FOURTH AMENDATORY AGREEMENT

This **FOURTH AMENDATORY AGREEMENT** is made between the **CITY AND COUNTY OF DENVER**, a home rule and municipal corporation of the State of Colorado (the "City") and **COLORADO HEALTH NETWORK, INC.**, a Colorado nonprofit corporation, whose address is 6260 East Colfax Avenue, Denver, Colorado 80220 (the "Contractor"), jointly ("the Parties").

RECITALS:

A. The Parties entered into an Agreement dated May 19, 2023, an Amendatory Agreement dated November 14, 2023, a Second Amendatory Agreement dated March 15, 2024, and a Third Amendatory Agreement dated January 31, 2025, (collectively, the "Agreement") to perform, and complete all of the services and produce all the deliverables set forth on Exhibit A, the Scope of Work, to the City's satisfaction.

B. The Parties wish to amend the Agreement to increase maximum contract amount, add new paragraph 4 (d) (3), updated paragraph 6-Termination, amend the scope of work exhibit, amend the budget exhibit, amend the Subrecipient financial administration exhibit, amend the CMC Service Standards exhibit, amend Federal Provisions exhibit, add Exhibit H, Notice of Award, and update the exhibit list.

NOW THEREFORE, in consideration of the premises and the Parties' mutual covenants and obligations, the Parties agree as follows:

1. Section 4 of the Agreement entitled "**COMPENSATION AND PAYMENT**:" subsection d. (1) entitled "**Maximum Contract Amount:**" is hereby deleted in its entirety and replaced with:

"**d. Maximum Contract Amount:**

(1) Notwithstanding any other provision of the Agreement, the City's maximum payment obligation will not exceed **SIX MILLION FOUR HUNDRED SIX THOUSAND FOUR HUNDRED TWENTY-TWO DOLLARS AND NO CENTS ($6,406,422.00)** (the "Maximum Contract Amount"). The City is not obligated to execute an Agreement or any amendments for any further services, including any services performed by

Contractor beyond that specifically described in **Exhibit A**. Any services performed beyond those in **Exhibit A** are performed at Contractor's risk and without authorization under the Agreement."

2. Section 4 of the Agreement entitled "**COMPENSATION AND PAYMENT**:" subsection d. "**Maximum Contract Amount:**", sub-subsection **(3)** is hereby added to the Agreement as follows:

"**(3)** The Contractor further understands that this Agreement is funded, in whole or in part, with federal funds as set forth in a federal financial assistance award, attached as **Exhibit H, Notice of Award**. The Contractor expressly understands and agrees that its rights, demands, and claims to compensation arising under this Agreement are contingent upon the City's actual receipt of such federal funds and the continued funding by the federal government. If such funds or any part thereof are not received, appropriated, or allocated by the City, the City and the Contractor may mutually amend the Agreement, or the City may unilaterally terminate this Agreement. If the federal government terminates the federal financial assistance awards, disallows the costs associated with this Agreement, or otherwise reduces the funds awarded or actually paid to the City under, the City reserves the right to make any necessary reductions to this Agreement.

3. Section 6 of the Agreement entitled "**TERMINATION**:" is hereby deleted in its entirety and replaced with:

"6: TERMINATION/ NOTICE TO STOP:

a. The City has the right to terminate the Agreement with cause upon written notice effective immediately, and without cause upon ten (10) days prior written notice to the Contractor. However, nothing gives the Contractor the right to perform services under the Agreement beyond the time when its services become unsatisfactory to the Executive Director or when it receives notice of termination.

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, kickbacks, 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. Upon termination of the Agreement, with or without cause, the

Contractor shall have no claim against the City by reason of, or arising out of, incidental or relating to termination, except for compensation for work duly 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".

e. The City has the right to issue a Notice to Stop Work ("Notice to Stop Work") if the City has reason to believe, in its sole discretion, that the federal funds for this Agreement are not available, delayed, or withheld for any reason. Upon receiving a Notice to Stop Work, the Contractor shall cease all work under the Agreement immediately, or within the time set forth in the Notice. Contractor shall submit an invoice for all outstanding work as soon as possible, but no later than fifteen (15) days after the date of the Notice to Stop Work or as directed in the Notice. The Contractor shall not resume work under the Agreement until it receives a Notice to Proceed ("Notice to Proceed") from the City. A Notice to Stop Work does not terminate the Agreement."

4. **Exhibit A, Exhibit A-1, Exhibit A-2,** and **Exhibit A-3** are hereby deleted in their entirety and replaced with **Exhibit A-4, Scope of Work**, attached and incorporated by reference herein. All references in the original Agreement to **Exhibit A, Exhibit A-1, Exhibit A-2,** and **Exhibit A-3** are changed to **Exhibit A-4**.

3. **Exhibit B**, **Exhibit B-1, Exhibit B-2, Exhibit B-3** are hereby deleted in their entirety and replaced with **Exhibit B-4, Budget**, attached and incorporated by reference herein. All references in the original Agreement to **Exhibit B**, **Exhibit B-1, Exhibit B-2, Exhibit B-3** are changed to **Exhibit B-4**.

4. **Exhibit D, Exhibit D-1, Exhibit D-2 are** hereby deleted in its entirety and replaced with **Exhibit D-3, Subrecipient Financial Administration**, attached and incorporated by reference herein. All references in the original Agreement to **Exhibit D** are changed to **Exhibit D-3**.

5. **Exhibit E** and **Exhibit E-1** are hereby deleted in their entirety and replaced with **Exhibit E-2, CMC Service Standards**, attached and incorporated by reference herein. All references in the original Agreement to **Exhibit E** and **Exhibit E-1**are changed to **Exhibit E-2**.

6. **Exhibit G** is hereby deleted in its entirety and replaced with **Exhibit G-1, Federal Provisions**, attached and incorporated by reference herein. All references in the original Agreement to **Exhibit G** are changed to **Exhibit G-1**.

7. **Exhibit H**, **Notice of Award**, is hereby added to the Agreement, attached and incorporated by reference herein.

8. The **Exhibit List** is hereby deleted in its entirety and is replaced as follows:

"Exhibit List:
Exhibit A-4 – Scope of Work.
Exhibit B-4 – Budget.
Exhibit C-2 – Certificate of Insurance.
Exhibit D-3 –Subrecipient Financial Administration.
Exhibit E-2 – CMC Service Standards.
Exhibit F-1 – Program Income Guidelines.
Exhibit G-1 – Federal Provisions.
Exhibit H - Notice of Award."

9. As herein amended, the Agreement is affirmed and ratified in each and every particular.

10. This Fourth Amendatory Agreement will not be effective or binding on the City until it has been fully executed by all required signatories of the City and County of Denver, and if required by Charter, approved by the City Council.

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK.]

Contract Control Number: ENVHL-202578474-04 [202368045-04]
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-202578474-04 [202368045-04]
Contractor Name: Colorado Health Network, Inc.

By: Signed by: Darrell Vigil F026B8BCAFB94E3... _____

Name: Darrell Vigil _____
(please print)

Title: Chief Executive Officer _____
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

DENVER PUBLIC HEALTH & ENVIRONMENT

EXHIBIT A-4
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 **$1,455,453.00** in Fiscal Year (FY) 2025 (March 1, 2025 – February 28, 2026).
- The Maximum includes a Phase I Initial Authorized Amount of $450,652.00 that may be expended upon execution of the contract, and a Phase II amount of $1,004,801.00 that may be expended only upon receiving a Notice to Proceed from DDPHE as set forth in the Agreement.

Note: Total Contract Value, $6,406,422.00, 03/01/2023 – 02/28/2026.

- Year 1 (03/01/2023-02/29/2024), Amount: $2,483,920.00
- Year 2 (03/01/2024-02/28/2025), Amount: $2,467,049.00
- Year 3 (03/01/2025-02/28/2026), Amount: $1,455,453.00

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. 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 is attached as **Exhibit E-2** and will be updated each fiscal year on an as-needed basis with each fiscal year's updated version as the Service Standards to be followed. The updated version of the Service Standards will be provided by DDPHE and shall be

effective immediately without requiring an amendment to the Agreement.

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	Phase I: FY2025 Initial Authorized Amount based on NoA Received	Phase II: FY2025 Amount Available Once Notice to Proceed is Given by DDPHE* (based on LOI)	Total FY2025 Award (Phase I + Phase II) Pending Receipt of Additional NoA**
Case Management Continuum	RW Part A	$96,233.00	$214,565.00	$310,798.00
Emergency Financial Assistance	RW Part A	$66,476.00	$148,220.00	214,696.00
Food Bank/Home Delivered Meals	RW Part A	$24,947.00	$55,624.00	$80,571.00
Housing Services	RW Part A	$66,590.00	$148,472.00	$215,062.00
Mental Health Services	RW Part A	$9,173.00	$20,453.00	$29,626.00
Medical Transportation Services	RW Part A	$17,276.00	$38,521.00	$55,797.00
Outpatient / Ambulatory Health Services	RW Part A	$21,630.00	$48,226.00	$69,856.00
Oral Health Care	RW Part A	$102,501.00	$228,544.00	$331,045.00
Oral Health Fund	RW Part A	$23,823.00	$53,116.00	$76,939.00
Other Professional Services	RW Part A	$7,260.00	$16,188.00	$23,448.00
Psychosocial	RW Part A	$7,689.00	$17,143.00	$24,832.00

Support Services				
Substance Abuse Outpatient Care	RW Part A	$7,054.00	$15,729.00	$22,783.00
Total Award Amounts		**$450,652.00**	**$1,004,801.00**	**$1,455,453.00**

* Contractor shall not expend or obligate Phase II funds unless DDPHE issues a Notice to Proceed as set forth in the Agreement.
** Reimbursement of all amounts is contingent upon the City's receipt of the funds from the federal sponsor, HRSA.

III. Case Management Continuum (CMC) Requirements

A. Contractors will be required to follow the CMC Service Standards **(Exhibit E-2)**
B. Contractors who are funded for CMC services will also help clients apply for Emergency Financial Assistance, Housing Assistance, Oral Health Fund, and Legal Assistance Fund to clients.
C. Contractors who are funded for CMC services will offer all four tiers of the Case Management Continuum (Medical Case Management, Non-Medical Case Management, Care Navigation, and Referral Services)
D. Contractors funded for CMC services will be required to report the number of clients served in each tier of service, as well as the number of service units. Reporting acuity of clients served will also be required. Contractors will include acuity in their monthly data collection.
E. Contractors will be required to participate in all trainings related to the Case Management Continuum.
F. Contractors' staff who are supervisors, managers, and organizational leaders are required to participate in supervisor/leadership trainings provided by DHR.

IV. Invoices and Schedule of Payments for Services

A. Within 45 days of when the contract is executed, invoices for all service months completed before the execution date are due. Subsequent invoices will be due on the 15th of the second month after the end of the billing period (e.g. September invoice due by November 15th, December invoice due by February 15th, etc.). The final invoice must be submitted by April 15th, 2026.
- Invoice totals will be based on Phase I: FY2025 Initial Authorized Amount listed above and in Exhibit B-4

Budget, until formal Notice to Proceed is received from DDPHE that states that Phase II: FY2025 Amounts can be invoiced.

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. Updated invoice forms are provided upon contract execution. A complete invoice package will include the following: a complete invoice template, backup documentation including receipts, payroll printouts, and any supporting documentation needed for all expenses listed on the invoice.

D. Complete invoice packages are due to DDPHE HIV Resources at HIVInvoiceIntake@denvergov.org. 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 D-3**.

E. The Contractor will complete a 30-day Contingency Plan which will detail a strategy to manage the Ryan White Part A program in the event that there are gaps in funding or if funding is discontinued.

- 30-day Contingency Plan due within 5 days of contract execution.

V. 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 D-3** 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.

VI. Administrative Cost Limit

The Contractor's total administrative costs cannot exceed **10%** of the maximum direct costs 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.

VII. Budget

A. Contractor shall submit a complete budget package using required DDPHE HIV Resources budget forms. The budget for this agreement is attached as **Exhibit B-4**.

VIII. Budget Modifications

A. Contractor may submit budget modifications to DDPHE for review and approval based on policies established in the Subrecipient Financial Administration attached as **Exhibit D-3**. Approval of such request is based on the discretion of the DDPHE Executive Director or his/her designee.

IX. Performance Management and Reporting

A. Performance Management
Monitoring will be performed by the DDPHE HIV Resources staff. Contractor will be reviewed for:

DENVER PUBLIC HEALTH & ENVIRONMENT

EXHIBIT A-4
SCOPE OF WORK

1. **Program Monitoring*:** Review and analysis of current program information to determine the extent to which contractors are achieving established contractual goals.
2. **Fiscal Monitoring*:** Review financial systems and billings to ensure that contract funds are allocated and expended in accordance with the terms of the agreement.
3. **Program Income.** DDPHE requires subrecipients to be able to report, upon request, 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. The Program Income Guidelines are attached as **Exhibit F-2**.

4. **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 DDPHE 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/library/rsr-manual and/or requirements subject to change by HRSA 2. Contractor may enter client- level data into CAREWare using two different methodologies: Direct manual data entry via the CAREWare	Manual Data Entry Provider: 15th of each month PDI: 25th of each month	Into CAREWare system

DENVER PUBLIC HEALTH & ENVIRONMENT

EXHIBIT A-4
SCOPE OF WORK

	interface; or Provider Data Import (PDI).		
2). Ryan White Part A Service Report (RSR)	Includes, but is not limited to: 1. Data input throughout the year 2. Review finalized CY2024 RSR report with DHR 3. Generate client-level XML (Extensible Markup Language) file for CY2024 and upload into the HRSA Web Application (per HRSA requirement) 4. Submit CY2024 RSR report into HRSA Web Application 5. Run Contractor RSR reports to clean existing data and/or input missing data with technical assistance from DHR	1. Due each month 2. Due by March 20, 2025 3. Due by March 20, 2025 4. Due March 27, 2025 5. Due by February 28, 2026	Into CAREWare system for data entry Into HRSA Web Application for RSR final reporting
3). Other reports, data, or processes as requested by the City	To Be Determined (TBD)	TBD	TBD

X. 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 State Drug Assistance Program (SDAP) surrogate data eligibility whenever said data is available in CAREWare to reduce barriers to care for Ryan White Part A clients.

XI. Required Acknowledgement and Disclaimer Language

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

EXHIBIT A-4
SCOPE OF WORK

"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.

Exhibit B-4
Budget

Colorado Health Network, Inc.

	Budget Category		
Service Category	*Phase I: FY2025 Initial Authorized Amount based on NoA Received*	*Phase II: FY2025 Amount Available Once Notice to Proceed is Given* (based on LOI)*	*Total FY2025 Award (Phase I + Phase II) Pending Receipt of Additional NoA***
CCS	$0.00	$0.00	$0.00
CMC-A	$96,233.00	$214,565.00	$310,798.00
CMC-M	$0.00	$0.00	$0.00
EIS-A	$0.00	$0.00	$0.00
EIS-M	$0.00	$0.00	$0.00
EFA	$66,476.00	$148,220.00	$214,696.00
FBM	$24,947.00	$55,624.00	$80,571.00
HS	$66,590.00	$148,472.00	$215,062.00
LS	$0.00	$0.00	$0.00
MHS-A	$9,173.00	$20,453.00	$29,626.00
MHS-M	$0.00	$0.00	$0.00
MTS	$17,276.00	$38,521.00	$55,797.00
OAH	$21,630.00	$48,226.00	$69,856.00
OHC	$102,501.00	$228,544.00	$331,045.00
OHF	$23,823.00	$53,116.00	$76,939.00
OPS	$7,260.00	$16,188.00	$23,448.00
PSS-A	$7,689.00	$17,143.00	$24,832.00
PSS-M	$0.00	$0.00	$0.00
SU-A	$7,054.00	$15,729.00	$22,783.00
SU-M	$0.00	$0.00	$0.00
Total	$450,652.00	$1,004,801.00	$1,455,453.00**

TOTAL CONTRACT PERIOD 03/01/2023 - 02/28/2026	**Contract Amount**	**Total Maximum Amount with each Addition**
Original Contract 03/01/2023 – 02/28/2024	$429,920.00	$429,920.00
Amendment 01 03/01/2023 – 02/29/2024	$2,054,000.00	$2,483,920.00
Amendment 02 03/01/2024 – 02/28/2025	$1,453,564.00	$3,937,484.00
Amendment 03 03/01/2024 – 02/28/2025	$1,013,485.00	$4,950,969.00
Amendment 04 03/01/2025 – 02/28/2026	$1,455,453.00**	$6,406,422.00**
TOTAL MAXIMUM AMOUNT		**$6,406,422.00****

***Phase II amounts shall not be expended unless notice to proceed is received from DDPHE.**
****Total reimbursement is contingent upon receipt of funds by DDPHE from Federal Sponsor, HRSA.**

Exhibit D-3

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. Invoice totals will be based on Phase I: FY2025 Initial Authorized Amount listed in Exhibit B-4 Budget, until formal Notice to Proceed is received from DDPHE that states that Phase II: FY2025 Amounts can be invoiced.

v. 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.

vi. 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. Include documentation of staff time attributed to Ryan White Part A (for example, time sheets or time and effort reports).

ii. Personnel Benefits – A schedule of benefits can be submitted once at the beginning of the fiscal year. Include documentation of personnel benefit costs with each invoice (for example, payroll journal or paystub).

iii. Consultants – Consultant invoice that reflects the job performed, rate, and hours.

iv. Contractual Expenses – Invoice from the sub-contractor that details the work and payment arrangements specified in the sub-contractual agreement and that all are properly approved by the Contractor.

v. Supplies/Equipment/Other Direct Costs – Copies of vendor invoices for all supply purchases or receipt(s). If sales tax is included on the invoice or receipt, demonstrate that the sales tax was not included

in the invoice to DDPHE (for example, general ledger reports can be used to show this).

vi. **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 not permitted.

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. No cash incentives for clients are allowed. Gift card incentives are allowed – documentation must be kept of what the gift card is for (for example, King Soopers), who it is given to, by whom it was given, and which date it was distributed. Gift cards may not be in the form of a pre-paid credit card or redeemable for cash. Gift card incentives must not be used to purchase alcohol, tobacco, illegal drugs, or firearms.
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 (including sales tax)
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 at least three (3) documented quotations be secured for all purchases or services (including insurance) supplies, or other property that costs more than ten thousand dollars ($10,000) 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 (Program Income)

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 Part A 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.

v. The contractor must provide tracking and documentation of program income derived from Ryan White Part A funded services and the use of such funds upon request. Review of program income tracking and documentation will occur at annual site visits.

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.

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 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 DDPHE to payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White Part A 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 E-2

DENVER HIV RESOURCES PLANNING COUNCIL

HIV RESOURCES
DENVER PUBLIC HEALTH & ENVIRONMENT

FY 2025
Service Standards

Ryan White Part A Denver TGA

Revised
January 2024 – January 2025
Approved by DHRPC
February 2025

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Introduction

This Service Standards document was prepared by Denver HIV Resources (**DHR**) with opportunities for community input and is regularly reviewed by the Denver HIV Resources Planning Council (**DHRPC**) 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 providers are expected to meet when providing HIV care and support services funded by the Ryan White Denver TGA. Providers may exceed these standards. Service Standards are tied to multiple processes throughout the Part A system and changes reverberate throughout the entire system.

Providers are expected to offer effective, equitable, understandable, and respectful quality services that are responsive to diverse experiences, cultural beliefs and practices, languages, learning styles, communication needs, and health literacy levels.

Denver HIV Resources – Part A provider, in partnership with CDPHE, acknowledges that racial, social, economic, and environmental inequities result in adverse health outcomes and have a greater impact than individual choices. Reducing health inequities through systematic change can help improve opportunities for all Coloradans. Ending the epidemic requires us to examine our current HIV service delivery system with the goal of eliminating policies, practices, ideas, and behaviors that do not support equity and allow for service provision that is culturally and linguistically appropriate. Providers should be culturally humble and utilize the strengths of the participants they serve.

This document should be viewed as fluid. The document may change based on Health Resources and Services Administration (**HRSA**) and HIV/AIDS Bureau (**HAB**) requirements, the needs of people living with HIV/AIDS in the TGA, and the effectiveness of the services offered by providers. In order to remain responsive, it is imperative that providers, community members, and people living with HIV notify DHR and DHRPC when changes or challenges occur that may impact the relevance and efficiency of this document, or the services provided.

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
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
PLHIV	Person(s) Living with HIV
PVD	Peripheral Vascular Disease
RID	Registry of Interpreters for the Deaf
ROI	Release of Information
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
SDAP	State Drug Assistance Program (formerly known as “ADAP”)
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. 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. Provider maintains and disseminates to clients: written client rights and responsibilities.	**A.1.** Clients are informed of rights and responsibilities through the following: • Discussing document with client; • Client will be offered a copy (electronic or hard copy) but may decline; • Client signature of client confirming review and receipt annually; • Posting in a visible location.	**Client's File** contains a signed copy of the client's Rights and Responsibilities. An electronic signature is acceptable.
	A.2. Client Rights and Responsibilities includes, at a minimum: • The client's expectations of the provider providing services; • Clients are able to access their file and have been informed of how to request access; • The client's right to file a grievance (see **Standard B below**); • The client's right to receive services that are provided in an affirming, inclusive, and accessible environment; • Adding: language access, transportation, etc. • The client's right to receive no-cost interpreter services;	**Program's Policies and Procedures** contains Client Rights and Responsibilities form.

	• The reasons for which a client's case may be closed/inactivated from services, including due process for involuntary closure/inactivation; • The provider expectations of the client as a participant of services • Available in at least English and Spanish.	
B. Provider maintains and disseminates to clients a written policy for how clients can submit compliments, concerns, and complaints (grievance policy).	**B.1.** Providers will inform client of grievance policies and procedures through: • Discussing document with client; • Client will be offered a copy (electronic or hard copy) but may decline; • Client signature of client confirming review and receipt annually • Posting in a visible location	**Client's File** contains a signed copy. An electronic signature is acceptable.
	B.2. Grievance policy to include, at a minimum: • How a client can submit compliments, concerns, and complaints; • How a client can submit concerns or complaints anonymously, • A variety of different options for submitting concerns and complaints (in-person, phone, written, email, etc.) • How submissions will be handled; • What the timeline will be for a client to receive follow up (max. of 14 days following submission of concern, complaint, or grievance)	**Program's Policies and Procedures** have a process for clients to provide compliments, concerns, and complaints (grievance policy). Program has process for collecting complaints, concerns, and/or compliments outside of formal grievance procedure. Concerns or complaints are a less formal process. Grievances will typically follow a formal internal grievance procedures.

	• Include steps that precede a formal grievance such as a conflict resolution process; • The client can submit a comment, concern, compliment and/or grievance to DDPHE/CDPHE via phone, text, email, or online form. • Available in at least English and Spanish.	
	B.3. Providers must review the grievance policy and procedure annually and update as appropriate.	**Provider's Policies and Procedures** include a grievance policy and procedure for review.
	B.4. Providers are responsible for notifying DHR and CDPHE of any formal grievance filed against the provider by a client seeking Ryan White services. Grievances must be reported to DHR at least quarterly and must be submitted to DHR and CDPHE with confidential information redacted as necessary.	**Provider's Reports** document grievances, including any corresponding documentation as submitted by the client, and the outcome of the grievance. Providers will make available at the DHR and CDPHE Site Visit any other concerns or complaints that have been submitted outside of the formal grievance procedure.
C. Clients are notified about the reasons they are being involuntarily discharged, the process for which discharge is determined, as referrals and support transitioning to other service providers.	**C.1.** Communication to client must include: • reasons they are being involuntarily discharged; • the process for which discharge is determined; • referrals and support transitioning to other service providers If suspension if temporary or permanent and what steps a client would need to take to reengage. Provider will also provide to DHR in the quarterly report a narrative of any customer service-related issues.	**Provider's Policies and** **Procedures** show the process for involuntary discharges and how clients are notified. **Provider** to report to DHR within 10 days that an involuntary discharge has occurred and the supporting documentation. **Client Files** will document discharge process, referrals made, transition support provided, and how and when client can reengage in services.

II. Confidentiality

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

STANDARD	MEASURE	DATA SOURCE
A. Providers will work with client, to identify their communication preferences, at least annually.	**A.1.** Agency will create and disseminate a mode of communication preference document.	**Client's File** will indicate how the client would prefer to be contacted.
B. Provider utilizes Client Release of Information (ROI) form which also describes under what circumstances client information can be released.	**B.1.** Clients are informed of Release of Information process and what is included at the time of signing an ROI. This should include: • Documentation of signed release of information prior to release of records (either electronic or written). ROI must be available in English and in Spanish.	**Client's File** contains a signed release of information form with all required elements appropriate to the services provided and information needed.
	B.2. There must be signed and dated ROI prior to the release or exchange of any information. Clients can determine which specific information is included or not included. Form must specify HIV, TB, STI, substance use, mental health and any other confidential information that is needed to provide the service.	**Client's File** contains a signed release of information form with all required elements appropriate to the services provided and information needed.
C. Providers shall have written policies and procedures addressing client confidentiality, privacy, and the use of a release of information form.	**C.1.** Written policies and procedures address include: • Compliance with state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), when applicable; • Storage of client records, including double lock with access limited to appropriate personnel retaining client records, as well	**Provider's Policies and Procedures** include a copy of the ROI, confidentiality, and privacy policies. ROI policy is publicly posted.

	as for destroying records that pass the retention date; • Protection of electronic client records through the use of encryption, passwords, screen savers/privacy covers, or other mechanisms; • Availability of private, confidential meeting space; • Measures to address suspected breaches of confidentiality.	
	C.2. Confidentiality, Privacy, and ROI 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 provider's policies and procedures regarding confidentiality.
	C.3. Changes in policies and procedures are presented to all the staff they impact.	**Personnel file** indicates that staff have been trained on any changes to policies and procedures that impact implementation of the policy.
	C.4. Provider will have an annual HIPAA training for employees.	**Provider Policies and Procedures** show documentation of annual HIPAA training.
D. All records and hard copy materials shall be securely maintained by the Provider.	**D.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**.**
	D.2. Each computer is password protected and staff/volunteers must change passwords at least every 120 days.	**Provider's Policies and Procedures** on confidentiality demonstrate compliance.
E. Provider must have a private space or appropriate accommodations to	**E.1.** The provider will make accommodations that ensure confidential client meetings in which others cannot hear the conversation	**Site Visit** inspection of provider’s facility**.**

conduct confidential client meetings.	(i.e., room with floor to ceiling walls and a door, white noise machine, etc.)	
F. Providers must have a policy for retaining client records, as well as for destroying records that are past the retention date.	**F.1.** Records must be stored and accessible for a period of seven years after the closing of the case. After the seventh year, records can be destroyed. Destroying documents must be done in a way that will maintain confidentiality.	**Provider's Policies and Procedures** on file retention demonstrate compliance

III. Eligibility

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. Thorough documentation is preferred, but Providers can use self-attestation, if needed.

STANDARD	MEASURE	DATA SOURCE
A. Services are available to all eligible clients. Eligible clients include people living with HIV who are at or below 500% FPL and reside in the Denver TGA.	**A.1.** Providers should periodically review eligibility guidelines to ensure that they are consistent with contracts and the Part A Service Standards. Providers should actively inform clients on how to access services.	**Provider's Policies and Procedures** has on file documentation of eligibility criteria, consistent with the Service Standards and other guidelines established by DHR.
B. Every provider must have the ability to screen clients RW Part A eligibility.	**B.1.** Providers will have an eligibility procedure.	**Provider's Policies and Procedures** include a procedure on eligibility screening process.
	B.2. Providers must have the necessary staff and systems for screening procedure.	**Provider's Policies and Procedures** demonstrate the necessary staff and systems for screening procedure.
	B.3. Document that all staff involved with eligibility determination have participated in a comprehensive, internal or	**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.	external training in eligibility determination requirements.
C. Every client's legal name will be documented and used in the creation of the eURN in CAREWare. And every client's chosen name and pronouns are documented and utilized by staff.	**C.1.** Providers are to use the client's legal name for data entry in CAREWare and the Single Payer Web App (SPWA).	**Client's intake/registration paperwork** collects the client's legal name.
	C.2. Ensure provider's client level data reporting is consistent with funding requirements including RSR data elements, and demonstrates that eligible clients are receiving allowable services.	**Client's File and CAREWare Data** demonstrate that client receives only allowable services.
	C.3. Client's chosen name and pronouns are documented in the client's file and utilized during visits.	**Client's File** will document that the client has provided their chosen name and pronouns.
D. Payer of Last Resort (PoLR): Providers will ensure that Ryan White Part A funds are used as PoLR for eligible services and eligible clients.	**D.1.** Providers will have written policies and procedures for ensuring that Ryan White Part A funds are used as a PoLR for eligible services and eligible clients.	**Provider's Policies and Procedures** will have policy and procedure regarding payer of last resort.
E. Providers will ensure appropriate screening and assessment of client eligibility every 12 months.	**E.1.** Providers will recertify eligibility every 12 months. Providers will document: • Verification of continued residency within the TGA • Client household income is at or below 500% of FPL • Client is not eligible for third party payer by screening each client for: • Insurance coverage and Ryan White eligibility Insurance coverage and eligibility for third party programs, and assist the client to apply for such	**Client's File** will document all updates to client's eligibility every 12 months when recertification should occur. It is recommended that eligibility align with SDAP and is collected at the client's birth, however, this is not required. At least once a year (whether defined as a 12-month period or calendar year). Providers must collect verification of an individual's income, residency, and insurance status. **Please note: client's original certification should happen within 30 days of enrollment in services.

	coverage, and assist the client to apply for such coverage	
F. Proof of HIV Status: Providers will verify and document individuals seeking services, of their HIV status, at initial determination only.	**F.1.** Verification of the client's HIV status should be from a medical program.	**Client's File** will contain documentation of their HIV status. This only needs to be verified when a client initiates services. Acceptable forms of verification include: • CAREWare Shared Eligibility Information • Lab work results (from EMR, copy sent by clinic, etc.) • A letter on letterhead signed by medical staff personnel • Current SDAP card or confirmation of application/renewal • CAREWare lab data
G. Proof of Income: Providers will verify and document that individuals receiving services meet income level guidelines. Providers should follow set criteria to include or exclude people when computing the client's household size.	**G.1.** Client must qualify as low income; a household income of less than or equal to 500% 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.	**Client's File** will contain documentation of the client's income. This should be verified every 12 months. Acceptable forms of verification may include: • CAREWare Shared Eligibility Information; • One month's worth of paystubs; • Bank statement within the last 30 days; • Current SDAP card; • Confirmation of SDAP application/renewal (verification through documentation, Ramsell and/or CAREWare);

		• AND/SSI/SSDI award letter; • Medicaid card or proof of Medicaid coverage If the client is reporting no income or is unable to provide proof of income, they may provide self-attestation.
H. Proof of Insurance: Providers will verify and document individuals seeking services insurance status.	**H.1.** Clients will demonstrate insurance status including: • Uninsured status; • Determination of eligibility and enrollment in other third-party insurance programs including Medicaid and Medicare; • Clients receiving VA or Indian Health Services benefits are exempt from the "payer of last resort" requirement.	**Client's File** will contain documentation of the client's insurance. This should be verified every 12 months. Acceptable forms of verification include: • CAREWare Shared Eligibility Information • Copy of dated insurance card or statement of coverage; • Current SDAP card • Confirmation of SDAP application/renewal • SSI/SSDI award letter if insurance is listed If the client is reporting no insurance, then the Provider will utilize an approved Insurance Screening attestation.
I. Proof of Residency: Providers will verify and document individuals seeking services are residents of the Denver TGA, composed of Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson counties.	**I.1.** Providers will document verification of residency within the TGA as part of the initial and annual eligibility process.	**Client's File** will contain documentation of the client's residency. This should be verified every 12 months. Acceptable forms of verification include: • CAREWare Shared Eligibility Information • An unexpired Colorado driver's license or state-issued identification card

		with a current valid TGA address; • A lease mortgage, rent receipts, hotel receipts, or other evidence that the client has obtained and/or paid for housing within the TGA; • A utility bill with a TGA service address in the client's name; • Another form of government-issued identification or documentation (i.e., benefits statement) with a valid TGA residential address. • Medicaid card (with proof of residence in the Denver TGA) • SDAP (formerly known as ADAP) enrollment verification (Denver TGA indicated by letter "M" on back of SDAP card) • 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 TGA residency due to homelessness, undocumented status, or other barriers. In such instances, acceptable forms of documentation may include: • A signed letter from a person with whom the client resides or who otherwise provides housing for the applicant, verifying the clients' residence in the Denver TGA. • A signed letter from a case manager or other

		professional explaining why the client's claim of Denver TGA residency is supportable. • 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.

VI. 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.

Denver HIV Resources – Part A provider, in partnership with CDPHE, acknowledges that racial, social, economic, and environmental inequities result in adverse health outcomes and have a greater impact than individual choices. Reducing health inequities through systematic change can help improve opportunities for all Coloradans. Ending the epidemic requires us to examine our current HIV service delivery system with the goal of eliminating policies, practices, ideas, and behaviors that do not support equity and allow for service provision that is culturally and linguistically appropriate. Providers should be culturally humble and utilize the strengths of the participants they serve.

Providers 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. "Translation Services" refer to written services.)

STANDARD	MEASURE	DATA SOURCE
A. Services are provided in an affirming, inclusive, and accessible environment. Clients are given information about section A when they start services with the provider.	**A.1.** Providers will update policies, practices, and procedures, as needed, to address barriers to accessing services.	**Provider's Policies and Procedures** document how they will be ensuring access and addressing barriers are on file and reviewed and updated annually. Providers will document client requests for modifications/accommodations and what actions were taken to accommodate such requests. Examples include:

		• Adopting and implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) as relevant to their provider. • Updating a policy about how intakes to services are completed, including asking clients if they need any help or accommodation during their visit and documenting it in their file • Granting earlier or later appointments for clients with anxiety so that fewer people will be in the office and the noise will be minimal • Client's chosen name and gender pronouns are documented in the client's file and utilized during visits • Creating a kid-friendly environment, including toys, children's books, and kid-sized furniture in the waiting room • Offering evening and weekend office hours to accommodate clients who can't make an appointment Monday through Friday
	A.2. Providers will ensure whatever is written or spoken is clear and understandable, and in the client's preferred language. Providers will notify clients of their right to receive free language assistance services, in their preferred language, and this will be posted in a visible location.	**Provider's Policies and Procedures** will include procedures about language and literacy accommodations. Providers document language assistance requests. This includes: • Written documents are available in multiple languages

		• Translation services are available, at no added cost • Providing information at an appropriate comprehension level • Websites are easy to access and can be used by screen reading technology Providers are trained in different ways to communicate, including: • the need to repeat the message so clients understand, • using visual aids to communicate health information
	A.3. 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.	**Client's File** contains signed consent form that requests family member or friend to provide interpretation services.
	A.4. Providers will ensure that their facilities are accessible, and any accommodation provided is documented.	**Site Visit** inspection of provider's facility**.** Facilities meet the Americans with Disability (ADA) standards, or appropriate accommodations are made. Examples include: • Wheelchair accessible restroom with clear turning space, grab bars and accessible sinks

		• Braille signage at office, elevator, and restroom doors, as applicable
	A.5. Facilities are easy to find and get to.	**Program's Policies and Procedures** should include the following: • ADA compliance with accessible parking options (which could include curb ramps, designated disability parking, or loading zones) • The facility is close to public transportation (ideally within .5 miles) and bus route information is available to clients • Transportation assistance availability information • Free parking options close to facility • Remote/tele-health options are available
	A.6. Providers will keep updated office hours and inform clients of how to access after-hours care. And, if possible, after-hours services are available to meet client needs.	**Provider's Policies and Procedures** will include procedures describing how to client's access emergency services after business hours and during unscheduled closings. Information on regular business hours and closures should be readily accessible and publicly available, including: • In a prominent place within the facility • On the provider's website and voicemail
B. Provider will have informational materials to inform individuals of HIV-	**B.1.** Availability of informational materials about the agency's	**Providers** will have documentation of activities that promote information related to

related services and how to access them.	services and eligibility requirements, such as: • Newsletters • Brochures • Posters • Community Bulletins • Any other type of promotional materials Materials will be culturally and linguistically appropriate.	the availability and access of HIV services as well as referral relationships and linkage agreements with key points of entry. **Providers** must maintain a file documenting agency activity for the promotion of HIV services to individuals, including copies of HIV program materials promoting services and explaining eligibility requirements.
C. Providers assure that waiting times for initial appointments and during service delivery are reasonable, based on existing resources.	**C.1.** Providers will monitor wait times for all funded services.	**Program's Files** will document appointment systems, client satisfaction surveys, or other methods of verification.
D. When a new or existing client requests a service, the provider will offer a list of resources and other HIV service providers.	**D.1.** All clients will be provided with a current list of other providers offering the same services, as well as resources outside of the Part A system. For additional information please refer to Program Guidance 06272022	**Providers** must maintain a file of current HIV service providers and other resources available to clients. This file should be updated annually. **Program's Policies and Procedures** will have a written policy and procedure detailing how and when clients are provided with information about other service providers and resources.
E. Providers must have policies and procedures in place that describe how they will maintain client waiting periods that are longer than 2 weeks (should include policy for maintaining waitlists and referring clients to other agencies).	**E.1.** During the waiting period and if a client is added to a waitlist, clients must be informed of other agencies who are accepting clients for that particular service.	**Program's Files** will have written documentation of appointment systems, client satisfaction surveys, or other methods of verification. **Client's File** include documentation that waitlist information was communicated. **Program's Policies and Procedures** detail how long waiting periods of 2 weeks or

		longer (waitlists) will be managed.
F. Providers 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. Clients who will need to wait longer than two weeks for services or are put on a waitlist will also be offered a referral to another organization.	**F.1.** Program has a referral and linkage system in place including referral procedures and a system to track completed referrals.	**Program's Files** will have written documentation of linkage procedures, linkage agreements, or documentation of referrals and linkage outcomes.
	F.2. To establish this base of referrals, providers need to network with other community-based HIV organizations and prevention providers as well as city, state, and private organizations providing similar or complimentary services in the community.	**Provider's policies and procedures** demonstrate that the provider has established a full range of service referrals and maintains effective referral relationships with other providers.
	F.3. Providers should make an active referral, or a passive referral based on the client's situation, preference, and need. Active referrals require referring agency to support the client in getting connected to the new organization and includes contacting the client to ensure they were connected to services. It may also include contacting the new organization to get the new client connected. Passive referrals require the referring agency to provide the client with the contact information for the new organization.	**Program's Policies and Procedures** demonstrate that the provider has processes for making active and passive referrals.
G. Programs have a process for staffing transition which is designed to minimize possible adverse effects to the clients and should include how clients will be informed.	**G.1.** Staffing transitions should be communicated to clients for services that require them to be connected to a specific provider. This will include: • Notification that provider is leaving and what their last day is (this can be in email,	**Client's File** contains documentation of: • Contact method(s) used; • What was included in the communication;

	letter, phone call, or text message) • Why reassignment was necessary; and • Contact information about the person the client will be working with. Program Supervisors should review and ensure process is followed and be prepared to answer any client concerns. When clients cannot be notified in a timely manner Supervisors will ensure clients are notified and client files are updated. For additional information please refer to Program Guidance 06272022	• If client had any concerns and what actions taken to address those concerns; If contact attempts made were not received.
	G.2 Programs have a policy and procedure describing how staffing transitions will be managed, including how clients will be notified and what timeline notification will occur.	**Program's Policies and Procedures** document the process of how clients will be communicated with and what the follow up procedure is.
H. Services are provided to eligible clients regardless of an individual's ability to pay for the service.	**H.1.** Providers will have a sliding scale fee that is consistent with state and federal guidelines. Provider 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. Billing and collection policies and procedures do not: • Deny services for non-payment;	**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.

	• Require full payment prior to service; • Include any other procedure that denies services for non-payment	
	H.2. Providers will have sliding scale fee that is consistent with state and federal guidelines. Sliding fee scale details are below. Individual Income Maximum Charges: • For clients at or below 100% of Poverty - $0; • For clients at 101% to 200% of Poverty - No more than 5% of gross annual income; • For clients at 201% to 300% of Poverty No more than 7% of gross annual income; For clients over 300% of Poverty No more than 10% of gross annual income. These limits shall apply only to agencies that impose any level of charges for services.	**Program's Policies and Procedures** will have sliding scale policy. Providers will develop policy and procedures for a sliding scale fee that is consistent with state and federal guidelines including: • Publicly post the schedule of charges. • Develop and maintain a system for tracking client charges and payments. • Develop a process to alert the billing system that cap limits have been reached to ensure that charges are discontinued once the client has reached his/her annual cap.
I. Provider will make HIPAA-compliant virtual services available to all RWHAP Part A clients.	**I.1.** Provider 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.
	I.2. Provider will have procedures in place that give clients the right to accept virtual services or deny virtual services and request meeting with a provider in person.	**Program's Policies and Procedures** show that clients have a right to accept or deny virtual services and to see a provider in person upon request.

V. Quality Management & Capacity Building

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. Providers will have a quality plan (using the DHR Quality Plan Template) including all initiatives for required performance measures (core and support).	**B.1.** Providers will have a quality plan to assess the quality of care provided, to ensure that inequities are identified and addressed, and to identify areas for improvement.	**Program's Reports** documents the use of a quality plan.
	B.2. Quality plan is updated annually**.**	**Program's Reports** document quality plan revisions.
C. Providers will document clinical quality management activities, and meetings, 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.
D. Providers will assure compliance with relevant service category definitions and Denver transitional grant area (TGA) service standards.	**D.1.** Providers will conduct quality assurance activities as needed to comply with Denver TGA service standards.	**Program's Files and Reports** document quality assurance activities.

E. Providers will involve people living with HIV in quality improvement efforts.	**E.1.** Providers will involve people living with HIV in one or more of the following ways: with surveys, focus groups, review of grievances filed, or key informant interviews, presentations, and feedback from a community advisory board and/or as members of a quality improvement committee.	**Program's Quality Plan** documents how clients are included in quality improvement efforts. A copy of the survey, interview questions, presentation, agenda for community advisory boards and/or quality improvement committee roster is available for review.
F. Program will implement structured and ongoing efforts to obtain input from clients regarding the design and delivery of services, including policies and procedures.	**F.1.** 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.
G. Agency uses internal data to identify inequities in health outcomes and service delivery among clients served and changes policies and/or practices to address inequities.	**G.1.** Agencies will: • Collect and analyze data related to equity of service delivery and health outcomes; • Identify projects or changes in policies that will impact inequities; • Measure impact of changes made	**Program's files** show how data is used to measure equity of services and health outcomes, as well as changes in policies and procedures as a result of this data. **Program's Quality Plan** documents equity efforts and has related action items.
H. Providers will use client grievances, complaints, concerns, and/or compliments to inform quality improvement activities.	**H.1.** Provider demonstrates that there is a process to include feedback provided by clients in quality improvement activities.	**Program's Files** document client grievances, complaints, concerns, and/or compliments and how these are being used in quality efforts.

VI. Staff and Volunteer Requirements and Training

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

STANDARD	MEASURE	DATA SOURCE

A. Providers recruit, retain, and promote a diverse staff and leadership that reflects the cultural lived experience and linguistic diversity that is reflective of the communities being served.	**A.1.** Providers have a strategy on file to recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	**Provider'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. **Job descriptions** contain language that prioritizes diverse hiring practices.
B. Supervisors will provide structured supervision to staff.	**B .1.** Every supervisor will provide supervision to employees working directly with clients. Supervision may include the following: • Support in personal and professional development • Support in knowledge, and skill building • Adequate resources to do the work • Trauma Informed Care skills • Ethical practices • Burnout and stress	**Program's Policies and Procedures** include documentation regarding supervision practices. **Personnel Files** include documentation of staff supervision meetings, and any action items or outcomes.
C. Staff and supervisors are qualified to provide the necessary services to clients.	**C.1.** Staff and Supervisors have the appropriate licensure, education and/or experience, as required by the position.	**Personnel file** has proof of licensure and/or education appropriate for the specific position**.**
D. Initial orientation and training shall be given to new staff.	**D.1** Newly hired staff are oriented as soon as possible, and within 30 days of employment on the following: • Cultural responsiveness • Basic HIV information including medical and support services	**Personnel File** demonstrates the type, amount (minutes or hours), and date of orientation and training that each staff receives both internally and externally.

	• Confidentiality and disclosure Newly hired staff are oriented as soon as possible and within 6 months of employment on the following: • Program's policy and procedures • Ryan White (RW) Care Act Part A services and other funding sources • Other government and community programs • Behavioral health services and support • Denver TGA Part A service standards and requirements • Data collection and methodologies Training can be internal and external to the organization.	
E. Providers will ensure that clients receive, from all staff members, responsive, equitable, understandable, respectful, and quality care that is provided in a manner compatible with the client's cultural beliefs, practices, communication style, and experience. Providers should use a client centered approach to delivering services.	**E.1.** All staff members receive appropriate diversity, equity, and inclusion training within the first year of employment and at least annually thereafter.	**Program's Policies and Procedures** contain requirements for diversity, equity, and inclusion 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.
F. Staff should receive the following training annually.	**F.1.** Every staff handling confidential information will receive an annual training concerning HIPAA, confidentiality, and disclosure.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.
	F.2. Every staff receives annual training on Occupational Safety	**Personnel file** demonstrates the type and amount of

	Health Administration regulations and universal precautions.	training each staff received both internally and externally.
	F.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.
G. Each program has a volunteer training program appropriate to support each volunteer position.	**G.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 responsiveness • Basic HIV information • Basic client contact skills • HIPAA, confidentiality, and disclosure • 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.
H. Staff or volunteers working with clients are to be screened in accordance with state and local laws.	**H.1.** Background checks must be obtained as required by state and local laws.	**Personnel or Volunteer file** contains background checks.
I. Staff or volunteers transporting clients will have a valid Colorado driver's license and proof of insurance.	**I.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.

Service Category Service Standards

Case Management Continuum

Case management is a multi-step process to ensure timely access to and coordination of medical and psychosocial services for a person living with HIV.

The goal of case management is to promote and support independence and self-sufficiency. As such, the case management process requires the consent and active participation of the client in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate, non-judgmental care, a culturally mindful provider, and quality case management services.

DHR has adopted this case management structure from the Colorado Ryan White Part B Program. The case management continuum is a four-tiered approach to case management service that includes, medical case management (intensive medical needs) and non-medical case management (intensive psychosocial needs), care navigation (health education risk reduction), and referral for health care and support services. The medical and non-medical models of case management provide different levels of service geared to the needs and readiness of the client.

This case management continuum model may be provided in health care or social service settings, in large institutions or small community-based organizations.

Please note that throughout the document the word “provider” will be used to mean the person providing the case management service to clients. Because most of the providers consider themselves “case managers” this term will be used in the narrative portions of the service standards.

Medical Case Management is a proactive case management model intended to serve persons living with HIV with multiple complex medical and/or adherence health-related needs. The model is designed to serve individuals who may require assistance with access, utilization, retention, and adherence to primary health care services. Medical Case management clients need or want ongoing support from case management to actively engage in medical care, and continued adherence to treatment. Medical Case Management services focus on improving health care outcomes. Medical case management services offer a range of client-centered services that link clients with health care, psychosocial, and other services.

Non-Medical Case Management is a proactive case management model intended to serve people living with HIV with multiple complex psychosocial needs and their families/close support systems. The model is designed to serve individuals who may require or want ongoing case management support to stabilize their psychosocial needs. Non-medical case management is also an appropriate service for clients who have completed medical case management but still require or want a maintenance level of periodic support from a provider (case manager or case management team). Non-medical case management clients manage their care well enough to avoid chronic disruption to their medical care but require psychosocial support to maintain a stable lifestyle. Non-medical case management may also be provided to clients with multiple complex needs who may best be served by a medical case management program, but who are not ready or willing at this time to engage in the level of participation required by the medical case management model.

Care Navigation is intended to assist people living with HIV in accessing services and decision-making for their health-related and/or psychosocial needs. This model is designed to assist individuals whose needs are minimal and infrequent. It may also be used to provide services to those who do not want or are not ready to engage in more intensive case management services. Care Navigation strives to provide a varying level of support to a client's need. When receiving Care Navigation services, the client may receive assistance in obtaining medical, social, community, legal, financial, and other needed services. However, Care Navigation does not involve coordination and follow-up of medical treatments, as medical case management does. Care Navigation also does not include the development and monitoring of a treatment plan.

Referral for Health Care and Support Services focuses on people living with HIV who were formerly engaged in more intensive tiers of case management and have progressed to self-management or are only in need of Referral Services at this time. Referral Services assist clients to connect with needed core medical or support services and may be provided in person or through telephone, written, or other type of communication. Referral Services is intended to assess the sufficiency of self-management and to provide additional services as indicated by the client. Referral Services clients may have low acuity or may have high acuity but do not want to engage in more intensive case management services at this time.

CORE ELEMENTS	MEDICAL CASE MANAGEMENT	NON-MEDICAL CASE MANAGEMENT	CARE NAVIGATION	REFERRAL
Approach	***Proactive*** Need/Want for frequent support to access services	***Responsive*** Need/Want for episodic support to access services	***Responsive*** Need/Want for minimal support to access services	***Responsive*** Self-managed no support needed/wanted.
Brief Intake	**Required**	**Required**	**Not Required**	**Not Required**
Comprehensive Assessment	**Required at intake** **Reassessed** at least every 6 months. May be face to face, virtual, or via phone.	**Required at intake** **Reassessed** at least annually. May be face to face, virtual, phone, or email.	**Required at intake** **Reassessed** at least annually. May be face to face, virtual, phone, or email.	**Required at intake**[1] **Reassessed** at least annually. May be face to face, virtual, phone, or email.
Service Plan	**Required** The Service Plan is updated when: • Unanticipated changes take place in the client's life, • A change in the plan is identified, • Or at least every 6 months when reassessment occurs.	**Required** The Service Plan is updated when: • Unanticipated changes take place in the client's life, • When a change in the plan is identified, • Or at least every 6 months when reassessment occurs.	**Not Required**	**Not Required**
Referral	• The provider will document all referrals. • The provider will document follow-up activities and outcomes in the record. • The provider will utilize a tracking mechanism to monitor completion of all case management referrals.	• The provider will document all referrals. • The provider will document client reported follow-up and outcomes in the record.	The provider will document all referrals.	The provider will document all referrals and will refer back into case management if client shows a need or desire for a more intense level of service.

[1] *However, brief assessment is allowed.*

CORE ELEMENTS	MEDICAL CASE MANAGEMENT	NON-MEDICAL CASE MANAGEMENT	CARE NAVIGATION	REFERRAL FOR SERVICES
Access to and coordination with medical care	• Coordination and follow up of medical treatment. • Providers shall maintain regular communication with client's primary care provider. • Assist with scheduling appointments, following up on missed appointments and adherence planning.	• Client reports on ability to self-manage care. • Assistance with coordination is provided upon request.	**Not Required**	**Not Required**
Adherence	• Development and implementation of adherence plan. • Plan is updated at least every 6 months.	Client reported.	**Not Required**	**Not Required**
Transition between tiers	Movement can take place at any time, after assessment shows stability, or at request of client.	Movement can take place at any time, after assessment shows stability or a need and/or desire for a more/less intense level of service.	Movement can take place at any time, after assessment shows a need and/or desire for a more/less intense level of service.	Movement can take place at any time, after client shows a need and desire for a more intense level of service.
Service Unit	A "service unit" of medical case management is defined as a visit or encounter lasting 15 minutes or less, face to face, virtually, via telephone, email, texting, or other mechanism used to provide the service.	A "service unit" of nonmedical case management is defined as a visit or encounter lasting 15 minutes or less, face to face, virtually, via telephone, email, texting, or other mechanism used to provide the service.	A "service unit" of care navigation is defined as a visit or encounter lasting 15 minutes or less, face to face, virtually, via telephone, email, texting, or other mechanism used to provide the service.	A "service unit" of Referral Services is defined as a visit or encounter lasting 15 minutes or less, face to face, virtually, via telephone, email, texting, or other mechanism used to provide the service.

Medical Case Management

Medical Case Management is a proactive case management model intended to serve persons living with HIV with multiple complex medical and/or adherence health-related needs. The model is designed to serve individuals who may require assistance with access, utilization, retention, and adherence to primary health care services. Medical Case management clients need or want ongoing support from case management to actively engage in medical care, and continued adherence to treatment. Medical Case Management services focus on improving health care outcomes.

Medical case management services offer a range of client-centered services that link clients with health care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management services will be culturally, and linguistically appropriate to the communities served. Medical case management may be delivered face-to-face, via telephone, or utilizing other forms of communication appropriate for the client. A primary goal of Medical Case Management is to assist the clients in moving toward empowerment, self-determination, and self- sufficiency. This allows the provider to transition clients to more appropriate programs and services as the client's medical and psychosocial status improves, freeing valuable resources for people who are most in need.

A "**service unit**" of Medical Case Management is defined as a visit or encounter lasting 15 minutes or less. This can be either face to face, virtually, via telephone, email, texting, or other mechanism used to provide Medical Case Management services.

Key activities

- Intake and eligibility determination for Ryan White services
- Assessment and reassessment
- Service Plan development
- Implementing and monitoring the Service Plan
- Coordination of services (medical or otherwise)
- Adherence Planning (for HIV and other Medications)
- Referral and follow up
- Transition and case closure
- Records management
- Case load management
- Address other barriers and make referrals as needed, including but not limited to: mental health, substance use, food bank, medical transportation, etc.
- Managing Ryan White emergency financial assistance, housing, oral health, legal assistance, and HOPWA requests

At a minimum, medical case management must include the following:

- Provision of treatment and adherence education to ensure readiness for, and adherence to, complex HIV treatments.
- Coordination and follow-up of medical treatments
- Client-specific advocacy and/or review of utilization of services
- Motivating and assisting clients to access long-term support for health care costs, including Medicaid, Medicare, COBRA, the Colorado Indigent Care Program (CICP), group or individual health+ insurance, coverage under someone else's health insurance policy, and pre-existing condition insurance plans.

Providers must also maintain proficiency regarding the following care-related services and must collaborate with the providers of such services:

- **SDAP** Colorado's State Drug Assistance Program (formerly known as "ADAP")
- Colorado's HIV Insurance Assistance Program, including Bridging the Gap, Colorado
- The Housing Opportunities for People with AIDS (HOPWA) program, administered by the Colorado department of Local Affairs, Division of Housing

Units of Service

1 unit = 15 minutes or less

Service Components

STANDARD	CRITERIA	DOCUMENTATION
Initial Assessment		
A. Key information concerning the client, family, caregivers, and informal supports is collected and documented to determine client enrollment eligibility, need for ongoing case management services, and appropriate level of case management service.	**A.1.** Intake must be completed when a client living with HIV is requesting services for the first time. If a client has emergency needs that must be satisfied, an intake can be completed at the earliest convenience of the client. However, the initial intake must be initiated, not necessarily completed within 7-10 days.	**Client's File** should document eligibility in terms of Denver TGA residency, HIV status, and income, as described in the Universal Standards. The client record should also document: • Date of intake • Source of referral • Contact information – home and mailing address, phone, emergency contact, preference on how to contact • Age/ Date of birth • Gender

		• Racial or ethnic identification
		• Year and location of diagnosis
		• Location of current medical care
		• Documentation of health insurance, (if applicable)
		• Any other current or chronic medical condition/need for care
		• All current medications
		• Household/current living situation
		• Current employment
		• Documentation of any current financial income/ pay stub
		• Education level
		• Social support
		• Whether basic needs are met (food, shelter, etc.)
		• History of incarceration/ parole status
		• Signed release of information, when applicable
		• Evidence the provider explained, and the client received the following:
		  • Client rights and responsibilities
		  • Client grievance procedure
		  • Information on confidentiality

B. Working collaboratively with the client, the provider conducts a confidential, comprehensive, face-to-face or phone needs assessment to assess the need for	**B.1.** The provider conducts a needs assessment with the following intake to case management services. As a client's status changes, it will be necessary for the provider to reassess their needs and acuity level. The provider should use an acuity scale as a	**Client's File** should contain a completed assessment form in the client record covering the following: • Medical, mental health, substance use, psychosocial needs, and basic needs (food, shelter, etc.). • A completed acuity level scale in

medical, dental, psychosocial, educational, financial, nutritional, mental health, substance use, risk reduction, and other services.	measurement tool to determine client needs. The acuity scale indicates: • The level of case management complexity • The frequency of contact • The complexity of the provider's overall caseload	the client's record, including: • Client's current level of need • Evidence that the assessment was completed • Evidence of client is assigned to case management tier based on acuity score. • Evidence acuity level has been updated as needed **Note:** Tools used for assessment and acuity determination available via DHR or CDPHE. Other assessment tools may include the Client Diagnostic Questionnaire (CDQ), Substance Abuse (Use) & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) which is used in the context of SBIRT.
C. Medical case management services should be responsive to the current situation of the client.	**C.1.** Reassessment of the client's needs is conducted as needed, but not less than once every six months.	**Client's File** documents reassessments.
Service Planning		
D. The client's individualized service plan is a strengths-based case management work plan, which systematically identifies agreed upon client needs based on a client assessment. The service plan worksheet shall be completed and utilized by the provider and the client.	**D.1.** The service plan is a strategy or plan of action designed by both the provider and client as a means to help the client achieve goals. Needs, goals, and tasks are identified and prioritized, including any outcome measures mandated by the agency or funding source. Service plan written in a **SMART** format includes: ▪ **S**pecific- Goals, Objectives and tasks should specify what the person wants to achieve ▪ **M**easurable- You and the person should be able to	All service plans are entered and updated in the agency's data system. Service plan written in a **SMART** format indicates: • Goals • Action steps • Actual outcomes • Changes or updates • Follow up At least one goal in the service plan should address health and wellness related to HIV, such as barriers, adherence, or medical care.

Clients should receive medical case management that is centered on their needs and based on client priorities.	measure whether the goals, objectives and tasks are being achieved. ▪ **A**chievable- Are the goals, objectives, and tasks achievable and attainable? ▪ **R**ealistic- Can the person realistically achieve the goals, objectives, and tasks with the resources /they have? ▪ **T**ime Framed- Is there a specific timeframe set for each goal, objective, and task? ▪ **S**trength-based –Were the person's strengths and resources used in developing the goals objectives and tasks?	
E. The provider and client will work together to decide a timeline and who will take responsibility for each task.	**E.1.** A reasonable timeline is determined for achievement of goals, with tasks assigned to either provider or client.	The service plan indicates the individual responsible for each task: • Provider (ex. Case Manager) • Client • Family or support • Other staff or agency The Service Plan indicates anticipated time frame for each task.
F. Reassessment is completed as needed, but not less than once every six months.	**F.1.** The service plan is updated for those clients actively seeking services, including those clients identified as needing services by other providers, when unanticipated changes take place in the client's life, when a change in the plan is identified, upon achievement of goals, or at least every six months when reassessment occurs.	Provider will document all updates to the service plan upon achievement of goals, when other issues or goals are identified, or at least every six months, when reassessment should occur.
G. Medical case management should be relevant to the	**G.1.** The strategy or plan of action should be consistent with the updated service plan including:	Progress notes signed and dated by the provider detailing the action taken should be in the client file. This should include ongoing

client's current situation.	• Assistance in arranging services, making appointments, and confirming service delivery dates • Encouragement to client to carry out tasks they agreed to • Support to enable clients to overcome barriers and access services • Negotiation and advocacy as needed • Other case management activities as needed	documentation of the following: • Progress made towards service plan and action taken to overcome barriers
H. Determination of the need for service plan revision.	**H.1.** Provider will revise service plan as changes in client circumstances warrant.	**Client's File** documents all updates to the service plan.
Referrals and Care Coordination		
I. Provider will provide referrals, advocacy, and interventions based on the service plan.	**I.1.** Providing a referral may include: • Providing referral contact information (in person, by phone, email, or in writing, etc.) • Conducting ongoing follow-up with clients and providers to confirm completion of referrals, service acquisition, maintenance of services, and adherence to medical care • Actively following up on established goals in the service plan to evaluate client progress and determine appropriateness of services • Assisting clients in resolving any barriers to completing goals in the service plan	**Client's File** includes ongoing documentation of the following: • Specific data about all encounters with the client, including date of encounter, type of encounter, duration of encounter, and services provided • All medical case management contacts with the client's support system, providers, and other participants • Changes in client status or circumstances • Progress made towards service plan • Barriers identified in goal process and actions taken to resolve them • Current status and results of linked referrals

J. Each client receiving medical case management services will receive referrals to those services critical to achieving optimal health and well-being.	**J.1.** The provider will support the client to initiate referrals that were agreed upon by the client and the provider. Referrals include: • Referral to a named agency • The name of a contact person at the referral agency • An exact address • Specific instructions on how to make the appointment • Identifying referral agency eligibility requirements • What to bring to the appointment.	**Client's File** documents All of the elements of referral.
K. As appropriate, providers shall facilitate referrals by obtaining releases of information to permit provision of information about the client's needs and other important information to the service provider.	**K.1.** Signed release of information forms are obtained as necessary.	**Client's File** contains signed release(s) of information, when necessary.
L. Each client will receive assistance to help problem solve when barriers impede access.	**L.1.** The provider will work with the client to identify barriers to referrals and assist in finding culturally responsive solutions to address barriers.	**Client's File** documents all barriers identified in referral process and the actions taken to resolve them.
M. The provider will ensure clients are accessing needed referrals.	**M.1.** The provider will utilize a tracking mechanism to monitor completion of all referrals.	**Client's File** documents follow-up activities and outcomes.
N. Providers shall maintain communication with client's primary care provider.	**N.1.** Providers will make contact with a client's primary care clinic at a minimum of twice a year, or as clinically indicated.	**Client's File** must include: • HIV care medical provider name/clinic

		• Documentation of contact with primary medical clinics and providers • Medical history • All current medications • Date of last clinic visit • Results of last CD4 and viral load It is strongly preferred that this clinical data be reported directly from the medical provider and not rely on client self-report.
O. Clients who are not engaged in care should be referred to a primary care physician.	**O.1.** If a patient is not seeing a primary care physician regularly, they should be urged to seek care, and a referral to a primary care physician should be made.	**Client's File** contains evidence that a culturally responsive method was used, including but not limited to motivational interviewing, trauma informed care, etc. approach was used in regard to seeking HIV care. Referral should be documented in client file.
P. Case reviewing utilized as a specific mechanism to enhance case coordination.	**P.1.** Interdisciplinary case review should be held for each client at least annually, or more often if clinically indicated.	**Client's File** provides evidence of timely case reviewing with key providers is found. Case reviews may take place face-to-face, by phone, or electronically. This may involve clients operating as a "go between" with the provider.
Adherence Planning		
Q. Adherence should be assessed and then discussed with the client. Any needed Adherence plan should be developed concurrently and collaboratively with the client.	**Q.1.** The adherence plan should address both medical and non-medical needs and reflect compliance of adherence counseling standards of care.	The written adherence plan in the client record should, strive to include: • Treatment education • Side effect management • Nutritional counseling • The use of reminder tools, when appropriate • Trauma Informed Care, and Motivational interviewing in support of mental health and substance use counseling

		• Relapse prevention and management strategies • Other practical strategies that support adherence
Transition/Case Closure		
R. At the conclusion of medical case management services, the client's goals should have been met and, when appropriate, there should be a seamless transition to less intensive case management services (such as non-medical case management or care navigation) or case closure.	**R.1.** Clients should demonstrate one of the medical case management case closure criteria.	**Client's File** should demonstrate one or more of the following case closure criteria being met: • Successful completion of all the goals in the service plan • Transition to a different level of case management continuum of care when applicable • Voluntary withdrawal from the service • Death of the client • Relocation outside of the service area • Client otherwise lost to the service (moved out of jurisdiction, unable to locate after multiple attempts, etc.) • Client demonstrates the ability to independently manage their care in a sustainable manner Severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the provider or unlikely to be helpful to the client
S. The Provider will complete a transition/case closure summary.	**S.1.** All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for transition/case closure.	Transition/case closure summaries will include: • Date and signature of Provider (may consist of date stamp/electronic signature in EHR/EMR) • Date of transition/case closure • Status of the service plan • Status of primary health care and support service utilization

		Reasons for case closure and criteria for re-entry into services
Confidentiality/Documentation		
T. Case management records will reflect compliance with the case management standards of care. Records should be complete, accurate, confidential, and secure.	**T.1.** All client record progress notes will document the date, the type of encounter, and description of the encounter. Transportation of client records should be handled only by authorized personnel and in a manner to ensure security and confidentiality.	There is one record per client. Each client record entry includes: • Date of client visit/contact, • Reason for visit/contact, • Any activities performed, • Outcome plan, and • Follow-up
Staff Qualifications		
U. Medical case management staff should be appropriately qualified and trained.	**U.1.** Personnel files should document that Medical Case Management staff are appropriately credentialed or demonstrate sufficient mastery of skill and knowledge to deliver the service. Medical case management staff will have a one-year period starting on their date of hire to document their qualifications.	**Personnel Records** should document qualification of providers by the following means: • As applicable, a copy of a license or certificate as a medical professional (e.g., a physician, nurse, or medical social worker); Official transcripts or certificates showing successful completion of courses of study of the areas listed below; and • (Optional) Completion of the MCM Certificate Online Training (available through DHR). This is in addition to the required trainings outlined in the Universal Service Standards.
V. Medical case management staff should receive appropriate supervision.	**V.1.** All medical case management staff must be supervised by a supervisor who meets same requirement as standard U., and who regularly reviews the client files, acuity, and service plans. Supervisory files should document supervisory activities,	**Personnel Records** should document qualifications of direct supervisor of providers. **Supervisory files** should contain the following: • A copy of a license or certificate as a medical professional (e.g., a physician, nurse, or medical social worker); Official transcripts or

	including direct observation of services, follow up actions, and effort to improve service quality.	certificates showing successful completion of courses of study of the areas listed below; **and** ○ (Optional) Completion of the MCM Certificate Online Training (available through DHR). ○ Evidence of training or quality improvement activities ○ Evidence staff received supervision ○ Evidence of client file reviews ○ Evidence of follow up action taken
X. Meet the client where they are at.	**X.1.** Providers ensure that client services are designed and provided in a way that supports the client but does not require participation in any element unless the client is willing.	**Client's File** demonstrates that if a client does not want to participate in a component of case management services, or does not prioritize an element, it is noted in the file and CM will reevaluate at the next assessment date.

Non-Medical Case Management

Non-Medical case management is a proactive case management model intended to serve persons living with HIV with multiple complex psychosocial needs and their families/close support systems. The model is designed to serve individuals who may require or want ongoing case management support to stabilize their psychosocial needs. Non-medical case management is also an appropriate service for clients who have completed medical case management but still require a maintenance level of periodic support from the provider (case manager or case management team). Non-medical case management clients manage their care well enough to avoid chronic disruption to their medical care but require psychosocial support to maintain a stable lifestyle.

Non-medical case management may also be provided to clients with multiple complex needs who may best be served by a medical case management program, but who are not ready or willing at this time to engage in the level of participation required by the medical case management model. In this case, non-medical case management serves as a means of assisting an individual at his/her/their level of readiness, while encouraging the client to consider more comprehensive services. Non-medical case management services provide guidance and assistance in improving access to and retention in needed core and support services.

Non-medical case management model includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical

case management does not involve coordination and follow-up of medical treatments, as medical case management does.

A "**service unit**" of Non-Medical Case Management is defined as a visit or encounter lasting 15 minutes or less. This can be either face to face, virtually, via telephone, email, texting, or other mechanism used to provide Non-Medical Case Management services.

Key activities

- Intake and eligibility determination for Ryan White services
- Assessment and re-assessment of service needs
- Development of a brief, individualized service plan
- Client monitoring to assess the efficacy of the plan
- Periodic re-evaluation and adaptation of the plan as necessary
- Address other barriers and make referrals as needed, including but not limited to: mental health, substance use, food bank, medical transportation, etc.
- Managing Ryan White emergency financial assistance, housing, oral health, legal assistance, and HOPWA requests

At a minimum, non-medical medical case management must include the following:

- Client-specific advocacy and/or review of utilization of services
- Motivating and assisting clients to access long-term support for health care costs, including Medicaid, Medicare, COBRA, the Colorado Indigent Care Program (CICP), group or individual health insurance, coverage under someone else's health insurance policy, and Cover Colorado.

Providers must also maintain proficiency regarding the following care-related services and must collaborate with the providers of such services:

- **SDAP** Colorado's State Drug Assistance Program (formerly known as "ADAP")
- Colorado's HIV Insurance Assistance Program, including Bridging the Gap, Colorado.
- The Housing Opportunities for People with AIDS (HOPWA) program, administered by the Colorado Department of Local Affairs, Division of Housing

Units of Service

1 unit = 15 minutes or less

Service Components

STANDARD	CRITERIA	DATA SOURCE
Initial Assessment		
A. Key information concerning the client, family, caregivers, and informal supports is collected and documented to determine client enrollment eligibility, need for ongoing case management services, and appropriate level of case management service.	**A.1** Intake must be completed when a client living with HIV is requesting services for the first time. If a client has emergency needs that must be satisfied, an intake can be completed at the earliest convenience of the client, but no later than two weeks after initial contact.	**Client's File** should document eligibility in terms of Colorado residency, HIV status, and income, as described in the Universal Standards. The client record should also document: • Date of intake • Source of referral • Contact information – home and mailing address, phone, emergency contact; preference on how to contact • Age/ Date of birth • Gender • Racial or ethnic identification • Year and location of diagnosis • Source of any current medical care • Documentation of health insurance, (if applicable) • Household/ current living situation • Current employment • Documentation of any current financial income/ pay stub • Education level • Social support • Whether basic needs are met (food, shelter etc.) • History of incarceration/ parole status • Signed release of information • Evidence the provider explained, and the client received the following:

		○ Client rights and responsibilities ○ Client grievance procedure ○ Information on confidentiality
B. Working collaboratively with the client, the provider conducts a confidential assessment of client's immediate needs.	**B.1** The provider conducts a Needs Assessment with the client following intake to case management services. As a client's status changes, it will be necessary for the provider to reassess their needs and acuity level. The provider should use an acuity scale as a measurement tool to determine client needs. The acuity scale indicates: • The level of case management complexity • The frequency of contact • The complexity of the caseload	**Client's File** should contain a completed assessment form in the client record covering the following: • Medical, mental health, substance use, psychosocial needs, HIV risk behaviors, and basic needs (food, shelter, etc.). A completed acuity level scale in the client's record, including: • Client's current level of need • Evidence that the assessment was completed • Evidence of client is assigned to case management tier based on acuity score. • Evidence acuity level has been updated as needed **Note:** Tools used for assessment and acuity determination available via DHR or CDPHE. Other assessment tools may include the Client Diagnostic Questionnaire (CDQ), Substance Abuse (Use) & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) which is used in the context of SBIRT.
C. Non-medical case management should be responsive to the current situation of the client.	**C.1** Reassessment of the client's needs is conducted as needed, but not less than annually.	**Client's File** documents reassessments.
Service Planning		
D. The client's individualized service plan is a case management work plan which systematically	**D.1** The service plan is a strategy or plan of action designed by both provider and client as a means to help the client achieve goals.	All service plans are entered and updated in the data system provided by DHR, or an approved equivalent.

identifies agreed upon client needs based on a comprehensive client assessment. The service plan worksheet shall be completed and utilized by the provider and the client.	Problems, goals, and tasks are identified and prioritized, including any outcome measures mandated by the agency or funding source. Service plan written in a SMART format includes: • **S**pecific- Goals, Objectives and tasks should specify what the person wants to achieve • **M**easurable- You and the person should be able to measure whether the goals, objectives and tasks are being achieved. • **A**chievable- Are the goals, objectives, and tasks achievable and attainable? • **R**ealistic- Can the person realistically achieve the goals, objectives, and tasks with the resources /they have? • **T**ime Framed- Is there a specific timeframe set for each goal, objective, and task? • **S**trength-based –Were the person's strengths and resources used in developing the goals objectives and tasks?	Service plan written in a **SMART** format indicates: • Goals • Action steps • Actual outcomes • Changes or updates • Follow up
E. The provider and the client will work together to create a timeline and decide who will take responsibility for each task.	**E.1.** A reasonable timeline is determined for achievement of goals, with tasks assigned to either the provider or client.	The service plan indicates the individual responsible for each task: • Provider (ex. Case manager) • Client • Family or support • Other staff or agency The service plan indicates anticipated time frame for each task

F. Reassessment of client needs is completed as needed, but not less than every six months.	**F.1.** The service plan is updated for those clients actively seeking services, including those clients identified as needing services by other providers, when unanticipated changes take place in the client's life, when a change in the plan is identified, upon achievement of goals or at least annually when reassessment occurs.	The Provider will document all updates to the service plan upon achievement of goals, and when other issues or goals are identified, or at least annually when reassessment should occur.
G. Clients should receive non-medical case management that is suited to their situation.	**G.1.** The service plan should be consistent with needs identified in the comprehensive client assessment.	The service plan should be signed and dated by the provider and client in the client's file.
H. Non-medical case management should be relevant to the client's current situation.	**H.1** The strategy or plan of action should be consistent with the updated service plan including: • Refer client needed services • Encouragement to client to carry out tasks they agreed to • Support to enable clients to overcome barriers and access services • Negotiation and advocacy as needed • Other case management activities as needed	Progress notes signed and dated by the provider detailing the action taken should be kept in the client's file. Ongoing documentation of the following should also be kept in the client's file: • Progress made towards service plan • Action taken to overcome barriers
Referrals and Care Coordination		
I. The provider will provide referrals, advocacy, and interventions based on the service plan.	**I.1** Monitoring involves carrying out of tasks listed in the plan, including the following activities: • Provider contact in person, by phone, or in writing • Assistance to client in applications for services • Assistance in arranging services	**Client's File** includes ongoing documentation, signed, and dated by the provider, of the following: • All client contacts made should include: ○ Date of encounter ○ Type of encounter ○ Duration of encounter ○ Services provided

	• Encouragement to client to carry out tasks they agreed to • Support to enable clients to overcome barriers and access services • Negotiation and advocacy as needed • Other case management activities as needed	• All case management contacts with the client's support system, providers, and other participants • Changes in client status Progress made towards service plan
J. Each client receiving non-medical case management services will receive referrals to those services critical to achieving optimal health and well-being.	**J.1** The provider will support the client to initiate referrals that were agreed upon by the client and the provider. Referrals include: • Referral to a named agency • The name of a contact person at the referral agency • An exact address • Specific instructions on how to make the appointment • Identifying referral agency eligibility requirements • What to bring to the appointment	**Client's File** documents all of the elements of referral.
K. As appropriate, providers shall facilitate referrals by obtaining releases of information to permit provision of information about the client's needs and other important information to the service provider.	**K.1.** Signed release of information forms are obtained as necessary.	**Client's File** contains signed release(s) of information, when necessary.
L. Each client will receive assistance to help problem solve when barriers impede access.	**L.1.** The provider will work with the client to identify barriers to referrals and assist in finding solutions to address barriers.	**Client's File** documents all barriers identified in referral process and the actions taken to resolve them.

M. The provider will ensure clients are accessing needed referrals.	**M.1.** Provider will utilize a tracking mechanism to monitor completion of all referrals.	**Client's File** documents follow-up activities and outcomes.
Transition/Case Closure		
N. At the conclusion non-medical case management services, the client's goals should have been met and, when appropriate, there should be a seamless transition to less or more intensive case management services. If the client's needs were not met, or the transition did not occur, the reasons should be appropriate and well-documented.	**N.1.** Clients should demonstrate one of the non-medical case management case closure criteria.	**Client's File** should demonstrate one or more of the following case closure criteria being met: • Successful completion of all the goals in the service plan • Transition to a different level of case management continuum of care when applicable • Voluntary withdrawal from the service • Death of the client • Relocation outside of the service area • Client otherwise lost to the service (moved out of jurisdiction, unable to locate after multiple attempts, etc.) • Client demonstrates the ability to independently manage their care in a sustainable manner Severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the provider or unlikely to be helpful to the client
O. Provider will complete a transition/case closure summary.	**O.1** All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for transition/case closure.	Transition/case closure summaries will include: • Date and signature of the provider • Date of transition/case closure • Status of the service plan • Status of primary health care and support service utilization • Reasons for transition/case closure and criteria for re-entry into services

Confidentiality/Documentation		
P. Case management records will reflect compliance with the non-medical case management standards of care. Records should be complete, accurate, confidential, and secure.	**P.1** A client record progress notes will document the date, the type of encounter, and description of the encounter. Transportation of client records should be handled only by authorized personnel and in a manner to ensure security and confidentiality.	There is one record per client. Each client record entry includes date of client visit/contact, reason for visit/contact, any activities performed, outcome plan, and follow-up.
Staff Qualifications		
U. Providers should be appropriately qualified and trained.	**U.1.** Personnel files should document that providers are appropriately credentialed or demonstrate sufficient mastery of skill and knowledge to deliver the service. Providers will have a one-year period starting on their date of hire to document their qualifications.	**Personnel Records** should document qualification of providers by the following means: • As applicable, a copy of a license or certificate as a medical professional (e.g., a physician, nurse, or medical social worker); Official transcripts or certificates showing successful completion of courses of study of the areas listed below; and • (Optional) Completion of the MCM Certificate Online Training (available through DHR). This is in addition to the required trainings outlined in the Universal Service Standards.
X. Meet the client where they are at.	**X.1.** Providers ensure that client services are designed and provided in a way that supports the client but does not require participation in any element unless the client is willing.	**Client's File** demonstrates that if a client does not want to participate in a component of case management services, or does not prioritize an element, it is noted in the file and CM will reevaluate at the next assessment date.

Care Navigation

Care Navigation is intended to assist people living with HIV in accessing services and decision-making for their health-related and/or psychosocial needs. This model is designed to assist

individuals whose needs are minimal and infrequent. It may also be used to provide services to those who do not want or are not ready to engage in more intensive case management services.

Care Navigation strives to provide a varying level of support to a client's need. When receiving Care Navigation services, the client may receive assistance in obtaining medical, social, community, legal, financial, and other needed services. However, Care Navigation does not involve coordination and follow-up of medical treatments, as medical case management does. Care Navigation also does not include the development and monitoring of a treatment plan.

Clients who are newly diagnosed, or new to the Denver system should have an opportunity to have a period of more intensive service (either medical or non-medical case management) to ensure needs have been met prior to being transferred to Care Navigation. Movement from Care Navigation into a more intensive tier can happen at any time client identifies a need, or if reassessment indicates that more support is needed.

A "**service unit**" of care navigation is defined as a visit or encounter lasting 15 minutes or less. This can be either face to face, virtually, via telephone, email, texting, or other mechanism used to provide Care Navigation services.

Key activities

- Initial assessment of service needs
- Periodic re-assessment of service needs
- Address other barriers and make referrals as needed, including but not limited to: mental health, substance use, food bank, medical transportation, etc.
- Managing Ryan White emergency financial assistance, housing, oral health, legal assistance, and HOPWA requests

Providers must also maintain proficiency regarding the following care-related services and must collaborate with the providers of such services:

- **SDAP** Colorado's State Drug Assistance Program (formerly known as "ADAP")
- Colorado's HIV Insurance Assistance Program, including Bridging the Gap, Colorado
- The Housing Opportunities for People with AIDS (HOPWA) program, administered by the Colorado Department of Local Affairs, Division of Housing

Service Units

1 unit = 15 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
Initial Assessment		
A. Working collaboratively with the client, the provider conducts a confidential	**A.1** The provider conducts a needs assessment at least annually or at the client's request. As a client's status	A completed assessment form in the client's record covering the following:

assessment of client's immediate needs.	changes, it will be necessary for the provider to reassess their needs and acuity level. The provider should use an acuity scale as a measurement tool to determine client needs. The acuity scale indicates: • The level of case management complexity • The frequency of contact • The complexity of the provider's overall caseload The provider must contact the client at least once during the year prior to reassessment to offer assistance. This contact may be by phone, mail, or in person.	• Medical, mental health, substance use, psychosocial needs, and basic needs (food, shelter, etc.). A completed acuity level scale in the client's record, including: • Client's current level of need • Evidence that the assessment was completed • Evidence of client is assigned to case management tier based on acuity score. • Evidence acuity level has been updated as needed If client opts out of assessment and/or acuity this is noted in the client's file. **Note:** Tools used for assessment and acuity determination available via DHR or CDPHE. Other assessment tools may include the Client Diagnostic Questionnaire (CDQ), Substance Abuse (Use) & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) which is used in the context of SBIRT.
B. Clients should be able to base their health care decisions on accurate, understandable information about their healthcare and support service options.	**B.1** Clients should be assessed and counseled regarding resources and programs that might be available to them based on their identified needs. Clients should be assessed for the SDAP Colorado's State Drug Assistance Program (formerly known as "ADAP"), including both Medication Assistance and Insurance Assistance.	**Client's File** should include information related to the client needs assessment and detail the available resources that were provided to the client. include

Referrals and Care Coordination		
C. The provider will develop referral resources to make available the full range of additional services to meet the needs of their clients.	**C.1** Provider will develop and maintain comprehensive referral lists for a full range of services.	Referral lists available upon request by DHR.
D. Providers will demonstrate active collaboration other agencies to provide referrals to the full spectrum of HIV-related and other needed services.	**D.1.** Provider will collaborate with other agencies and providers to provide effective, appropriate referrals.	Memoranda of Understanding with services providers on file.
E. Each client receiving Care Navigation services will receive referrals to those services critical to achieving optimal health and well-being.	**E.1.** The provider will support the client to initiate referrals that were agreed upon by the client and the provider.	The provider will document when referrals are made as well as attempts to verify follow up of referrals.
Transition/Case Closure		
F. At the conclusion of Care Navigation services, the client's goals should have been met and, when appropriate, there should be a seamless transition to more intensive case management services.	**F.1** Clients should demonstrate one of the brief contact management case closure criteria.	**Client's File** should demonstrate one or more of the following case closure criteria being met: • Voluntary withdrawal from the service • Death of the client • Relocation outside of the service area • Client otherwise lost to the service (moved out of jurisdiction, unable to locate after multiple attempts, etc.) • Client no longer demonstrates the ability to independently manage their care. Transition to a different level of case management continuum of care when applicable. This typically occurs when client needs are more

		appropriately addressed in a more intense level of service.
G. provider will complete a transition/case closure summary.	**G.1.** All attempts to contact the patient and notifications about case closure will be documented in the patient file, along with the reason for transition/case closure.	Transition/case closure summaries will include: • Date and sign-off of provider • Date of transition/case closure • Reasons for transition/case closure • Criteria for re-entry into services
Confidentiality/Documentation		
H. Care Navigation records should be complete, accurate, confidential, and secure.	**H.1**. Client record progress notes will document the date, the type of encounter and description of the encounter. Storage and transportation of client records should be handled only by authorized personnel and in a manner to ensure security and confidentiality.	There is one record per client. Client record entry includes: • Date of client visit/contact • Reason for visit/contact • Any activities performed • Outcome plan
Staff Qualifications		
I. Providers staff should be appropriately qualified and trained.	**I.1.** Personnel files should document that Providers staff are appropriately credentialed or demonstrate sufficient mastery of skill and knowledge to deliver the service. Providers staff will have a one-year period starting on their date of hire to document their qualifications.	**Personnel Records** should document qualification of the provider by the following means: • As applicable, a copy of a license or certificate as a medical professional (e.g., a physician, nurse, or medical social worker); Official transcripts or certificates showing successful completion of courses of study of the areas listed below; and • (Optional) Completion of the MCM Certificate Online Training (available through DHR). This is in addition to the required trainings outlined in the Universal Service Standards.

X. Meet the client where they are at.	**X.1.** Providers ensure that client services are designed and provided in a way that supports the client but does not require participation in any element unless the client is willing.	**Client's File** demonstrates that if a client does not want to participate in a component of case management services, or does not prioritize an element, it is noted in the file and CM will reevaluate at the next assessment date.

Referral for Health Care and Support Services

Referral Services is intended to assist people living with HIV who were formerly engaged in more intensive tiers of case management and have progressed to self-management or are only in need of Referral Services at this time. Referral Services assist clients to connect with needed core medical or support services and may be provided in person or through telephone, written, or other type of communication. Referral Services is intended to assess the sufficiency of self-management and to provide additional services as indicated by the client. Referral Services clients may have low acuity or may have high acuity but do not want to engage in more intensive case management services at this time.

A "**service unit**" of Referral Services is defined as a visit or encounter lasting 15 minutes or less. This can be either face to face, virtually, via telephone, email, texting, or other mechanism used to provide Referral Services.

In order to qualify as a "service unit" under "Referral Services", the service must have been provided as a stand-alone service, outside the context of any other service such as ongoing case management or linkage to care. This may mean that the service was provided to a client who is not engaged in case management services, or it may mean that the client is seeking a onetime referral service from someone who is not their provider (case manager).

Key activities

- Providing enrollment and eligibility assistance for Ryan White services
- Address identified barriers and make referrals as needed, including but not limited to: mental health, substance use, food bank, medical transportation, etc.
- Managing Ryan White emergency financial assistance, housing, oral health, legal assistance, and HOPWA requests

Service Units

1 unit = 15 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
Initial Assessment		

A. Working collaboratively with the client, the provider conducts a confidential assessment of client's immediate needs. If client opts out, then not required to complete service.	**A.1**. The provider conducts a brief needs assessment annually, beginning at the time of service, or at the client's request. Part of this assessment should be notifying the client about other case management services. As a client's situation changes, it may be necessary for the provider to reassess their needs and acuity level. The provider should use an acuity scale as a measurement tool to determine client needs (abbreviated tool may be used). The acuity scale indicates: The level of case management complexity • The frequency of contact • The complexity of the provider's overall caseload The provider must contact the client at least once during the year prior to reassessment to offer assistance. This contact may be by phone, mail, email, or in person.	A completed assessment form in the client's record covering the following: • Medical, mental health, substance use, psychosocial needs, and basic needs (food, shelter, etc.). A completed acuity level scale in the client's record, including: • Client's current level of need • Evidence that the assessment was completed • Evidence of client is assigned to case management tier based on acuity score. • Evidence acuity level has been updated as needed If client opts out of assessment and/or acuity this is noted in the client's file. **Note:** Tools used for assessment and acuity determination available via DHR or CDPHE. Other assessment tools may include the Client Diagnostic Questionnaire (CDQ), Substance Abuse (Use) & Mental Illness Symptom Screener (SAMISS) and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) which is used in the context of SBIRT.
B. Providers should gather sufficient information from or about the client in order to inform the referral process.	**B.1.** Information collected should include a minimum of: • Name • DOB • Phone Number • Other Contact Information	Referrals are documented in the client file.

	• Type of Referral Requested • Reasons for Request	
Referrals and Care Coordination		
C. A referral service or session(s) covers the information necessary for the client to make an informed decision about the referrals offered and provides the necessary information to the client.	**C.1.** The referral service will cover: • When possible, multiple options for referrals to meet the client's needs • Referrals to appropriate consumer assistance offices (HIV service providers, non-profits, governmental agencies, etc.) • Clients will receive name, contact information, and any other information to follow-up on the referral • Hands-on help completing any necessary applications, including paper and web-based applications	**Client's File** documents all of the elements of referral.
D. Provider has a referral policy that explains how referrals to other providers are made and tracked.	**D.1.** Provider will detail referral procedures and tracking processes.	Provider has a referral policy on file.
E. Provider will track all referrals made and will document follow-up plan with client and follow-up on referral if agreed upon.	**E.1.** Provider will determine best follow-up plan with the client. If client does not want or need referral follow-up, provider may close referral request. If client would like provider to follow-up, provider will document follow-up plan and contact the client and agency referring to. Clients who would like extensive follow-up may be screened for more intensive case management services. All referrals will be tracked by provider, and follow-up/completion is documented when applicable.	**Client's File** shows follow-up plan, and documents follow-up efforts.
F. Providers will maintain appropriate referral relationships with entities that provide core medical and support services, and are HIV aware, and	**F.1**. Provider will develop and maintain comprehensive referral lists for a full range of services. Including but not limited to: • Medical providers;	Referral lists and resources available upon request.

Trauma Informed. This includes the development of a referral resource document to make available the full range of additional services to meet the needs of their clients.	• Oral Health providers; • Substance Use and Mental Health support programs; • Case Management providers; • Housing Services; • Services supporting those experiencing Homelessness; • Legal Services; • Sexual Health Clinics; • Homeless shelters; • HIV counseling and testing sites; • Financial Assistance Services; • Food and Nutrition Support Services; • Employment/Educational/Income support services; • Vision; • Immigration Services**.**	
Confidentiality/Documentation		
G. Provider maintains progress notes of all communication between providers and clients. (This can also be used as the tracking and follow-up mechanism as required in **E.**)	**G.1.** Progress notes are kept in client file and detail client's situation, request for referral, type of referral given, and other details related to the referral.	Documentation in client chart.
H. If client needs cannot be met in a single session, providers will actively schedule and follow up on additional sessions.	**H.1**. Clients should receive as many sessions as necessary to complete the referral process. If ongoing support is required, or if many referrals are needed, client should be considered for more intensive case management services.	**Client's File** show scheduling and follow-up on multiple sessions as needed.
J. Provider has policies and procedures in place regarding client consent for requesting or releasing information.	**J.1.** Provider will provide evidence of policies and procedures for client consent for requesting or releasing information.	**Client's File** has release of information on file when necessary (electronic signatures allowable).
Staff Qualifications		

K. Referral Services staff should be appropriately qualified and trained.	**K.1.** Personnel files should document that Referral Services staff are appropriately credentialed or demonstrate sufficient mastery of skill and knowledge to deliver the service. Referral Services staff will have a one-year period starting on their date of hire to document their qualifications.	**Personnel Records** should document qualification of providers by the following means: • As applicable, a copy of a license or certificate as a medical professional (e.g., a physician, nurse, or medical social worker); Official transcripts or certificates showing successful completion of courses of study of the areas listed below; and • (Optional) Completion of the MCM Certificate Online Training (available through DHR). This is in addition to the required trainings outlined in the Universal Service Standards.
X. Meet the client where they are at.	**X.1.** Providers ensure that client services are designed and provided in a way that supports the client but does not require participation in any element unless the client is willing.	**Client's File** demonstrates that if a client does not want to participate in a component of case management services, or does not prioritize an element, it is noted in the file and CM will reevaluate at the next assessment date.

Childcare Services

The Ryan White HIV Program (RWHAP) supports intermittent child-care services for the children living in the household of people living with HIV who are RWHAP-eligible clients. The assistance provides short-term, or emergency childcare that enables a client to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.

Allowable uses of funds include, but not limited to:

- A licensed or registered childcare provider to deliver intermittent care
- Informal childcare provided by a neighbor, family member, of other person (federal restrictions prohibit giving cash to clients or caregivers to pay for these services)

Units of Service

1 unit = 30 minutes

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Childcare Services are provided to clients who do not have childcare support available to them and is provided to allow the client to connect to HIV-related health and support services.	**A. 1.** Childcare services will be delivered to clients with barriers to access HIV-related health and support services.	**Client's File** documents barriers and how childcare funds are used to access HIV-related health and support services.
	A.2. Providers will document: • Date(s); • Duration; • Reason for the assistance (i.e., attending a medical visit); • Actual cost of service.	**Client's File** documents reasons, dates, and cost of services.

Early Intervention Services

An Early Intervention Services (EIS) program is a package of services designed to identify and link individuals living with HIV to Outpatient/Ambulatory Health Services (OAHS), Case Management Continuum (CMC), and Behavioral Health Services (Mental Health/Substance Use/Psychosocial), 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, as well as providing health education and literacy. Once a client has been successfully linked to OAHS, the EIS engagement is complete. If a client needs ongoing support, the support will happen in CMC Services.

Early Intervention Services (EIS) for Part A may include:

- HIV testing to help those unaware learn of their HIV status, 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 points of entry;
- Access and linkage to HIV care and treatment services such as OAHS, CMC, MH, and SAO/SU; and
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

If an EIS program provides focused 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, active referral(s) to medical case management, behavioral health, or other supportive services was made

Active referral process 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).

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

Acronyms

AIDS	**Acquired Immunodeficiency Syndrome**
DHR	Denver HIV Resources
DHRPC	Denver HIV Resources 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

SDAP	State Drug Assistance Program (formerly known as “ADAP”)

Units of Service

1 unit = 15 min or less

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Programs funded for EIS Linkage services may provide focused HIV testing services to vulnerable populations.	**A.1.** Programs providing HIV testing services must create a focused testing plan.	**Program’s Policies and Procedures** will contain an approved focused 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.	**Program’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.	**Program’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 identified as not being	**B.1.** Clients eligible for EIS are individuals identified as not being connected to services needed for them to maintain their HIV care.	**Client's File** contains the date of a client’s HIV diagnosis.

connected to services needed to maintain their HIV care.	**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 reflects 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 (for example: a referral for confirmatory testing), the responsibility for linking the client to an HIV medical provider, and/or CMC 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.	**Client's File** will contain the Linkage Referral and documentation confirming the client connected to the new EIS Provider.
C. Clients receiving EIS services will be assessed to identify needs and potential barriers to services. The provider will then develop a Linkage Plan.	**C.1.** Within three days of referral to EIS services, the client will be contacted to schedule or complete EIS assessment.	**Client's File** will contain documentation regarding contact with the client, documentation that the client was scheduled to be screened within three business days of a new diagnosis, and an identified need for EIS.
	C.2. Provider will conduct an assessment of needs and barriers linking to medical care and Case Management Continuum as indicated. It may include: • Barriers to medical care; • Client's behavioral health; • Substance use; • Financial situation; • Housing situation;	**Client's File** contains an EIS assessment of needs that includes the date of diagnosis, date of the assessment, and the identified priority need areas.

	• Transportation needs; • Payer source for medical care; and • Health education, risk reduction, and health literacy needs.	
D. EIS program will link client to an HIV medical provider within 30 days and not to exceed 90 days of entry into EIS.	**D.1.** Clients will be referred to an 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 an HIV medical provider within 30 days and not to exceed 90 days of entry into EIS. If a client has not been linked by day 90, the provider will continue to conduct outreach and engagement efforts until client has been linked.	**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. If a client has not been linked by day 90, documentation will reflect, at a minimum, one attempt every two weeks, until the client is linked, or they have opted out of EIS services.
E. EIS providers will make a linkage referral to a Case Management Continuum program within 30 days of entry if CMC services are needed and if the client agrees.	**E.1.** If the EIS screening indicates CMC services are needed and the client agrees, a linkage referral will be made to an CMC program. If the client does not agree, they will be offered information about available CMC 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 CMC services will occur within 30 days of entering EIS if CMC needs have been identified and/or requested.	**Client's File** documents the date of linkage referral reflecting that it was within 30 days of entry into EIS and additional support is documented.

	Program will continue to support the client as needed until they have attended the first CMC appointment.	
	E.3. A release of information will be established between the EIS provider and the CMC program.	**Client's File** documents the date of the linkage referral release of information between the EIS program and the CMC 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 summarize the needs, action steps, and any noted 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, the Linkage Plan will be updated or a new plan completed.	**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.	**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.

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

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
PLHIV	Person(s) Living With HIV
RWHAP	Ryan White HIV/AIDS Program
SDAP	State Drug Assistance Program (formerly known as “ADAP”)

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 (but is not limited to the listed services below), and may include past due charges, but do not include items in collections: • **Phone & Internet:** Payment for cable is not allowable. • **Essential utilities:** water, trash, and heat, etc. • **HIV-related medication** not covered by SDAP (single occurrence or short duration)	**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	• **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 SDAP. Utilization of SDAP 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, and exams. Payments cannot be made to a current Ryan White Part A Program. • **Housing Related Application Fees** • **Child Care Services:** Payments can be made to provide intermittent childcare through a licensed childcare 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 CDPHE 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 CDPHE (link here) demonstrating that the limitation on amount guidelines would cause immediate devastating medical harm.	**Client's File** contains complete and signed medical waiver, if applicable.

	• 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. This waiver is available only for Ryan White Part B eligible Emergency Financial Assistance options, which include essential utilities.	
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 3 – 5 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 them 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

I. All Food Bank/Home Delivered Meal 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;	**Provider's policies and procedures** will document un-allowable costs under RWHAP.

	• Permanent water filtration systems for water entering the house; and • Other non-essential products.	
	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.

II. 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
E. Food banks will make sure their services are accessible for clients.	**E.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.
	E.2. Program should be accessible via public transportation.	**Program's Policies and Procedures** document program accessibility via public transportation.

III. 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
F. Home delivered meals will be provided in a manner convenient to the client and will meet the client's nutritional needs.	**F.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.
	F.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.
	F.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.

G. 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.	**G.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.
H. Program must assess needs of each client receiving home-delivered meals at least once a year to assure compliance with service requirements.	**H.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
PLHIV	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 $1,500 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 $750 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 CDPHE 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 CDPHE (link here) demonstrating that the limitation on 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	**Client's File** contains complete and signed medical waiver, if applicable.

	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.

Linguistic Services

Linguistic Services include interpretation and translation activities, including oral, visual, and written services to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services. Linguistic Services must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Definitions and Descriptions

Translation services are written services provided by a qualified individual as a component of HIV service delivery between the provider and the client.

Interpretation services are oral and visual services provided by a qualified individual as a component of HIV service delivery between the provider and the client.

Acronyms

AACI	American Consortium of Certified Interpreters
AIDS	Acquired Immunodeficiency Syndrome
DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
PLHIV	People Living With HIV
LEP	Limited English Proficiency

Units of Service

Service units of linguistic services are defined as the number of minutes of provided interpretation and/or translation provided on behalf of the client.

1 Unit = 30 minutes or less

Service Components

STANDARD	MEASURE	DATA SOURCE
A. The program will provide linguistic services when interpretation and/or translation is necessary to facilitate communication between the provider and client, as well as support delivery of RWHAP-eligible services.	**A.1.** Linguistic services will be provided as a component of HIV service delivery between the healthcare provider and the client.	**Program's Policies and Procedures** show linguistic services as a component of service delivery
	A.2. Linguistic services will comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) (link here).	**Program's Policies and Procedures** show compliance with CLAS
B. Linguistic services are provided by appropriately trained and qualified individuals holding the appropriate State or local certification.	**B.1.** Individuals providing interpretation and/or translation services will have completed a medical interpreter training that includes, but is not limited to: • Proficient interpreting skills; • Code of ethics; • Knowledge of the healthcare system (and HIV care preferred); • Basic medical terminology; • Culture and its impact on medical interpretation; and • Communication skills for advocacy.	**Personnel file** demonstrates the type, amount (minutes or hours), and date of training that each staff receives both internally and externally.
C. Linguistic services include in-person, over-the phone, and video interpretation services as well as written translation services. Services will be provided in a manner that has the greatest likelihood of ensuring	**C.1.** Programs ensure access to in one or a combination of the following ways for clients with Limited English Proficiency (listed in order of preference): • Bilingual staff or who can communicate directly with clients in preferred language;	**Program's Policies and Procedures** demonstrate that interpretation services are provided in various ways to meet the clients' needs.

maximum participation in the program involved.	• Interpretation provided by:
	  ○ Qualified staff, contract interpreters, or volunteer interpreters in-person;
	  ○ Phone service interpretation; or
	  ○ Video interpretation services.
	• Written translation; or
	• Referral to programs with bilingual clinical administrative and support staff and/or interpretation services by a qualified bilingual/bicultural interpreter	

	C.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.

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 is 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.

Medical Transportation Services funding may not be used to purchase monthly bus passes.

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 another 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. Clients will be informed of the transportation options available to them at the agency in which client receives services. Not all providers offer the same resources at their agency.	**B.1.** Providers should review policy and procedures for the use of medical transportation options with the client and explain the allowable and unallowable uses include the following: Allowable: • Bus tickets • Cab vouchers • Milage reimbursement • Rideshare Unallowable: • Monthly bus passes	**Program's Policies and Procedures** document how clients are informed about allowable and unallowable Medical Transportation Service options with that provider.
C. The program will provide mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical and other support services.	**C.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.
D. The program utilizes RTD discount purchase programs when possible.	**D.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.
E. Rideshare services can be provided by the program, or the client can be reimbursed through a non-cash system for using	**E.1.** If the program uses its own account to provide transportation via rideshare, the rideshare program used must be HIPAA compliant, for example Uber Health and Lyft Business.	**Program's Policies and Procedures** detail which rideshare services the program partners with, and evidence of HIPAA compliance.

a personal rideshare account.	**E.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 the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. They are conducted in a group or individual setting and provided by a licensed mental health professional or authorized professional within the state to render such services. Such professionals typically include psychiatrists, psychologists, licensed professional counselors, nurse practitioners, and licensed clinical social workers.

In some cases, a client may be seen for psychotherapy services, psychiatric needs, or for a brief intervention in an integrated care setting. The standards that apply to all services provided under this category are listed first under "All Mental Health Services Components". The standards that apply to only ongoing psychotherapy services are listed under "Psychotherapy Services Components," and the standards that apply only to brief interventions are listed under "Integrated MH Service Components." Psychiatric services are covered in the "Psychiatric Services Components" section.

Acronyms

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

Units of Service

1 unit = 15 min or less

I. 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; • Or other licensed/authorized providers.	**Personnel File** has proof of certification/ Licensure for the position.
	A.2. Mental health services can be provided by registered psychotherapist, masters level candidate status provider or graduate level student interns with appropriate supervision per licensure or internship regulations and in compliance with Colorado Mental Health statutes (link here).	**Personnel File** clearly designates a supervisor.
B. Treatment will be offered in a timely manner.	**B.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.
C. Referrals made to services related to the treatment 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; • Assess and 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.

II. Psychotherapy Services Components

STANDARD	MEASURE	DATA SOURCE
E. Providers of mental health services will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**E.1.** Therapeutic disclosure will be reviewed and signed by all clients and must be compliant with Colorado Mental Health statutes (link here). 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	**Client's File** contains a copy of the therapeutic disclosure, signed, and dated by both client and therapist.

	• Information about confidentiality and the legal limitations of confidentiality.	
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; • Mental Status Exam (MSE) - physical, behavioral, cognitive, and functional condition; • Medical and psychiatric history; • Family history; • Treatment history; • Cultural issues; • Spiritual issues when pertinent; • Brief psychosocial history; • Diagnosed mental health illness or condition;	**Client's File** contains a copy of the biopsychosocial assessment.
G. Every client shall have a treatment plan which guides their care.	**G.1.** All treatment plans will be discussed and created in collaboration with the client and reflects the client's individual needs and preferences. Treatment plans will: • Be based on the biopsychosocial assessment indicating the client's specific needs and preferences; • Contains client driven goals which define what the client expects to achieve during treatment; • Be completed by the fourth session and updated every six months.	**Client's File** contains a copy of the treatment plan.

H. Upon closure of active mental health services, a client case is closed and contains a closure summary documenting the case disposition.	**H.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; • Documentation of referrals and recommendations for follow-up care	**Client's File** contains a copy of closure summary if patient's case has been closed.
I. The provider will regularly review client's access/barriers to medical appointments and medications.	**I.1.** The provider will document the discussion with the client about access/barriers to medical appointments and medications. Discussions may include: • Assessing for barriers; • Impact on mental and emotional health; • Need for support; • Identifying additional areas where collaboration and/or coordination may be needed.	**Client's File** contains documentation of the discussion with the client and/or any coordination of care as clinically indicated.

J. The program must use evidence-based practices or care supported by empirical evidence.	**J.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. This may include a formal policy and/or inclusion in the provider disclosure.

III. Integrated MH Services (Brief Intervention) Components

STANDARD	MEASURE	DATA SOURCE
K. Integrated Brief Intervention Services will be provided as a part of a larger, integrated, medical visit with the client.	**K.1.** Clients will be offered the opportunity to engage with brief intervention services while at a clinic visit and/or are provided brief services upon request.	**Program's Policies** and Procedures document how in an integrated behavioral health care program, brief intervention services are being implemented and how clients can access services.
L. A brief, informal, clinical assessment of the client's presenting needs will be conducted to determine that the client's needs are appropriate for engagement in brief intervention services (limited to 1-2 consecutive, integrated clinical encounters) and would not be better supported by referral and engagement in ongoing mental health treatment.	**L.1.** An informal assessment of the client's presenting needs will be done at each integrated visit and will document how the client's needs are appropriate for engagement in a brief intervention service.	**Client's File** contains documentation that the client's needs were assessed and the indication for a brief intervention was documented and is in the encounter note for the visit.
	L.2 All client assessments will include a safety assessment and plan.	**Client's File** contains a copy of the safety assessment and plan. The safety assessment and plan is documented in an

		encounter (or visit) note or other EMR record.
	L.3 There should be a documented plan (encounter note) outlining next steps and it will: • Be based on the presenting needs of the client. • Contain the identified next steps	**Client's File** contains a copy of the plan. The plan is documented in an encounter (or visit) note or other EMR record.
	L.4. The program will refer to other services for ongoing mental health or psychiatric care as needed and will document all referrals to internal or external care and services.	**Client's File** contains documentation of referrals. Referrals may be documented in an encounter (or visit) note or other EMR record.

IV. Psychiatric Services Components

Psychiatric treatment services are conducted in an individual setting and provided by a psychiatrist, psychiatric nurse practitioner, or another clinician authorized within the State of Colorado to render such services and may include the prescription of medication and/or referrals to other types of mental health services.

STANDARD	MEASURE	DATA SOURCE
M. A psychiatric assessment will be completed for all patients.	**M.1** The psychiatric assessment is completed at the first visit and that it reflects the client's immediate clinical needs.	**Client's File** contains results from psychiatric assessment, with evidence that charting was completed within 48 hours of visit.

N. Every client shall have a treatment plan which guides their care.	**N.1** All treatment plans will be discussed and created in collaboration with the client and will reflect the client's individual needs and preferences. Treatment plans will: • Be based on the psychiatric assessment and should indicate the client's needs and preferences; • Plans should be reviewed and revised as needed, depending on the scope of the services being provided. • 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** documentation of the treatment plan.
O. The program will refer to other services for ongoing mental health or other behavioral health service as needed.	**O.1.** Referrals to qualified practitioners and/or services will occur if clinically indicated. All internal and/or external referrals will be documented in the client's file.	**Client's File** will contain documentation of referrals.

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 PLHIV. 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
eURN	Encrypted Unique Record Number
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
SDAP	State Drug Assistance Program (formerly known as “ADAP”)

Units of Service

1 unit = 1 visitation of any duration

I. Oral Health 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;	**Client's File** will have a signed and dated oral evaluation on file in patient chart.

	• 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; • 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 Professional Conduct, and respective agencies code of ethics.	**Client's File** demonstrates the provider is acting ethically and in the best interest of the client.
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	**Client's File** shows proper treatment is given based on

	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.	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.

II. Oral Health Fund

The Oral Health Fund (**OHF**) is a percentage of the Oral Health Care service category allocations annually decided upon by the Denver HIV Resources Planning Council (**DHRPC**) 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
J. Clients must be eligible for services, including at or below 500% of the Federal Poverty Level (**FPL**). They also must have current eligibility documentation on file.	**J.1.**Client eligibility must be provided and cover the duration of the OHF request and treatment plan estimated timeline.	**Client's File** contains documentation that shows client eligibility for dental assistance.
	J.2. Clients eligible for dental assistance, may only access up to $5,000 maximum for the current fiscal year (**FY**), regardless of the number of requests.	**OHF Administrator Records** will ensure the client has not exceeded the annual cap prior to pre-approval.
K. In alignment with the payer of last resort legislative requirement, the program will make a reasonable effort to secure other funding sources prior to requesting dental assistance from the Ryan White Part A Program.	**K.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.
	K.2. The client will complete the Oral Health Fund (OHF) Agreement form (link here) prior to the application, pre-approval and payment of OHF assistance.	**Client's File** contains a signed copy of the OHF Agreement form. This form only needs to be signed once initially and again when/if the form is updated by CDPHE/DDPHE.
L. OHF assistance payments can be made for client out-of-pocket	**L.1.** Dental assistance payments can be made for client out-of-pocket costs including:	**Client's File** contains documentation that the services fall within the

costs for oral health care services.	• Routine exams/cleaning • X-rays • Fillings and crowns • Endodontic care (like root canals) • Extractions • Dentures and bridges • Periodontal care (like gingivitis) • Oral cancer screenings • Emergency care • Night guard(s) • Orthodontics and implants (if medically necessary)	scope of allowable services under the RWHAP. If services are out of scope, the file must also include documentation of referrals made and contains a statement of medical necessity.

	L.2. Oral Health Fund cannot pay for:
	• Cosmetic procedures, including:
	  • Teeth whitening;
	  • Veneers;
	  • Orthodontics and implants for cosmetic purposes	

	L.3. Oral health funds cannot be used for direct cash payments to clients.	**OHF Application and Invoice(s)** documents that direct cash payments are not made to clients.
M. Providers, including dental clinic staff, will apply for OHF assistance after confirming that requirements J-L have been met.	**M.1.** Providers must complete an online application (link here) for OHF assistance that meet the requirements outlined in J-L. Submission of the application does not guarantee funding.	**Client's File and OHF Online Application** contains documentation that J-L have been completed prior to the application submission.
	M.2. Online applications must include the following information and supporting documentation	**OHF Online Application** contains all required documentation, and relevant supporting

	• Client eURN,
	• Date of Birth,
	• Details about need/service,
	• A copy of the dental treatment plan, which should include:
	  • Client and dental clinic/provider information (with client information blacked out)
	  • Diagnosis
	  • List of recommended procedures/services and their costs
	  • Insurance and discount adjustments
	  • Treatment timeline
	Ideally, treatments can be completed within 90 days.
		documentation, as outlined in M.2.
		
		OHF Administrator Records include additional documents that were not included in the initial OHF application.

	M.3. The OHF Administrator will review all information for completeness as outlined in M.2. Applications will be processed in the order they are received.
	The OHF Administrator will contact the requestor within 5-7 business days of submission.
	Requestors will receive one of the following:
	• A pre-approval, pending funding availability:
	  • Client eURN;
	  • Dollar amount to be held;
	  • Dental clinic/provider;
	  • Expiration date of hold
	• A denial if the application does not meet requirements outlined in these Service Standards, specifying the reason for the denial, if applicable;
		OHF Administrator Records will include documentation of the review, follow-up date, any missing or clarifying questions, the pre-approved amount, the expiration date of the assistance held, and, if applicable, the estimated waitlist timeline.

	• An estimated waitlist timeline, if funding is not available, but may be in the future.	
	M.4. If pre-approved, funding can only be held for services related to the current Fiscal Year (FY). Requestors must apply for assistance only for services that can be completed within the FY they are applying for. If services are not completed within the FY, requestors will need to resubmit an OHF application in the next FY. Prior pre-approval of funds does not guarantee approval of future funds.	**OHF Administrator Records** will include the expiration date for funds in Google Sheets and in pre-approval emails.
N. Upon pre-approval of a dental assistance request, the OHF Administrator will hold the pre-approved dollar amount for 90 days. The OHF Administrator may use discretion to extend the 90 days hold on funding.	**N.1.** The OHF Administrator will track all applications and supporting documents, regardless of the decision, using Google Sheets and SharePoint (or other secure file management system). This tracking will include: • Date of Application; • Request details (including estimated completion date and amount requested); • Client eURN.	**OHF Administrator Records** will include all documentation related to each application, regardless of the decision made.
	N.2. Requests approved on or after November 30th will expire on the last day of the fiscal year.	**OHF Administrator Records** contain documentation of the dental assistance request expiration dates.
O. Providers, including dental staff, will assist the client with accessing and receiving dental assistance, including scheduling, and	**O.1.** The client and provider 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.

coordinating dental appointments.	**O.2.** Clients will receive assistance in accessing Oral Health Funds and scheduling related dental services. Clients will be informed that services should be completed within the current FY. • Ryan White Part A Dental Providers will submit OHF applications and invoices on behalf of the client; • Non-Ryan White Part A Dental Providers may submit OHF applications and invoices directly or they may be submitted by a case manager	**Client's File** includes documentation of scheduled appointments.

P. OHF invoices will be submitted and processed within the 90-day hold period (unless another deadline is established by the OHF Administrator).	**P.1.** Providers must submit OHF invoices through the Single Payer Web App (**SPWA**) and include the following:
	• OHF Administrator's pre-approval email(s)
	• Dental invoice(s) for the current FY, which includes:
	  • Name of client and dental clinic;
	  • Date of invoice;
	  • Description of services, including dates of service(s);
	  • Itemized cost of each service with insurance and discount adjustments;
	  • Client's portion of amount due and due date;
	  • Invoice from provider within 60 days of treatment.
		Single Payer Records include the details outlined in for P.1.

	P.2. Checks for OHF assistance will be issued by the contracted Single Payer program.	**Single Payer Records** contain check information.

	P.3. Checks will be sent to the vendor address provided or the requestor may pick up the check from the SPWA office to deliver/mail to the vendor directly. Checks cannot be payable or issued to clients.	**Single Payer Records** demonstrate that checks are issued directly to the vendor.
	P.4. The Single Payer will maintain electronic records of checks related to dental assistance requests.	**Single Payer Records** contain check information.
	P.5. Approved check request will be completed within 5-7 business days of the Single Payer Web App (**SPWA**) submission date.	**Single Payer Records** demonstrate that check requests were completed in a timely manner.
	P.6. The OHF Administrator will maintain the Google spreadsheet with updated information to manage waitlists and funding availability.	**OHF Administrator Records** documents updates to OHF funding tracking and funding availability.

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
PLHIV	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 PLHIV.	**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 (link here)	**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 (link here)	**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 (link here)	**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 PLHIV 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.

Other Professional Services

People living with HIV may encounter restrictive social, economic, and systemic conditions that can be mitigated through access to legal information, advice, and services. Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities.

Other professional services are services to individuals with respect to powers of attorney, living wills, do-not-resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program. Legal services to arrange for guardianship, joint custody, or adoption of children after the death of their primary caregiver should be reported as a permanency planning service.

Other professional services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP. It is expected that all other sources of funding in the community for other professional services will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort.

Acronyms

ABA	American Bar Association
AIDS	Acquired Immunodeficiency Syndrome
CBA	Colorado Bar Association
DHR	Denver HIV Resources
HIV	Human Immunodeficiency Virus
PLHIV	Person(s) Living With HIV
SSDI	Social Security Disability Insurance
SSI	Social Security Income
TGA	Transitional Grant Area

Units of Service

1 unit = 1 visit

1 unit = 1 assistance request (*included denied requests*)

Service Components

STANDARD	MEASURE	DATA SOURCE
A. Other professional services attorneys are licensed by the state of Colorado and practice according to professional rules of conduct.	**A.1.** Attorneys and pro bono attorneys are licensed by the state of Colorado and are members in good standing with the State Bar of Colorado.	**Personnel File** contains appropriate licensure.
	A.2. Attorneys and pro bono attorneys will practice according to the: • American Bar Association's Model Rules for Professional Conduct and • Colorado Bar Association's Rules of Professional Conduct.	**Program's Policies and Procedures** demonstrate that attorneys practice according to the rules of conduct.
	A.3. Unlicensed staff are supervised by licensed attorneys.	**Program's Policies and Procedures** show that unlicensed staff are supervised.
B. Program staff will respond to clients in a timely manner.	**B.1.** Program staff will respond to clients within three business days.	**Program's Policies and Procedures** contain a process for responding to clients.
C. Program will have a client intake process.	**C.1.** Program intake process will include: • Assessment of legal needs and medical care status; • Screening for duplication of services; and • Collection of client information.	**Program's Policies and Procedures** contain a client intake process.

D. The provision of other professional services is provided to eligible clients for services allowable under the RWHAP Part A.	**D.1.** Allowable other professional services include: • Legal representation, assistance, counselling, advocacy, and education; • Assistance with public benefits such as SSI and SSDI; • Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP; • Preparation of healthcare power of attorney, durable powers of attorney, and living wills; • Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including: o Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney; and o Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption; • Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits; and • Immigration and naturalization; • ID cards;	**Program's Policies and Procedures** document what services are provided to the client.

	• Colorado Bureau of Investigation (CBI) background investigation fees.	
	D.2. RWHAP Part A funds unallowable costs include: • traffic violations; • criminal defense; and • class-action lawsuits unless related to access to services eligible for funding under the RWHAP.	**Program's Policies and Procedures** document unallowable other professional services.
E. Program will refer clients to other programs for other professional services that are beyond the scope of the RWHAP funded program.	**E.1.** If the client's needs are beyond the scope of the other professional services provided by the RWHAP-funded program, the program will make referrals to services and/or programs based on the requests and preferences of the client.	**Program's Policies and Procedures** include a process for referring clients.
	E.2. Program will inform clients of additional RWHAP core and support services and refer the client to these services if requested.	**Program's Policies and Procedures** include a process for referring clients to additional RWHAP services.

Psychosocial Support Services

Psychosocial support services and programs are designed to help clients connect with peers, promote self-advocacy, and explore strategies for living self-defined healthy lives.

Psychosocial services are not clinical in nature and differ from mental health and substance use services. It is strongly encouraged that people leading services in this category are people living with HIV.

Services funded under Psychosocial can include:

- Support Groups
- One-on-One support
- Spiritual and Faith Based support services

Support services may include food, transportation, or childcare assistance to support participation in one-on-one and group sessions.

Units of Service

1 unit = 15 min 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.** Clients will receive support to: • Navigate medical and support services; • Develop and enhance social and communication tools; • Promote and sustain a sense of self-efficacy; • Ability to self-advocate; • Develop and utilize coping strategies; • Reduce stigma around HIV and disclosure; • Increase social connection with peers; • Meet other Psychosocial need(s).	**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 support discussion and a safe environment.	**B.1.** Facilitator(s) and session participants will develop and use ground rules, which at a minimum cover: • Confidentiality; • Aspects of self-care, safety, and inclusivity; • Respectful Communication; • Applicable Mandatory Reporting.	**Program's File** contain a copy of the ground rules with the sessions' records.
	B.2. Ground rules are in written form and verbally reviewed at each session.	
C. Psychosocial support sessions will be open to PLHIV regardless of whether they are current service recipients at the program providing the service.	**C.1.** Programs will permit attendance for PLHIV not receiving other Ryan White Part A services. 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.
	C.2. Services may involve affected individuals in need of social support.	**Program's Policies and Procedures** demonstrate 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 spiritual or faith based support services, 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 core and support services,	**E.1.** The program will have a process for referring clients to programs that provide behavioral health services, medical case management, and/or other core and support services.	**Program's Policies and Procedures** documents process of referring clients to

as appropriate and indicated by the client.		the appropriate services.
F. The structure, content and logistics of psychosocial support groups will be based on the clients' needs and interests identified through ongoing 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 may consider the following: ● Meeting Logistics (location, date, time, etc.) ● Meeting content and structure ● Need for supplemental media or other resources to enhance content ● Need for transportation, childcare, and/or food ● Ground rules ● 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 upon request.
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.
H. It is recommended that sessions be facilitated by a person with lived experience pertaining to the purpose and focus of the group.	**H.1.** Facilitators should have the appropriate skills and training.	**Personnel Files** demonstrate facilitators' experience, skills, and/or training.

	H.2. It is encouraged that participant facilitators be compensated. Compensation amount and type should be discussed with facilitators prior to beginning sessions.	**Program's Files** demonstrate that participant facilitators were compensated (amount, date of facilitation, receipt of compensation)

Substance Use (Outpatient) Services

Substance use services (outpatient) are medical, treatment, and/or counseling to address substance use problems in an outpatient setting, under the supervision of qualified personnel.

Services may include:

- Pre-treatment/recovery readiness programs, such as, the Screening, Brief Intervention, and Referral to Treatment (**SBIRT**) Program;
- Harm reduction (may include syringe access services);
- Mental health counseling for substance use and to reduce depression, anxiety and other disorders associated with substance use;
- Individual treatment and counseling;
- Group treatment and counseling;
- Peer Specialist led intervention;
- Medication Assisted Therapy (**MAT**) (e.g., suboxone, buprenorphine, naloxone, methadone, naltrexone, etc.);
- Psychiatric medication;
- Relapse prevention;
- Acupuncture/Auricular detox (AcuDetox) services; and
- Other evidence-based methods.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ASAM	American Society of Addiction Medicine
BHA	Behavioral Health Administration, Colorado Dept. of Human Services
DHR	Denver HIV Resources
DORA	Colorado Dept. of Regulatory Agencies
HIV	Human Immunodeficiency Virus
MAT	Medication Assisted Therapy
SUD	Substance Use Disorder

Units of Service

1 unit = individual or group session of 15 minutes or less

1 unit = methadone or other MAT dispensing visit

1 unit = medical visit of 15 minutes or less

I. Substance Use (Outpatient) Counseling Services

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 (link here). 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 (link here)	**Program's Policies and Procedures** indicate standards of supervision.
B. Treatment will be offered in a timely manner.	**B.1.** Clients will be contacted within 5 business days of first contact or referral to offer appointment options. Treatment appointments will be completed within 10 business days if the client is not in crisis. During the waiting period, other harm reduction support services will be provided. If the client is in crisis, they will be seen immediately, or proper referrals will be made.	**Client's File** documents date of first contact or referral, and whether or not the client is in crisis.

C. The program will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**C.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; • DORA 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 DORA; • 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 therapeutic disclosure, signed, and dated by both client and counselor.

D. A biopsychosocial assessment will begin at the first session and be completed by the second session.	**D.1.** The biopsychosocial assessment will be completed within the first 2 sessions for all clients seeking ongoing treatment and will include, but is not limited to: • Presenting issue and/or SUD diagnosis; • ASAM; • Mental Status Exam (MSE) - physical, behavioral, cognitive, and functional condition; • Medical and psychiatric history; • Family history; • Treatment history; • Cultural issues; • Spiritual issues when pertinent; • Brief psychosocial history; • History or diagnosis of mental health illness or condition	**Client's File** contains a copy of the biopsychosocial assessment.
	D.2. The assessment is completed in compliance with BHA regulations (link here) and ASAM criteria (link here)	**Program** keeps on file most recent BHA audit or review reports if applicable.
E. Every client shall have a treatment plan which guides their care.	**E.1.** All treatment plans will be discussed and created in collaboration with the client and reflect the client's individual needs and preferences. Treatment plans will: • Be based on the biopsychosocial assessment indicating the client's specific needs and preferences; • Contains client driven goals which define what the client expects to achieve during treatment; • Be completed by the fourth session and updated every six months.	**Client's File** contains a copy of the treatment plan.

F. The provider will regularly review client's access/barriers to medical appointments and medications.	**F.1.** The provider will document the discussion with the client about access/barriers to medical appointments and medications. Discussions may include: • Assessing for barriers; • Impact on substance use, and/or mental and emotional health; • Need for support; • Identifying additional areas where collaboration and/or coordination may be needed.	**Client's File** contains documentation of the discussion with the client and/or any coordination of care as clinically indicated.
G. Referrals made to services related to the treatment plan shall be made in a timely manner and documented.	**G.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.
H. Upon closure of active substance use services, a client's case is closed and contains a closure summary documenting the case disposition.	**H.1.** Closure summaries shall be completed within 5 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; • Documentation of referrals and recommendations for follow-up care.	**Client's File** contains a copy of closure summary if client's case has been closed.

I. Progress notes shall be completed after every contact with the client.	**I.1.** Progress notes should: • Be a written chronological record; • Assess and document any change in physical, behavioral, cognitive, and functional condition; • Document any action taken by staff to address the client's changing needs; and • An assessment of the client's adherence to substance use treatments. • 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 progress notes.
J. The program must use evidence-based practices or care supported by empirical evidence.	**J.1.** The program uses evidence-based practices, which may include, but are not limited to: • Group Therapy; • MAT Services; • Peer Services; • Motivational Interviewing; • Cognitive Behavioral Therapy (CBT); • Dialectical Behavioral Therapy (DBT); • Harm Reduction; • Overdose Prevention; • Relapse Prevention; • Trauma-Informed and Trauma-Responsive Treatment; and • Psychoeducation.	**Program's Policies and Procedures** documents which practices are implemented.

II. Brief Intervention Services

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 (link here). 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 (link here)	**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; • DORA 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 DORA; • 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 therapeutic disclosure, signed, and dated by both client and counselor.
C. Brief Intervention Services will be provided as a part of a larger, integrated, medical visit with the client.	**C.1.** Clients will be offered the opportunity to engage with brief intervention services while at a clinic visit and/or are provided brief services upon request.	**Program's Policies** and Procedures document how in an integrated behavioral health care program, brief intervention services are being implemented and how clients can access services.

D. A brief, informal, clinical assessment of the client's presenting needs will be conducted to determine that the client's needs are appropriate for engagement in brief intervention services (limited to 1-2 consecutive, integrated clinical encounters) and would not be better supported by referral and engagement in ongoing substance use services.	**D.1.** An informal assessment of the client's presenting needs will be done at each integrated visit and will document how the client's needs are appropriate for engagement in a brief intervention service.	**Client's File** contains documentation that the client's needs were assessed and the indication for a brief intervention was documented and is in the encounter note for the visit.
	D.2. All client assessments will include a safety assessment and plan.	**Client's File** contains a copy of the safety assessment and plan. The safety assessment and plan is documented in an encounter (or visit) note or other EMR record.
	D.3 There should be a documented plan (encounter note) outlining next steps and it will: • Be based on the presenting needs of the client. • Contain the identified next steps	**Client's File** contains a copy of the plan. The plan is documented in an encounter (or visit) note or other EMR record.
	D.4. The program will refer to other services for ongoing substance use, and/or other behavioral health services as needed and will document all referrals to internal or external care and services.	**Client's File** contains documentation of referrals. Referrals may be documented in an encounter (or visit) note or other EMR record.

E. Progress notes shall be completed after every contact with the client.	**E.1.** Progress notes should: • Be a written chronological record; • Assess and document any change in physical, behavioral, cognitive, and functional condition; • Document any action taken by staff to address the client's changing needs; and • An assessment of the client's adherence to substance use treatments. • 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 progress notes.

III. MAT Services

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 (link here). 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 (link here)	**Program's Policies and Procedures** indicate standards of supervision.

B. Treatment will be offered in a timely manner.	**B.1.** Clients will be contacted within 5 business days of first contact or referral to offer appointment options. Treatment appointments will be completed within 10 business days if the client is not in crisis. During the waiting period, other harm reduction support services will be provided. If the client is in crisis, they will be seen immediately, or proper referrals will be made.	**Client's File** documents date of first contact or referral, and whether or not the client is in crisis.
C. The program will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**C.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; • DORA 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 DORA; • 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 therapeutic disclosure, signed, and dated by both client and counselor.
D. Clients will be assessed for MAT services.	**D.1** The initial MAT assessment is completed at the first visit and that it reflects the client's immediate medication needs.	**Client's File** contains results from MAT assessment, with evidence that

	D.2 Reassessment for MAT will be conducted at subsequent visits as clinically indicated.	charting was completed within 48 hours of visit. **Client's File** will contain documentation that they have received the information as outlined in D.3 and consents to the medication plan.
	D.3 Clients will be informed of potential side effects, risks, and alternative treatments. If being prescribed a controlled medication, clients will be educated on the significance of the medication as well as the clinic policy for monitoring and providing refills.	
E. Every client shall have a prescription medication plan which guides their care.	**E.1** All prescription medication plans will be discussed and created in collaboration with the client and will reflect the client's individual needs and preferences. Prescription medication plans will: • Be based on the MAT assessment and should indicate the client's needs and preferences; • Plans should be reviewed and revised as needed at minimum every six months, depending on the scope of the services being provided. • Include reason if prescribing a medication that has the potential to interact negatively with the client's HIV medications, and a plan for monitoring of the client's health.	**Client's File** documentation of the prescription medication plan.

F. The provider will regularly review client's access/barriers to medical appointments and medications.	**F.1.** The provider will document the discussion with the client about access/barriers to medical appointments and medications. Discussions may include: • Assessing for barriers; • Impact on substance use, and/or mental and emotional health; • Need for support; • Identifying additional areas where collaboration and/or coordination may be needed.	**Client's File** contains documentation of the discussion with the client and/or any coordination of care as clinically indicated.
G. The program will refer to other services for substance use, mental health**,** or other behavioral health services, as needed.	**G.1.** Referrals to qualified practitioners and/or services will occur if clinically indicated. All internal and/or external referrals will be documented in the client's file.	**Client's File** will contain documentation of referrals.
H. Progress notes shall be completed after every contact with the client.	**H.1.** Progress notes should: • Be a written chronological record; • Assess and document any change in physical, behavioral, cognitive, and functional condition; • Document any action taken by staff to address the client's changing needs; and • An assessment of the client's adherence to substance use treatments. • 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 progress notes.

IV. Psychiatric Services

Psychiatric treatment services are conducted in an individual setting and provided by a psychiatrist, psychiatric nurse practitioner, or another clinician authorized within the State of Colorado to render such services and may include the prescription of medication and/or referrals to other types of mental health services.

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 (link here). 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 (link here)	**Program's Policies and Procedures** indicate standards of supervision.
B. Treatment will be offered in a timely manner.	**B.1.** Clients will be contacted within 5 business days of first contact or referral to offer appointment options. Treatment appointments will be completed within 10 business days if the client is not in crisis. During the waiting period, other harm reduction support services will be provided. If the client is in crisis, they will be seen immediately, or proper referrals will be made.	**Client's File** documents date of first contact or referral, and whether or not the client is in crisis.

C. The program will utilize a mandatory disclosure form in compliance with Colorado mental health statutes.	**C.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; • DORA 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 DORA; • 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 therapeutic disclosure, signed, and dated by both client and counselor.
D. A psychiatric assessment will be completed for all clients.	**D.1** The psychiatric assessment is completed at the first visit and that it reflects the client's immediate clinical needs.	**Client's File** contains results from psychiatric assessment, with evidence that charting was completed within 48 hours of visit.

E. Every client shall have a treatment plan which guides their care.	**E.1** All treatment plans will be discussed and created in collaboration with the client and will reflect the client's individual needs and preferences. Treatment plans will: • Be based on the psychiatric assessment and should indicate the client's needs and preferences; • Plans should be reviewed and revised as needed, depending on the scope of the services being provided. • 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 a copy of the treatment plan.
F. The provider will regularly review client's access/barriers to medical appointments and medications.	**F.1.** The provider will document the discussion with the client about access/barriers to medical appointments and medications. Discussions may include: • Assessing for barriers; • Impact on substance use, and/or mental and emotional health; • Need for support; • Identifying additional areas where collaboration and/or coordination may be needed.	**Client's File** contains documentation of the discussion with the client and/or any coordination of care as clinically indicated.
G. The program will refer to other services for ongoing mental health or other behavioral health services as needed.	**G.** The program will refer to other services for ongoing mental health or other behavioral health services as needed.	**Client's File** will contain documentation of referrals.

H. Progress notes shall be completed after every contact with the client.	**H.1.** Progress notes should: • Be a written chronological record; • Assess and document any change in physical, behavioral, cognitive, and functional condition; • Document any action taken by staff to address the client's changing needs; and • An assessment of the client's adherence to substance use treatments. • 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 progress notes.

V. Peer Support Services

Peer Support Services for substance use outpatient care provide treatment support through trained peers with lived experience. This approach emphasizes mutual support and empowerment to foster recovery and improve health outcomes. Peer Support Specialists should offer effective, client-centered, and culturally sensitive support to individuals with substance use disorders, helping them access resources and remain engaged in care.

STANDARD	MEASURE	DATA SOURCE
A. Peer Support Substance Use Services will be provided by qualified peers. Peer Specialists should receive a documented, competency-based training based on a recognized peer support curriculum, such as Certified Peer Recovery Training Program in Colorado.	**A.1.** Individuals providing peer support services must have personal lived experience with mental health, substance use, recovery, trauma, and/or co-occurring conditions. Peers should receive ongoing training to effectively support individuals and maintain their Colorado Peer Specialist Certification.	**Personnel File maintains** detailed staff qualifications.
	A.2. Peers should complete or be offered the following training either before or upon beginning service: • Substance use basics, • Harm reduction	

	• Crisis intervention • Treatment interventions • Motivational interviewing • Effective communication • Ethics and boundaries • Goal setting	
B. Peer Support Providers should receive regular supervision to offer guidance, address challenges and ensure quality support.	**B.1.** Supervisors of peer support programs should be qualified, which may include meeting Colorado Mental Health statutes. At minimum, they should have the following trainings/competencies: • Peer Support Supervisor training or certification (like CPSS-S) • Effective communication and active listening • Strength-based supervision • Ethics and boundaries • Recovery focused	**Personnel File maintains** detailed staff qualifications.
	B.2. Peer support staff will receive regular supervision and should include the following: • Case conferencing, • Burnout prevention, • Identifying additional training and certification opportunities • Assisting Peer Support Specialists in identifying areas for personal growth and creating professional development plans. • Building trust and integrity in the supervisory relationship with Peer Support Specialists through honest and respectful communication.	**Personnel File** details documentation of supervision.

C. Peer Support Services include individual counseling, peer support groups, recovery coaching, referral to services, care navigation, outreach and engagement, networking, and education on substance use and health.	**C.1.** Clients will be offered the opportunity to engage with peer support staff through internal programs or external referrals. Peers should engage in self- care and practice non-judgmental and effective listening skills.	**Program's Policies** and Procedures document how Peer Support Substance Use services will be offered to clients, if requested or indicated. **Client's File** will document any referral made on behalf of the client.
D. Peer Support Providers will meet clients where they are in their recovery journey.	**D.1.** Peer-led substance use support services will be provided in a client-centered manner, allowing clients to dictate their needs and goals. Peers should respect an individual's right to choose the recovery pathway they believe works best for them.	**Client's File** will document client-centered goals and needs.
	D.2. Client's goals can be documented in a recovery wellness plan or through other methods. All interactions with clients should be recorded in the client's file including: • Phone calls • voicemail • Text messages • Emails • In-person meetings • Group meetings	**Client's File** will document any encounters made by peer support staff.

Service Unit Summary Table

Service Category	Description of 1 Service Unit =
Case Management Continuum	15 minutes or less
Childcare Services	30 minutes or less
Early Intervention Services	15 minutes or less
Emergency Financial Assistance	1 assistance request (*included denied requests*)
Food Bank/Home Delivered Meals	1 meal
	1 bag of groceries
Housing Services	1 assistance request (*included denied requests*)
Linguistic Services	30 minutes or less
Medical Transportation Services	1 bus trip (bus trip = one ticket)
	1 one-way cab voucher
	1 vehicle mileage reimbursement
	1 one-way rideshare trip
Mental Health Services	15 minutes or less
Oral Health Services	1 visitation of any duration
Oral Health Fund	1 assistance request (*included denied requests*)
Outpatient Ambulatory/Health Services	1 visitation of any duration
Other Professional Services	1 visitation of any duration
	1 assistance request (*included denied requests*)
Psychosocial Support Services	15 minutes or less
Substance Use Outpatient Services	Individual or group session of 15 minutes or less
	Methadone or other MAT dispensing visit
	Medical visit of 15 minutes or less

Revision History

SERVICE CATEGORY	DATE OF REVISION
Definitions and Descriptions	
Acronyms	
Universal Standards	11/25/24
Case Management Continuum	10/3/24
Childcare Services	1/5/23
Early Intervention Services	2/1/24
Emergency Financial Assistance	10/3/24
Food Bank and Home-Delivered Meals	
Housing Services	10/3/24
Linguistic Services	
Medical Transportation Services	1/27/25
Mental Health Services	2/1/24
Oral Health Care Services	1/27/25
Other Professional Services	10/3/24
Outpatient Ambulatory/Health Services	
Psychosocial Support Services	1/5/23
Substance Use (Outpatient) Services	11/25/24

DENVER
PUBLIC HEALTH & ENVIRONMENT

Exhibit G-1
Federal Provisions

Ryan White Part A Funds

Federal Award ID (FAIN) #: H8900027
Federal Award Date: 01/13/2025
Federal Awarding Agency:
Department of Health and Human Services
Health Resources and Services Administration

Pass-Through Entity:
City & County of Denver
Department of Public Health and Environment (DDPHE)
201 W. Colfax Ave., Floor 8, Denver, CO 80202

Contact Information forwarding official of the pass-through entity:
Robert George, Section Manager
Robert.George2@denvergov.org

Assistance Listing Number: 93.914
Federal Award Project Title: HIV Emergency Relief Project Grants

Total Federal funds obligated to subrecipient this fiscal year, FY2025:
$450,652.00 – Ryan White Part A Funds

Total amount of Federal Award: $1,406,203.00

Was SAM.gov verified and search documented: Yes

Exhibit H

Department of Health and Human Services
Health Resources and Services Administration

Notice of Award
FAIN# H8900027
Federal Award Date: 01/13/2025

Recipient Information

1. Recipient Name
DENVER CITY & COUNTY MAYOR'S OFFICE
200 W 14th Ave
Denver, CO 80204-2732

2. Congressional District of Recipient
01

3. Payment System Identifier (ID)
1846000582A1

4. Employer Identification Number (EIN)
846000582

5. Data Universal Numbering System (DUNS)
145454687

6. Recipient's Unique Entity Identifier
NHCESD6KEFH1

7. Project Director or Principal Investigator
Robert George
Program Manager
robert.george2@denvergov.org
(720)891-1617

8. Authorized Official
Robert George
Program Manager
robert.george2@denvergov.org
(720)891-1617

Federal Agency Information

9. Awarding Agency Contact Information
Marie E Mehaffey
Grants Management Specialist
Office of Federal Assistance Management (OFAM)
Division of Grants Management Office (DGMO)
MMehaffey@hrsa.gov
(301) 945-3934

10. Program Official Contact Information
Dzifa Awunyo-Akaba
Project Officer
HIV/AIDS Bureau (HAB)
dawunyoakaba@hrsa.gov
(240) 290-2269

Federal Award Information

11. Award Number
2 H89HA00027-32-00

12. Unique Federal Award Identification Number (FAIN)
H8900027

13. Statutory Authority
42 U.S.C. § 300ff-11-20 and § 300ff-121

14. Federal Award Project Title
HIV EMERGENCY RELIEF PROJECT GRANTS

15. Assistance Listing Number
93.914

16. Assistance Listing Program Title
HIV Emergency Relief Project Grants

17. Award Action Type
Competing Continuation

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19. Budget Period Start Date 03/01/2025 - End Date 02/28/2026	
20. Total Amount of Federal Funds Obligated by this Action	$1,406,203.00
20a. Direct Cost Amount	
20b. Indirect Cost Amount	$0.00
21. Authorized Carryover	$0.00
22. Offset	$0.00
23. Total Amount of Federal Funds Obligated this budget period	$1,406,203.00
24. Total Approved Cost Sharing or Matching, where applicable	$0.00
25. Total Federal and Non-Federal Approved this Budget Period	$1,406,203.00
26. Project Period Start Date 03/01/2025 - End Date 02/29/2028	
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	$1,406,203.00

28. Authorized Treatment of Program Income
Addition

29. Grants Management Officer – Signature
Karen Mayo on 01/13/2025

30. Remarks

This award consists of the following amounts:
FY25 FRML - $1,334,597
FY25 MAI - $71,606
Total Funding - $1,406,203

HRSA
Health Resources & Services Administration

Notice of Award
Award Number: 2 H89HA00027-32-00
Federal Award Date: 01/13/2025

HIV/AIDS Bureau (HAB)

31. APPROVED BUDGET: (Excludes Direct Assistance)

[X] Grant Funds Only

[ ] Total project costs including grant funds and all other financial participation

a.	Salaries and Wages:	$0.00
b.	Fringe Benefits:	$0.00
c.	Total Personnel Costs:	$0.00
d.	Consultant Costs:	$0.00
e.	Equipment:	$0.00
f.	Supplies:	$0.00
g.	Travel:	$0.00
h.	Construction/Alteration and Renovation:	$0.00
i.	Other:	$0.00
j.	Consortium/Contractual Costs:	$0.00
k.	Trainee Related Expenses:	$0.00
l.	Trainee Stipends:	$0.00
m.	Trainee Tuition and Fees:	$0.00
n.	Trainee Travel:	$0.00
o.	TOTAL DIRECT COSTS:	$1,406,203.00
p.	INDIRECT COSTS (Rate: % of S&W/TADC):	$0.00
	i. Indirect Cost Federal Share:	$0.00
	ii. Indirect Cost Non-Federal Share:	$0.00
q.	TOTAL APPROVED BUDGET:	$1,406,203.00
	i. Less Non-Federal Share:	$0.00
	ii. Federal Share:	$1,406,203.00

32. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:

a.	Authorized Financial Assistance This Period	**$1,406,203.00**
b.	Less Unobligated Balance from Prior Budget Periods	
	i. Additional Authority	$0.00
	ii. Offset	$0.00
c.	Unawarded Balance of Current Year's Funds	$0.00
d.	Less Cumulative Prior Award(s) This Budget Period	$0.00
e.	AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	**$1,406,203.00**

33. RECOMMENDED FUTURE SUPPORT:
(Subject to the availability of funds and satisfactory progress of project)

YEAR	TOTAL COSTS
33	$1,406,203.00
34	$1,406,203.00

34. APPROVED DIRECT ASSISTANCE BUDGET: (In lieu of cash)

a. Amount of Direct Assistance	$0.00
b. Less Unawarded Balance of Current Year's Funds	$0.00
c. Less Cumulative Prior Award(s) This Budget Period	$0.00
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	**$0.00**

35. FORMER GRANT NUMBER
BRH890027

36. OBJECT CLASS
41.15

37. BHCMIS#

38. THIS AWARD IS BASED ON THE APPLICATION APPROVED BY HRSA FOR THE PROJECT NAMED IN ITEM 14. FEDERAL AWARD PROJECT TITLE AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE AS:
a. The program authorizing statue and program regulation cited in this Notice of Award; b. Conditions on activities and expenditures of funds in certain other applicable statutory requirements, such as those included in appropriations restrictions applicable to HRSA funds; c. 45 CFR Part 75; d. National Policy Requirements and all other requirements described in the HHS Grants Policy Statement; e. Federal Award Performance Goals; and f. The Terms and Conditions cited in this Notice of Award. In the event there are conflicting or otherwise inconsistent policies applicable to the award, the above order of precedence shall prevail. Recipients indicate acceptance of the award, and terms and conditions by obtaining funds from the payment system.

39. ACCOUNTING CLASSIFICATION CODES

FY-CAN	CFDA	DOCUMENT NUMBER	AMT. FIN. ASST.	AMT. DIR. ASST.	SUB PROGRAM CODE	SUB ACCOUNT CODE
25 - 377RA25	93.914	25H89HA00027	$1,334,597.00	$0.00	FRML	25H89HA00027
25 - 377RA24	93.914	25H89HA00027	$71,606.00	$0.00	MAI	25H89HA00027

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NoA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NoA. After you have completed the initial registration steps (i.e.,created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772.

Terms and Conditions

Failure to comply with the remarks, terms, conditions, or reporting requirements may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Term(s)

1. During each budget period, recipients must include in their program budget travel support for recipient staff members to attend meetings/conferences identified by HRSA HAB as essential to RWHAP administration and implementation. HRSA HAB meetings may include, but are not limited to, the biennial National Ryan White Conference on HIV Care and Treatment, grant-specific Administrative Reverse Site Visits (ARSV), or targeted technical assistance events. Meetings are generally held in the Washington, D.C. metropolitan area. If no essential meetings are held during the budget period, recipients can reallocate funds for other allowable grant expenses. Recipients must comply with 45 CFR Part 75.474 and all other applicable HHS and Federal policies governing travel supported under Federal assistance awards.
2. This award is subject to 45 CFR part 75--Uniform Administrative Requirements, Cost Principles, and Audit Requirement for HHS Awards.
3. Due to the provision of partial funding, this award is being made without itemized reporting requirements. Award recipients are reminded of the continuation of FY2024 specialized reporting requirements and provided reference to previous HRSA guidelines and instructions. Subsequent FY2025 reporting requirements to include defined due dates will be contained on the final FY2025 NoA. Failure to comply with reporting requirements will result in deferral or additional restrictions for future funding decisions.
4. Funds may not be used by recipients for the purchase of vehicles without written prior approval from the Division of Grants Management Operations (DGMO).
5. This Notice of Award is issued to approve the Core Medical Services Waiver Request for budget period FY 2025, which waives the statutory requirement that not less than 75 percent of grant funds be used for provision of core medical services. Subsequent budget periods will require a new waiver request. All previously conveyed terms and conditions remain in effect unless specifically removed.

Program Specific Term(s)

1. RWHAP Part A recipients are required to use a minimum amount/percentage of this award to provide services to women, infants, children and youth (WICY) living with HIV/AIDS. The minimum set-aside amounts/percentages for each eligible metropolitan area/transitional grant area (EMA/TGA) must be determined separately for each priority population, and may not be less than the percentage of each population to the total number of persons estimated to be living with HIV/AIDS within the EMA/TGA.
   Waiver: If the recipient can document that one or more WICY priority populations are receiving HIV-related services through the state Medicaid program under Title XIX of the Social Security Act, the Children's Health Program (CHIP) under Title XXI of the same Act, or other qualified federal or state programs in accordance with HRSA guidelines, then the recipient may request a waiver of the minimum WICY expenditure requirement from HRSA. Recipients requesting a waiver may utilize the WICY Expenditure Report to document that all priority populations are receiving HIV/AIDS health services through other funding sources
2. The recipient is required to notify the Project Officer, within 30 days, of any changes to Planning Council (PC) composition that impact legislative compliance with "reflectiveness", the mandated membership categories, and/or the composition requirement that 33% of the PC membership should be comprised of persons receiving Part A HIV-related services who are non-conflicted and accurately reflect he demographics of the epidemic in the EMA/TGA.
   You must notify your Project Officer to initiate a Request for Information via EHB to submit this requirement. The notification and letter must be accompanied by revised PC roster and reflectiveness tables or a narrative describing compliance with PC composition and Reflectiveness.
   Reflectiveness must be based on the prevalence of HIV Disease (AIDS Prevalence plus HIV Prevalence, real or estimated) in the EMA/TGA as reported in the current fiscal year application.
3. Consistent with Departmental guidance, HRSA recipients that purchase, are reimbursed or provide reimbursement to other entities for

outpatient prescription drugs are expected to secure the best prices available for such products and to maximize results for the recipient organization and its patients. Eligible health care organizations/covered entities that enroll in the 340B Program must comply with all 340B Program requirements and will be subject to audit regarding 340B Program compliance. 340B Program requirements, including eligibility, can be found at www.hrsa.gov/opa.

4. The recipient shall make all files, including captioning, audio descriptions, videos, tables, graphics/pictures, registration forms, presentations (both audio and video) or other types of proprietary format files – e.g., Adobe Portable Document Format (.pdf), Microsoft Office PowerPoint (.ppt) and Microsoft Excel (.xls), fully accessible to members of the public with disabilities. Technical and functional standards for accessibility are codified at 36 CFR Part 1194 and may be accessed through the Access Board's Web site at http://www.access-board.gov
5. Submit, every two (2) years, to the lead State agency for the Ryan White HIV/AIDS Part B program, audits consistent with 45 CFR 75 Subpart F, regarding funds expended in accordance with this title and include necessary patient level data to complete unmet need calculations and the Statewide Coordinated Statements of Need process.
6. Jurisdictions that 1) are legislatively mandated to establish planning councils or 2) have elected to establish a planning council, must adhere to the requirement that the chief elected official (CEO) retains sole responsibility for appointment and removal of planning council members, as recommended by Planning Council leadership.
7. In accordance with the RWHAP guidance on determining client eligibility and complying with the payor of last resort requirement, while minimizing administrative burden and enhancing continuity of care and treatment services (HRSA HAB PCN 21-02: Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program), HRSA HAB expects all RWHAP recipients and subrecipients to establish, implement, and monitor policies and procedures to determine client eligibility based on each of the three factors outlined in PCN 21-02, including documentation requirements. See https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-21-02-determining-eligibility-polr.pdf
8. The recipient is required to establish and maintain a process for protecting client confidentiality throughout the project period. Client confidentiality requirements apply to all phases of the project.
9. HRSA is operating under a Continuing Resolution; therefore, this award provides partial funding based on the continuation of FY 2024 program requirements, funding levels, and specialized reporting requirements. Additions and revisions to these Terms and Conditions may be necessary once HRSA receives a final FY 2025 appropriations. A revised NoA will be issued to reflect any changes to funding amounts, Terms and Conditions, and/or reporting requirements.
10. All Ryan White HIV/AIDS Program Part A, B, C, and D recipients must adhere to the legislative requirement to establish a clinical quality management program. HRSA HIV/AIDS Bureau expectations for clinical quality management are outlined in Policy Clarification Notice 15-02 (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-02-cqm.pdf).
11. The Ryan White HIV/AIDS Program legislation specifies criteria for the expenditure of Part A funds as follows:
    The recipient may not use more than ten percent (10%) of total grant funds for direct and indirect costs associated with administering the award (including Planning Council or planning body expenses), and in accordance with the legislative definition of administrative activities and the allocation of funds to subrecipients, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes. See Policy 15-01 for additional information on the 10% administrative cap.
    The recipient shall not exceed the lesser of 5 percent of the total grant funds or $3 million for the required clinical quality management (CQM) program.
    The recipient must expend not less than 75% of total grant funds, exclusive of administration and CQM expenses, for core medical services, unless waived by the Secretary. Also see PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds.
12. Unless otherwise specified, all Conditions and Reporting Requirements must be electronically submitted through the HRSA Electronic Handbooks (EHBs).
13. Funds awarded for pharmaceuticals must only be spent to assist clients who have been determined not eligible for other pharmaceutical programs, especially the AIDS Drug Assistance Program and/or for drugs that are not on the State ADAP or Medicaid formulary.
14. These funds may not be used for the following: purchasing or construction of real property, international travel, payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made, with respect to that item or service under any State compensation program, insurance policy, Federal or State health benefits program or by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services or the U.S. Department of Veterans Affairs; see HAB PCN 16-01 available online at https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/clarification-services-veterans.pdf for additional information regarding services provided to veterans).
15. RWHAP funds may not be used to make cash payments to intended clients of core medical or support services. This prohibition includes cash incentives and cash intended as payment for RWHAP services. Where direct provision of the service is not possible or effective, store gift cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be

used. Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the RWHAP are also allowable as incentives for eligible program participants. Recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and gift cards cannot be exchanged for cash or used for anything other than allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards. Note: General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are also unallowable.

16. The Ryan White HIV/AIDS Program (RWHAP) legislation requires, to the maximum extent practicable, that core medical and support services will be provided without regard to an individual’s ability to pay, or to the current or past health condition of the individual to be served. Consequently, HRSA expects that RWHAP recipients and subrecipients utilize a grievance process, articulated in writing, to investigate complaints for denial of services.
17. Recipients must follow the guidance in all applicable HIV/AIDS Bureau Policy Notices and Program Letters to ensure compliance with programmatic requirements. See https://ryanwhite.hrsa.gov/grants/policy-notices and https://ryanwhite.hrsa.gov/grants/program-letters.
18. In accordance with Policy Clarification Notice 16-02, grant funds may not be used for outreach programs which have HIV prevention education as their exclusive purpose. See https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf.
19. The recipient must maintain EMA/TGA political subdivision expenditures for HIV-related activities at a level which is not less than the level of expenditures for such activities during the one-year period preceding the fiscal year for which the applicant is applying to receive the grant (see Section 2605(a)(1)(B) of the PHS Act).
20. All providers of services available in the Medicaid State plan must have entered into a participation agreement under the State plan and be qualified to receive payments under such plan, or receive a waiver from this requirement.
21. Minority AIDS Initiative (MAI) funds available under Section 2693 of the Public Health Service Act are disbursed on a formula basis together with the RWHAP Part A formula grant funds as required by legislation. Funds must be used to improve HIV-related health outcomes to reduce existing racial and ethnic disparities. MAI funds must be tracked and reported separately.
22. RWHAP Part A recipients are required to meet specific legislative, programmatic, and grant regulations requirements regarding the monitoring of both their grant and their subrecipients. Guidance for compliance is detailed in the National Monitoring Standards for RWHAP recipients. (https://ryanwhite.hrsa.gov/grants/manage/recipient-resources)
23. Recipients must submit an annual Non-Competing Continuation (NCC) progress report via the HRSA EHBs within 150 days prior to the budget period end date. Please refer to HRSA EHBs for the specific due date. Submission and HRSA approval of this NCC progress report triggers the budget period renewal and release of subsequent year funds.
24. Prior approval for rebudgeting is required when cumulative transfers among direct cost budget categories (i.e., Personnel, Fringe, Travel, Equipment, Supplies, Contractual, etc.) for the current budget period exceed 25% of the total approved budget (which includes direct and indirect costs) for that budget period or $250,000, whichever is less; or substantial changes are made to the approved work plan or project scope (e.g., changing the model of care, transferring substantive work from personnel to contractual); or the recipient wants to purchase a piece of equipment that exceeds $10,000 and was not included in the approved project budget/application. Any of the aforementioned post-award changes in Part A and/or Minority AIDS Initiative (MAI) grant allocations must be submitted to the Project Officer via prior approval along with a letter of concurrence from the Planning Council Chair(s).
25. This action reflects a new document number. Please refer to this number when contacting the Payment Management System or submitting drawdown requests. Reporting on the Federal Financial Report (FFR) SF-425 Federal Cash Transaction Report (FCTR) should reflect this number for all disbursements related to this project period.
26. Ryan White HIV/AIDS Program (RWHAP) funds cannot pay for pre-exposure prophylaxis (PrEP) or non-occupational Post-Exposure Prophylaxis (nPEP) as the person using PrEP is not an individual living with HIV and the person using nPEP is not diagnosed with HIV prior to the exposure and therefore are not eligible for RWHAP funded medications or medical services. RWHAP Parts A and B recipients and subrecipients may provide some limited services under the EIS service category. (See the HIV/AIDS Bureau June 22, 2016 Program Letter available online at https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/prep-letter-06-22-2016.pdf.)
27. Recipients are required to track and report all sources of service reimbursement as program income on the annual Federal Financial Report and in annual data reports. All program income earned must be used to further the objectives of the RWHAP program. For additional information, see PCN #15-03 available online at https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-03-program-income.pdf
28. The funds for this award are sub-accounted in the Payment Management System (PMS) and will be in a P type (sub accounted) account. This type of account allows recipients to specifically identify the individual grant for which they are drawing funds and will assist HRSA in

monitoring the award. The P sub account number and the sub account code (provided on page 1 of this Notice of Award) are both needed when requesting grant funds. You may use your existing PMS username and password to check your organizations P account access. If you do not have access, fill out a New User Access Request form at: https://pmsapp.psc.gov/pms/app/userrequest/request/newuser?. If you have any questions about accessing PMS, contact the PMS Liaison Accountant as identified at: https://pms.psc.gov/find-pms-liaison-accountant.html.

29. The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR § 75.352, requires recipients to monitor the activities of subrecipients to ensure funding is used only for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward, as well as to ensure that performance goals are achieved. To meet the monitoring requirements, RWHAP Parts A and B recipients must conduct annual subrecipient site visits. Recipients must ensure that drug rebates and program income earned as a result of the RWHAP award are used only for allowable activities and only for purposes of the RWHAP award. See section 2616(g) of the Public Health Service Act and 45 CFR 75.307(e)(2). Therefore, recipients must monitor awards funded through drug rebates and/or program income.
30. Some aspects of Syringe Services Programs are allowable with HRSA's prior approval and in compliance with HHS and HRSA policy. See https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs.
31. If applicable, recipients must submit the Tangible Personal Property Report (TPPR) (SF-428) and any related forms. The report must be submitted within 90 days after the project period ends. Recipients are required to report all equipment with an acquisition cost of $10,000 or more per unit acquired by the recipient with award funds. TPPRs must be submitted electronically through HRSA EHBs.

Standard Term(s)

1. Your organization must have policies, procedures, and financial controls to follow all the General Terms and Conditions. HRSA awards are based on the application submitted and approved by HRSA. All awards are subject to the General Terms and Conditions, in addition to those included in the Notice of Award or referenced in documents and attachments.

Reporting Requirement(s)

1. **Due Date: Annually (Budget Period) Beginning: Budget Start Date Ending: Budget End Date, due 90 days after end of reporting period.**
   The recipient must submit, within 90 days after budget period end date, an annual Federal Financial Report (FFR). The report should reflect cumulative reporting within the project period of the document number. **All FFRs must be submitted through the Payment Management System (PMS).** Technical questions regarding the FFR, including system access should be directed to the PMS Help Desk by submitting a ticket through the self-service web portal (**PMS Self-Service Web Portal**), or calling 877-614-5533.
2. **Due Date: 12/31/2025**
   The recipient must submit an estimate of their FY 2025 Unobligated Balances (UOB) and an estimated carryover request no later than December 31, 2025, consistent with reporting guidelines, instructions, and/or reporting templates provided in the HRSA EHBs.
3. **Due Date: 05/29/2026**
   The recipient must submit a Final FY 2025 Part A Annual Progress Report no later than 90 days after the budget period end date, consistent with reporting guidelines, instructions, and/or reporting templates provided in the HRSA EHBs.
4. **Due Date: 05/29/2026**
   The recipient must submit the Ryan White HIV/AIDS Program Expenditure Report no later than 90 days after the budget period end date, consistent with reporting guidelines, instructions, and/or reporting templates provided in the HRSA EHBs.
5. **Due Date: 03/30/2026**
   Submit the Ryan White Services Report (RSR) which consists of recipient, service provider, and patient level reports for the calendar year via the EHBs by 6:00 PM ET on the last Monday in March. See http://hab.hrsa.gov/manageyourgrant/reportingrequirements.html for additional information.

Failure to comply with these reporting requirements will result in deferral or additional restrictions of future funding decisions.

Contacts

NoA Email Address(es):

Name	Role	Email
Robert George	Program Director	robert.george2@denvergov.org
Robert George	Authorizing Official, Business Official, Point of Contact	robert.george2@denvergov.org

Note: NoA emailed to these address(es)

All submissions in response to conditions and reporting requirements (with the exception of the FFR) must be submitted via EHBs. Submissions for Federal Financial Reports (FFR) must be completed in the Payment Management System (https://pms.psc.gov/).