chronological record; • Document any change in physical, behavioral, cognitive, and functional condition; • Document any action taken by staff to address the client's changing needs; and • Be signed and dated by the author at the time they are written, with at least a first initial, last name, degree and/or professional credentials.	**Client's File** contains copies of progress notes.

I. Ongoing Mental Health Service Components

STANDARD	MEASURE	DATA SOURCE
E. Treatment will be offered in a timely manner.	**E.1.** Treatment will be offered within 15 business days from the time of referral, if the client is not in crisis. If the client is in immediate crisis, they will be seen immediately or proper referrals will be made.	**Client's File** contains a dated referral, and evidence of the date of first treatment.
F. A biopsychosocial assessment will begin at the first session and be completed by the second session.	**F.1.** The biopsychosocial assessment will be completed within the first two sessions for all clients seeking ongoing treatment and will include, but is not limited to: • Presenting problem; • Medical and psychiatric history; • Family history; • Treatment history; • Cultural issues; • Spiritual issues when pertinent; • Brief psychosocial history; and • Diagnosed mental health illness or condition	**Client's File** contains a copy of the biopsychosocial assessment.
G. A mental status exam/assessment will be completed within the first three sessions.	**G.1.** The mental status exam/assessment will be completed within the first three sessions for all clients seeking ongoing treatment.	**Client's File** contains results from mental status exam/assessment.
H. Every client shall have a treatment plan which guides their care.	**H.1.** All treatment plans will: • Be based on the biopsychosocial assessment and mental status exam/assessment indicating the client's needs and preferences; • Contain goals which define what the client expects to achieve during treatment; • Contain measurable, reasonable, and achievable objectives for each goal, stating how the client will reach the goals; and • Be updated every six months.	**Client's File** contains copy of treatment plan.
	H.2. In addition to the requirements in F.1., for patients receiving non-psychiatric care, treatment plans will: • Be completed by the fourth session; and • Contain an estimated case closure date.	**Client's File** contains copy of treatment plan.

	H.3. In addition to the requirements in H.1., for patients receiving psychiatric care, treatment plans will: • Be completed by the third session; and • Include reason if prescribing a medication that has the potential to interact negatively with the client's HIV drugs, and a plan for monitoring of the client's health.	**Client's File** contains copy of treatment plan.
I. Upon termination of active mental health services, a client case is closed and contains a closure summary documenting the case disposition.	**I.1.** Closure summaries shall be completed within five business days after closure and documented in progress notes. Records shall contain a written closure summary to include, but not limited to the following information where applicable: • Reason for admission; • Reason for closure; • Primary and significant issues identified during course of services; • Diagnoses; • Summary of services, progress made, and outstanding concerns; • Coordination of care with other service providers; • Advance directives developed or initiated during course of services; • Summary of medications prescribed during treatment, including the client's response(s) to the medications; • Documentation of referrals and recommendations for follow-up care; and • Information regarding the death of the client.	**Client's File** contains copy of closure summary, if patient's case has been closed.
J. The program will assess client adherence to mental health services, HIV medical appointments, and HIV medications.	**J.1.** The program will document appointment adherence and monitor clients for participation in mental health services.	**Client's File** contains documentation of scheduled appointments and attendance.
	J.2. The program will document appointment adherence to HIV medical appointments that are provided by the program and by other providers.	**Client's File** contains documentation of scheduled appointments and attendance.
	J.3. The program will document which HIV medications the client is taking and adherence to medication schedule.	**Client's File** contains documentation of HIV medications and

		adherence including reports from EMR.
K. The program must use evidence-based practices or care supported by empirical evidence.	**K.1.** The program uses evidence-based practices, including but not limited to: • Motivational Interviewing; • Harm Reduction; • Cognitive Behavioral Therapy; • Dialectical Behavior Therapy; • Trauma-Informed Treatment; and • Psychoeducation.	**Program's Policies and Procedures** documents which practices are implemented.

II. Brief Intervention Service Components

STANDARD	MEASURE	DATA SOURCE
L. A biopsychosocial assessment will be completed at the first session.	**L.1.** A brief biopsychosocial assessment given the depth of interaction with the client will include, but is not limited to: • Presenting problem; • Medical and psychiatric history; • Treatment history; and • Brief psychosocial history.	**Client's File** contains a copy of the biopsychosocial assessment.
M. A mental status exam/assessment will be completed at the first session.	**M.1.** The mental status exam/assessment will be completed at the first session for all clients seeking a brief intervention.	**Client's File** contains results from mental status exam/assessment.
N. Every client shall have a treatment plan which guides their care.	**N.1.** All treatment plans will: • Be based on the biopsychosocial assessment and mental status; exam/assessment indicating the client's needs and preferences; • Contain goals which define what the client expects to achieve during treatment; and • Contain measurable, reasonable, and achievable objectives for each goal, stating how the client will reach the goals.	**Client's File** contains copy of treatment plan. Treatment plan can be part of a session note or other EMR record.
	N.2. Include reason if prescribing a medication that has the potential to interact negatively with the client's HIV drugs, and a plan for monitoring of the client's health.	**Client's File** contains copy of treatment plan and prescribed medications.
O. The program will assess the client's adherence to HIV medications.	**O.1.** The program will document which HIV medications the client is taking and adherence to medication schedule.	**Client's File** contains documentation of HIV medications and adherence.

P. The program will refer to other services for ongoing care or psychiatric care as needed.	**P.1.** The program will document referrals to internal or external care and services.	**Client's File** contains documentation of referrals.
	P.2. The program will maintain referral relationships with other programs.	**Program's Files** contains documentation of referral relationships.

Oral Health Care

Oral health care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, licensed to provide health care in the State or jurisdiction, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

The goal of the Oral Health service category is to prevent and control oral and craniofacial disease, conditions, and injuries, and improve access to preventive services and dental care for eligible PLWH. Services shall be provided in a manner that has the greatest likelihood of ensuring maximum participation in the program involved.

Oral Health Care Services include emergency, diagnostic, preventive, basic restorative including removable partial and complete prosthetics, limited oral surgical and limited endodontic services.

Definitions and Descriptions

Phase 1 completion reflects that the patient has been moved to stable oral health. This is the minimal and expected level of care for all patients.
Phase 2 completion reflects restoration of complete function and esthetics for the patient that requires laboratory-based treatments.

Acronyms

ADAPP	American Dental Association Dental Practice Parameters
AIDS	Acquired Immunodeficiency Syndrome
DHR	Denver HIV Resources
DHRPC	Denver HIV Resources Planning Council
FPL	Federal Poverty Level
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
OHF	Oral Health Fund
RDA	Registered Dental Assistant
RDH	Registered Dental Hygienist

Units of Service

1 unit = 1 visitation of any duration

Service Components

STANDARD	MEASURE	DATA SOURCE

A. Providers of dental care services must have the proper qualifications and expertise to deliver services.	**A.1.** Dentists must be licensed to practice dentistry by the State of Colorado.	**Personnel file** contains copies of diplomas or other proof of degree or licensure. Any outcomes passed by the State Board will be in the Dentist's file.
	A.2. If a program utilizes the services of dental students, these students must be supervised according to their program guidelines and work under the license of a program's dentist.	**Program's policies and procedures** demonstrate how students are supervised to ensure high levels of quality.
B. Treatment will be offered in a timely and appropriate manner.	**B.1.** Program can demonstrate that waiting list procedure properly manages the wait time for new clients.	**Program's Policies and Procedures** demonstrate how the program handles waiting lists. **Client's File** shows that there are no unnecessary delays in getting services.
	B.2. Program determined emergencies will be addressed or referred to another provider within 24 hours.	**Client's File** demonstrates that emergencies are addressed in a timely manner and documents that the patient was seen by the referred provider and follow up was completed. **Program's Policies and Procedures** outline how emergencies are handled in a timely manner.
C. A comprehensive oral evaluation will be given to people with HIV presenting for dental services.	**C.1.** The evaluation will include: • Documentation of patient's presenting complaint; • Caries charting; • Radiographs or panoramic and bitewings and selected periapical films; • Complete periodontal exam or PSR (periodontal screening record); • Comprehensive head and neck exam; • Complete intra-oral exam, including evaluation for HIV associated lesions;	**Client's File** will have a signed and dated oral evaluation on file in patient chart.

	• Pain assessment; • Dental and Medical History; • Psychological and behavioral health histories; • Dental Treatment Plan; and • Oral Health Education.	
	C.2. An assessment of general dental and medical needs and histories are conducted and if the client is not in primary care, the program will help the client access care. This should be updated at least annually.	**Client's File** contains a medical needs evaluation and a referral to primary care if necessary.
	C.3. Provider clinical decisions are supported by the American Dental Association Dental Practice Parameters.	**Program's Policies and Procedures** reference the American Dental Association Dental Practice Parameters.
D. A comprehensive treatment plan is developed based upon the initial examination of the client.	**D.1.** Completed treatment plan in client file at the subrecipient location, submitted by dentist.	**Client's File** contains a treatment plan.
	D.2. For non-emergent care, the treatment plan should be completed after the evaluation and before the first treatment.	**Client's File** contains treatment plan that is completed and documents the medical necessity of restorative care.
E. Treatment plan is reviewed and updated as deemed necessary by the dental provider.	**E.1.** Updated treatment plan in client file at the subrecipient location, submitted by dentist, and revised and approved by dental program director.	**Client's File** contains an updated treatment plan.
F. Progress notes shall be completed after every contact with the client.	**F.1.** Progress notes demonstrate that the phase 1 treatment plan is being implemented, followed, and completed within 12 months of establishing a treatment plan, excluding external factors outside of the dental provider's control (e.g. client missing appointments).	**Client's File** contains progress notes related to treatment plan.
	F.2. Progress notes demonstrate that the client received oral health education at least once in the measurement year.	**Client's File** contains progress notes showing client received oral health education.
G. Providers will follow ethical and legal requirements.	**G.1.** Providers will act in accordance to Colorado State law and the American Dental Association's Principles of Ethics and Code of	**Client's File** demonstrates the provider is acting ethically and in the best interest of the client.

	Professional Conduct, and respective agencies code of ethics.	
H. Closure shall be documented and proper referrals made if applicable.	**H.1.** Closure from dental care services will be completed at the request of the client, the dental care provider, or at death; using pre-established program guidelines and criteria. Clients should be referred to appropriate provider on closure, if appropriate. (See Universal Standards)	**Client's File** states reason for closure and that proper referrals are made.
	H.2. Any treatment performed shall be with concurrence of the patient and the dentist. If the patient's requested treatment is outside of the scope of the dentist's practice, then the patient needs to be communicated of this limitation and the dentist should attempt to make a referral.	**Client's File** shows proper treatment is given based on the dentist's professional opinion.
I. Programs shall strive to retain patients in oral health treatment services.	**I.1.** Programs shall develop a missed appointment policy to ensure continuity of service and retention of clients.	**Program's Policies and Procedures** contain a written policy for missed appointments.
	I.2. Programs shall provide regular follow-up procedures to encourage and help maintain a client in oral health treatment services.	**Client's File** contains documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls; • Written correspondence; or • Direct contact.

I. Oral Health Fund

The Oral Health Fund is a percentage of the Oral Health Care service category allocations annually decided upon by the Denver HIV Resources Planning Council in alignment with regulations from the Health Resources and Services Administration (HRSA).

Units of Service

1 Unit = Any assistance request (including denied requests)

Service Components

STANDARD	MEASURE	DATA SOURCE

A. Program will assess client eligibility for dental assistance.	**A.1.** Client eligibility is based on income level, residence in the Denver TGA, and HIV status. Clients between 0 - 500 percent of Federal Poverty Level (FPL) are eligible for dental assistance not to exceed $5,000 for the current fiscal year.	**Client's file** contains documentation that shows client eligibility for dental assistance.
	A.2. Clients with dental assistance needs that exceed $5,000 may submit an oral health financial assistance waiver requesting additional funds. The requestor, working with the client, will submit the waiver to DHR for approval.	**Client's file** contains the submitted oral health waiver with DHR staff signature, if approved.
B. Dental assistance payments can be made for client out-of-pocket costs for oral health care services.	**B.1.** Dental assistance payments can be made for client out-of-pocket costs for emergency, diagnostic, preventive, basic restorative oral health care services including, but not limited to removable partial and complete prosthetics, limited oral surgical and limited endodontic services.	**Program's Policies and Procedures** documents dental services paid for by Ryan White Part A funds.
	B.2. Oral health funds cannot be used for direct cash payments to clients.	**Program's Policies and Procedures** demonstrates that direct cash payments are not made to clients.
C. Program will assist the client with accessing and receiving dental assistance, including scheduling and coordinating dental appointments.	**C.1.** The client and program will meet in a way that allows client participation (i.e. in person, virtually, by email, or by phone) to process the dental assistance request.	**Client's file** contains documentation of client participation in the process.
	C.2. The program will schedule and coordinate all initial dental appointments and educate the client about scheduling any follow up appointments.	**Client's file** includes documentation of scheduled appointments.
E. Single payer will respond to check requests in a timely manner and maintain payment records.	**E.1.** Checks for dental assistance will be issued by the contracted single payer program.	**Single payer records** contain check information.
	E. 2. Checks will be sent to the vendor address listed on the invoice or delivered directly to the vendor	**Single payer records** demonstrate that checks are issued directly to the vendor.

	on the day of service. Checks cannot be payable or issued to clients.	
	E. 3. The single payer will maintain electronic records of checks related to dental assistance requests.	**Single payer records** contain check information.
	E. 4. Approved check request will be completed within three business days of the request date.	**Single payer records** demonstrate that check requests were completed in a timely manner.
E. Upon approval of a dental assistance request, the single payer will hold the requested dollar amount for 90 days.	**E.1.** The single payer will maintain records of each dental assistance request approval, the 90-day holding period of the requested dollar amount, and the request expiration date.	**Single payer records** contain documentation of pertinent dental assistance request information.
	E.2. The single payer will inform the requestor of the approval and availability of the requested dollar amount for 90 days, with the date of expiration explicitly stated.	**Single payer records** contain a process for communicating with the requestor.
	E.3. Requests approved on or after November 30th will expire on the last day of the fiscal year.	**Single payer records** contain documentation of dental assistance request expiration dates.
F. In alignment with the payer of last resort legislative requirement, the program will make reasonable effort to secure other funding sources prior to requesting dental assistance from the Ryan White Part A Program.	**F. 1.** The requestor will explore payment options through the client's insurance and other funding sources prior to submitting a Ryan White Part A dental assistance request.	**Client's file** will demonstrate that other funding sources were explored.

Outpatient Ambulatory/Health Services

Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Settings include clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits. Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category. Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Allowable activities include diagnostic testing (including HIV confirmatory and viral load testing), early intervention and risk assessment, preventive care and screening, physical examination, medical history taking, treatment and management of physical and behavioral health conditions, behavioral risk assessment, subsequent counseling, and referral, preventive care and screening, pediatric

developmental assessment, prescription and management of medication therapy, treatment adherence, education and counseling on health and prevention issues, and referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology. Primary medical care for the treatment of HIV includes the provision of care that is consistent with the U.S. Department of Health and Human Services guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
PLWH	Person(s) Living With HIV
USDHHS	United States Department of Health and Human Services

Units of Service

1 unit = 1 visitation of any duration

Service Components

STANDARD	MEASURE	DATA SOURCE
A. The program will ensure that clients have timely access to medical care.	**A.1.** The program has policies and procedures in place that address identifying new and established patients as having emergent, urgent, and acute needs.	**Program's Policies and Procedures** indicate how emergent, urgent, and acute needs are identified.
	A.2. The program has policies and procedures that facilitate timely, appropriate care determined by the level of need of the client.	**Program's Policies and Procedures** indicate how emergent, urgent, and acute needs are managed.
	A.3. The program will have availability to see new clients diagnosed with HIV within 30 days of referral or first contact.	**Program's Policies and Procedures** detail how new clients are accepted, processed, and scheduled.
B. Clients will have access to information about how to obtain care and health information.	**B.1.** The program should, at a minimum, inform the client about: • How to access emergency services; • How to schedule appointments; and • How to obtain laboratory or other diagnostic screening results.	**Program's Policies and Procedures** demonstrate how they educate patients on access to care and health information.
	B.2. The program will provide health literacy assistance, when necessary.	**Program's Policies and Procedures** demonstrate

		how they assess and address health literacy.
C. If a client is in need of inpatient care, the program must be able to refer or provide the client with inpatient care.	**C.1.** Outpatient programs that do not provide inpatient care will maintain referral relationships with other programs that provide inpatient care to PLWH.	**Program's Policies and Procedures** demonstrate the process by which clients are referred to inpatient care.
D. At baseline and through ongoing clinical evaluation and monitoring, the program will obtain a comprehensive HIV-related history, perform a comprehensive physical examination, and conduct relevant laboratory tests according to the USDHHS guidelines.	**D.1**. The program will obtain a comprehensive HIV-related history, perform a comprehensive physical exam, and conduct relevant laboratory tests according to USDHHS guidelines: https://aidsinfo.nih.gov/guidelines	**Client's File** contains a comprehensive HIV-related history, evidence of physical exams, and relevant laboratory results.
	D.2. The program will schedule regular client visits based on provider recommendation and according to the USDHHS guidelines: https://aidsinfo.nih.gov/guidelines	**Client's File** contains documentation of client visits and provider recommendation for frequency of client follow-up visits.
E. The program will assist the client with management of medication therapy and treatment adherence.	**E.1.** The program will have access to medication therapy and medication financial assistance programs, and prescribe medication based on the USDHHS guidelines: https://aidsinfo.nih.gov/guidelines	**Program's Policies and Procedures** outline access to medication therapy and medication financial assistance programs.
	E.2. The program will develop, implement, and monitor strategies to support treatment adherence and retention in care.	**Program's Policies and Procedures** outline strategies to support treatment adherence and retention in care.
F. If the client needs specialty care, the program must be able to refer them to a specialty care provider.	**F.1.** The program establishes and maintains relationships with specialty care providers. Specialty care providers can include clinical sub-specialties (i.e. cardiology, neurology, gynecology, etc.) and other services relevant to PLWH including substance use treatment, oral health, and case management.	**Program's Policies and Procedures** contain documentation of the process for making referrals to specialty care providers. **Client's File** indicates care coordination with or referral to specialty care provider.

G. The program will systematically assess retention of clients.	**G.1.** The program will use monitoring and outreach strategies for clients who have not received recommended care.	**Program's Policies and Procedures** outline strategies to outreach clients. **Client's File** indicates that the program used outreach strategies to attempt to reengage client in care.
	G.2. The program will outreach clients who have missed visits or who have not been seen for a medical follow-up according to the provider's recommendation.	**Program's Policies and Procedures** contains follow-up procedures that encourage client retention in medical treatment.

Psychosocial Support Services

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities funded under Psychosocial Support Services may include:

- Bereavement counseling;
- Child abuse and neglect counseling;
- HIV support groups;
- Nutrition counseling provided by a non-registered dietitian;
- Pastoral care/counseling services; and
- Support services may be provided by the program to increase participation in one-on-one or group sessions including food, transportation, or child care.

Funds under Psychosocial Support Services may not be used to provide nutritional supplements and social/recreational activities or to pay for a client's gym membership.

Definitions and Descriptions

Facilitator: A facilitator may be either a staff member or a group member, provided the group member has sufficient training and support.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ASL	American Sign Language
CDI	Certified Deaf Interpreter
HIV	Human Immunodeficiency Virus
LEP	Limited English Proficiency
RID	Registry of Interpreters for the Deaf
DHR	Denver HIV Resources

Units of Service

1 unit = 30 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
A. The program offers services to reduce the client's sense of social isolation, through either one-on-one sessions and/or group sessions.	**A.1.** The services offered will help the client to: • Develop and enhance social and communication skills; • Improve sense of self-efficacy; • Improve self-advocacy skills; • Improve coping skills; and • Reduce feelings of social isolation and stigma.	**Client's File** contains documentation of the encounter, topics discussed, and strategies used to reduce the client's sense of social isolation.
B. Psychosocial support group sessions will have established ground rules to guide behavior, discussion, and ensure a safe environment.	**B.1.** Facilitator(s) and session participants will develop and use ground rules, which at a minimum cover: • Confidentiality; • Safety; • Interpersonal relations; • Preferred communication styles; • Grievance procedures; • Description of session topic and purpose; and • Mandatory reporting, if applicable.	**Program's File** contain a copy of the ground rules with the sessions' records.
	B.2. Ground rules are in written form and verbally discussed at each session.	
C. Psychosocial support sessions may be open to PLWH regardless of whether they are current service recipients at the program providing the service.	**C.1.** Programs may permit attendance for PLWH not receiving Ryan White Part A services and affected individuals in need of social support. If an attendee does not currently receive other Ryan White Part A services, the program will determine attendee eligibility for Ryan White Part A services.	**Program's Policies and Procedures** demonstrate a process for determining client eligibility for attendees and how service utilization will be documented.
D. Psychosocial support services must be open to all eligible clients regardless of religious affiliation.	**D.1**. If the program provides pastoral counseling, it must be available to all eligible clients regardless of religious denominational affiliation.	**Program's Policies and Procedures** indicates that services are open to all eligible clients regardless of religious affiliation.
E. The program will refer clients to behavioral health services, medical case management, and/or other	**E.1.** The program will have a process for referring clients to programs that provide behavioral health services, medical case	**Program's Policies and Procedures** documents process of referring

core and support services, as appropriate.	management, and/or other core and support services.	clients to the appropriate services.
F. The structure, content and logistics of psychosocial support groups will be based on the clients' needs and interests identified through formative evaluation or group discussion.	**F.1.** To ensure groups are responsive to the needs of clients, the facilitator(s) and/or program should conduct formative evaluations or group discussions which consider the following: • Location; • Length of meeting; • Time of day; • Meeting frequency; • Minimum and maximum number of participants; • Topics of conversation; • Meeting content; • Meeting structure; • Ground rules; • Need for supplemental media or other resources to enhance content; • Need for transportation, food or child care; • If applicable, how to recruit new members; • If applicable, when and how to end the group, if no longer needed; and • Whether affected individuals and/or partners are permitted to attend the group sessions.	**Program's Files** contain formative evaluation findings or minutes of discussion on the group's structure, content, and logistics. These files must be made available to clients.
G. Programs may create up-to-date, medically accurate print or electronic media that supplement the services provided.	**G.1.** Medical information included in print or electronic media created by the program will be reviewed by a medical professional for accuracy.	**Program's Files** will contain electronic or hard copies of the media created that are signed and dated by the medical professional who reviewed them, and details about distribution including quantity and dates.
H. Facilitators will receive ongoing orientation, training, supervision and clinical supervision as applicable.	**H.1.** Facilitators will be given orientation prior to providing services.	**Program's Files** document orientation curriculum and evidence that the facilitators received training, for example a signed and dated sign-

		in sheet from an orientation session.
	H.2. All facilitators will be supervised by qualified program staff.	**Program's Policies and Procedures** documents how facilitators are supervised.
	H.3. The facilitator's supervisor routinely evaluates psychosocial services.	**Program's Files** contain signed and dated form that outlines responsibilities, obligations, and liabilities of each facilitator.
	H.4. Facilitators will receive training so they can help participants improve their communication skills, sense of self efficacy, self-advocacy, coping skills, and reduce feelings of social isolation and stigma. Trainings to be considered include: HIV 101; legal and ethical issues, including discrimination; facilitator self-care; referrals; stigma; boundaries; crisis management; safety; use of self; conflict management; coping skills; facilitation and group process; and communication skills.	**Program's Files** contain evidence of the facilitator's training, for example a training certificate.
I. It is recommended that sessions be facilitated by trained peer and trained professional. It is encouraged that facilitators be reimbursed for their time and at least one facilitator be living with HIV.	**I.1.** The facilitator(s) are culturally aware and have training or experience in group process, facilitation and communication skills.	**Personnel File** demonstrates facilitators' experience and/or training.

Substance Abuse Outpatient Care

Substance use services (outpatient) are medical or other treatment and/or counseling to address substance use problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel. They include limited support of auricular detox services to HIV-positive clients provided by registered, certified, or licensed practitioners and/or programs.

Funds used for outpatient drug or alcohol substance use treatment, including expanded HIV-specific capacity of programs if timely access to treatment and counseling is not available, must be rendered by a physician or provided under the supervision of a physician or other qualified/licensed personnel. Such services should be limited to the following:

- Pre-treatment/recovery readiness programs, such as, the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program;

- Harm reduction;
- Mental health counseling to reduce depression, anxiety and other disorders associated with substance use;
- Outpatient drug-free treatment and counseling;
- Medication Assisted Therapy (e.g., suboxone, buprenorphine, naloxone, methadone, naltrexone);
- Neuro-psychiatric pharmaceuticals;
- Relapse prevention; and
- Other evidence-based methods with evidence provided.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ASAM	American Society of Addiction Medicine
DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
OBH	Office of Behavioral Health, Colorado Department of Human Services

Units of Service

1 unit = individual or group session of 30 minutes or less

1 unit = methadone or other chemical treatment dispensing visit

1 unit = medical visit of 30 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Providers of substance use services must have the proper qualifications and expertise to deliver service.	**A.1.** In order to practice as a substance use counselor, one must qualify to perform the service under current Colorado mental health statutes, found here: https://sehd.ucdenver.edu/cpce-internships/files/2010/08/Statute.pdf Psychiatric services must be provided by a psychiatrist or a licensed psychiatric nurse practitioner, psychiatric physician's assistant, or addiction medicine providers.	**Personnel File** details staff qualifications.
	A.2. Standards of supervision will be in compliance with current Colorado mental health statutes, found here: https://sehd.ucdenver.edu/cpce-internships/files/2010/08/Statute.pdf	**Program's Policies and Procedures** indicate standards of supervision.

B. The program will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**B.1.** Therapeutic disclosure will be reviewed and signed by all clients. At a minimum, the disclosure must include: • Therapist's name, degrees, credentials, certifications, and licenses; • Business address and business phone; • OBH description and contact information; • Treatment methods and techniques; • Options for second opinion; • Option to terminate therapy at any time; • Statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to OBH; • Information about confidentiality and the legal limitations of confidentiality; and • Space for the client and therapist's signature and date.	**Client's File** contains a copy of the disclosure.
C. Treatment will be offered in a timely manner.	**C.1.** If the client is not in crisis, a scheduled treatment appointment will be offered within 5 business days from the time of first contact or referral. If the client is in crisis, they will be seen immediately or proper referrals will be made. During the waiting period, other harm reduction support services will be provided.	**Client's File** documents date of first contact or referral, and whether or not the client is in crisis.
D. A comprehensive evidence-based or best practices assessment shall be completed in a timely manner for each client.	**D.1.** The assessment will be completed upon admission and no later than seven business days after enrollment into services.	**Client's File** contains a comprehensive assessment.
	D.2. The assessment is completed in compliance with OBH regulations and ASAM criteria. https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8387&fileName=2%20CCR%20502-1 https://www.asam.org/resources/the-asam-criteria/about	**Client's File** contains a comprehensive assessment.
E. An initial service plan shall be developed with the client based on the comprehensive assessment.	**E.1.** The initial service plan will: • Identify the type, frequency, and duration of services for the client; • Address the immediate needs of the client; • Document referrals;	**Client's File** contains an initial service plan.

	• Be developed no later than 15 business days after the assessment, and signed by both the therapist and the client; and • Include specific, measurable, and attainable goals and objectives, with a realistic expected date(s) of achievement.	
	E.2. The service plan will demonstrate that the client will get HIV medical care as medically indicated.	**Client's File** contains service plan demonstrating client's connection to HIV medical care.
	E.3. If the initial or any subsequent service plan includes prescribing a medication that has the potential to interact with the client's HIV drugs, the reason for this decision is documented and a plan for monitoring the client's health is included in the service plan, if clinically indicated.	**Client's File** documents which, if any medications are prescribed and potential interactions with HIV drugs.
F. All service plans will be reviewed and updated on a regular basis.	**F.1.** Service plan revisions shall be completed and documented when there is a change in the client's level of functioning or service needs and no later than: • Medication assisted treatment: every 3 months; and • Outpatient: every 6 months.	**Client's File** documents revisions of the service plan.
	F.2. The service plan review shall include documentation of progress made in relation to planned treatment outcomes and any changes in the client's treatment focus.	**Client's File** documents revisions of the service plan.
G. The program must use evidence-based practices or care supported by empirical evidence.	**G.1.** The program uses evidence-based practices, including but not limited to: • Motivational Interviewing; • Cognitive Behavioral Therapy; • Harm Reduction; • Relapse Prevention; • Trauma-Informed Treatment; and • Psychoeducation.	**Program's Policies and Procedures** documents which practices are implemented.
H. Referrals made to services related to the service plan shall be made in a timely manner and documented.	**H.1.** Referrals to qualified practitioners and/or services will occur, if clinically indicated. If the client is in immediate crisis, they will be seen immediately, or proper referrals will be made.	**Client's File** contains documentation of any referrals.
I. Progress notes shall be completed after every contact with the client.	**I.1.** Progress notes should be a written chronological record, documented after every contact with the client.	**Client's File** contains progress notes.
	I.2. Progress notes should document:	

	• Any change in physical, behavioral, cognitive, and functional condition; • Action taken by program staff to address the clients changing needs; and • An assessment of the client's adherence to substance use treatments.	
	I.3. Progress notes shall be signed and dated by the author at the time they are written, with at least a first initial, last name, degree and/or professional credentials.	
J. The program, at least once yearly, will assess client adherence to SAO medications, SAO appointments, HIV medical appointments and HIV medications.	**J.1.** The program will document adherence to SAO and HIV medical appointments that are provided by the program and by other providers.	**Client's File** contains documentation of scheduled appointments and attendance.
	J.2. The program will document which SAO and HIV medications they prescribe to the client, adherence to the medication schedule, and whether the client's substance use impacts medication adherence.	**Client's File** contains documentation of HIV medications and adherence.
K. Upon termination of active substance use services, a client case is closed and contains a closure summary documenting the case disposition.	**K.1.** Closure summaries shall be completed within thirty business days after closure and documented in progress notes. Records shall contain a written closure summary to include, but not limited to the following information where applicable: • Reason for admission; • Reason for closure; • Primary and significant issues identified during course of services; • Diagnoses; • Summary of services, progress made, and outstanding concerns; • Coordination of care with other service providers; • Advance directives developed or initiated during course of services; • Summary of medications prescribed during treatment, including the client's response(s) to the medications; • Documentation of referrals and recommendations for follow-up care; and	**Client's File** contains copy of closure summary, if patient's case has been closed.

	• Information regarding the death of the client.	

CARES Act Supplemental Funding Allowable Costs

On Wednesday, April 15, 2020, HHS through HRSA awarded $90 million for Ryan White HIV/AIDS Program (RWHAP) recipients to prevent, prepare for, and respond to coronavirus disease 2019 (COVID-19). This funding is provided by the fiscal year 2020 Coronavirus Aid, Relief and Economic Security (CARES) Act, which President Trump signed into law on Friday, March 27, 2020.

This funding supports 581 Ryan White HIV/AIDS Program recipients across the country, including city/county health departments, health clinics, community-based organizations, state health departments, and AIDS Education and Training Centers, in their efforts to prevent or minimize the impact of this pandemic on people with HIV.

The Denver TGA Ryan White Part A program was awarded $540,961 in additional funding, and the allocation for this funding was approved by the Denver HIV Resources Planning Council on Thursday, May 7, 2020 with the following allocation:

Service Category	Percent Allocation	Dollar Amount Allocation
Emergency Financial Assistance	25%	$127,466
Housing Services	25%	$127,466
Outpatient Ambulatory Health Services	35%	$178,749
Food Assistance	7%	$35,690
Behavioral Health	8%	$40,494
Total Service Allocation	100%	$509,865
DHR Admin	6%	$31,096
Total Award	100%	$540,961

FY2020 CARES Act Supplemental Funding Allowable Costs:
Please follow these links for more information about CARES Act supplemental funding allowable costs:
FY2020 CARES Act Funding for Ryan White HIV/AIDS Program Recipients
Examples of Allowable Uses of Funds – Prevent, Prepare, Respond
Examples of CARES Act Supplemental Funding Uses by Service Category
CARES Act Funding Frequently Asked Questions (FAQ)

EXHIBIT G

CLINICAL QUALITY MANAGEMENT PLAN TEMPLATE

RWHAP Part A Clinical Quality Management (CQM) Plan Template		
Provider Name: Click or tap here to enter text.	**Program Quality Lead:** Click or tap here to enter text.	**Last Updated:** Click or tap to enter a date.
Part A Funded Service Categories:	Core Medical ☐ Early Intervention Services ☐ Medical Case Management ☐ Mental Health ☐ Oral Health ☐ Outpatient Ambulatory Health Services ☐ Substance Abuse Outpatient ☐ Other: Click or tap here to enter text.	Support Services ☐ Emergency Financial Assistance ☐ Housing Services ☐ Food Bank/Home Delivered Meals ☐ Psychosocial Support Services ☐ Transportation ☐ Other Professional Services ☐ Linguistic Services ☐ Other: Click or tap here to enter text.

Clinical Quality Management Priorities for the Denver TGA
Sub-recipient Clinical Quality Plans must address the following priorities addressed in the CQM Plan for the Denver TGA
1. **Access, Engagement, and Retention in Healthcare:** Plans must address how Ryan White Part A Funded services support a client's active involvement with their healthcare. 2. **Health Outcomes:** Plans must address how Ryan White Part A funded services support a client's viral suppression and other health and wellness goals including medication adherence. 3. **End Disparities Efforts:** Plans must describe how Ryan White Part A funded services impact the following communities' access to and engagement with services and treatment. The communities are Transgender, MSM of Color, African American and Latina Women, and Youth ages 13-24. 4. **Client Experience and Satisfaction:** Plans must describe efforts and to understand clients' experience with Ryan White Part A funded services and their satisfaction with those services.

Quality Statement
Describe the ultimate goal of the clinical quality management program
Click or tap here to enter text.

Quality Infrastructure
Describe how leadership guides, endorses, and champions the clinical quality management program
Click or tap here to enter text.
Describe who serves on the quality management committee, who chairs and facilities the meetings, how often the quality management committee meets, and the purpose of the quality management committee
Click or tap here to enter text.
Describe the staff positions responsible for developing and implementing the clinical quality management program and related activities including the role of contractors funded to assist with the clinical quality management program
Click or tap here to enter text.
Describe who writes, reviews, updates, and approves the quality management plan
Click or tap here to enter text.

Describe how people l with Hare involved in the development and implementation of the clinical quality management program
Click or tap here to enter text.
Describe how the effectiveness of the clinical quality management program is evaluated
Click or tap here to enter text.

Quality Improvement
Address patient care, health outcomes, ending disparities, and patient satisfaction in quality improvement activities.
Click or tap here to enter text.
Describe the quality improvement approach or methodology used (e.g. Model for improvement/PDSA, Lean, etc.).
Click or tap here to enter text.
Click or tap here to enter text.

Work Plan (Description)
Provide a thorough overview of implementation, including timelines, milestones, and accountability for all clinical quality management program activities outlined in the quality management plan.
Click or tap here to enter text.
Describe how the work plan will be shared/communicated with all stakeholders, including staff, consumers, board members, parent organizations, other grant recipients, funders, etc.
Click or tap here to enter text.

Work Plan (Matrix)			
Activities	Timeline	Responsible Staff Person	Outcomes
	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

EXHIBIT H

CLINICAL QUALITY MANAGEMENT PLAN SUMMARY TEMPLATE

RWHAP Part A Clinical Quality Management (CQM) Plan Summary Template		
Provider Name: Click or tap here to enter text.	**Program Quality Lead:** Click or tap here to enter text.	**Last Updated:** Click or tap to enter a date.
Part A Funded Service Categories:	Core Medical ☐ Early Intervention Services ☐ Medical Case Management ☐ Mental Health ☐ Oral Health ☐ Outpatient Ambulatory Health Services ☐ Substance Abuse Outpatient ☐ Other: Click or tap here to enter text.	Support Services ☐ Emergency Financial Assistance ☐ Housing Services ☐ Food Bank/Home Delivered Meals ☐ Psychosocial Support Services ☐ Transportation ☐ Other Professional Services ☐ Linguistic Services ☐ Other: Click or tap here to enter text.

Clinical Quality Management Priorities for the Denver TGA
Sub-recipient Clinical Quality Plans must address the following priorities addressed in the CQM Plan for the Denver TGA
1. **Access, Engagement, and Retention in Healthcare:** Plans must address how Ryan White Part A Funded services support a client's active involvement with their healthcare. 2. **Health Outcomes:** Plans must address how Ryan White Part A funded services support a client's viral suppression and other health and wellness goals including medication adherence. 3. **End Disparities Efforts:** Plans must describe how Ryan White Part A funded services impact the following communities' access to and engagement with services and treatment. The communities are Transgender, MSM of Color, African American and Latina Women, and Youth ages 13-24. 4. **Client Experience and Satisfaction:** Plans must describe efforts and to understand clients' experience with Ryan White Part A funded services and their satisfaction with those services.

Current State
Describe the current state of your clinical quality management program and improvement projects
Click or tap here to enter text.

Challenges
Describe the current challenges of your clinical quality management program and improvement projects
Click or tap here to enter text.

Successes
Describe the current successes of your clinical quality management program and improvement projects
Click or tap here to enter text.

Quality Statement
Describe the ultimate goal of the clinical quality management program
Click or tap here to enter text.

EXHIBIT I

RYAN WHITE PART A SELF ATTESTATION / NO CHANGE FORM

HIV RESOURCES
DENVER PUBLIC HEALTH & ENVIRONMENT

Denver TGA Ryan White Part A
Self-Attestation/No Change Form

Name: _____ **Birth Date:** _____

For Administrative Use Only:
eURN: _____ Start Date: _____ End Date: _____

New Ryan White Eligibility:
Case Manager/ Eligibility Specialist Name: _____

RESIDENCY

Since your Annual Certification six months ago, have you moved/changed residence?

☐ No, my address has not changed.
☐ Yes, my address has changed. *(Please provide new Denver TGA residency documentation)*

HOUSEHOLD SIZE

Since your Annual Certification six months ago, has your household size changed? Household size helps to determine overall income, which affects Ryan White eligibility.

☐ No, there is no change in my household size.
☐ Yes, my household size has changed. *(Please provide new household size)*

INCOME

Since your Annual Certification six months ago, has your income changed?

☐ No, my income has remained the same.
☐ Yes, my income has changed. *(Please provide new income documentation)*

HEALTH INSURANCE

Since your Annual Certification six months ago, has your insurance status changed?

☐ No, there is no change in my insurance status.
☐ Yes, my insurance status has changed. *(Please provide new health insurance documentation)*

Since your Annual Certification six months ago, have you become eligible for employer insurance, or marketplace insurance, or Medicaid, or Medicare?

☐ No, there has been no change in insurance eligibility
☐ Yes, I have become eligible for health insurance *(Please provide new health insurance documentation)*

AGREEMENT

I fully understand that by participating in this program, I am divulging personal information that will be used to assist me with benefits associated with the Denver Ryan White Part A program. I understand this information will be kept confidential but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify all eligibility information provided.

I fully acknowledge:

1. **It is my responsibility to renew my eligibility every six (6) months.**
2. **It is my responsibility to report any changes to my household income, my address, my contact information, my health insurance, or any other information that may affect my eligibility or services.**
3. **If I fail to recertify, my participation in Ryan White Part A funded services may be limited.**

I certify that the information provided in this application is true and accurate as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in my inability to receive Ryan White Part A funded services.

Printed Name	Signature	Date