

Florida HIV/AIDS Ryan White Part B Eligibility Procedures Manual



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SECTION 1: General Information

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under X07HA00057, and the Ryan White Care Act Title II for \$117,881,760. This information or content and conclusions are those of the author; and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

As per [Chapter 64D-4, Florida Administrative Code \(F.A.C.\)](#), Eligibility Requirements for HIV/AIDS Patient Care Programs, this manual standardizes the eligibility requirements for all programs funded through the HIV/AIDS Section. These procedures can be used in both centralized and non-centralized eligibility determination systems.

Purpose

The purpose of the patient care programs within the HIV/AIDS Section is to provide primary health care and support services to low-income persons living with HIV disease, based on availability, accessibility, and funding. The patient care programs are responsible for ensuring services are provided to those intended by establishing eligibility requirements and procedures that will be fairly applied to all who request eligibility for services.

Goals

- To provide a standardized system of core eligibility across HIV/AIDS patient care programs
- To prevent duplication of effort

Staff Procedures Manual

When determining eligibility, this manual:

- Provides eligibility staff with standardized procedures and forms
- Ensures persons requesting services from the patient care programs have been appropriately determined eligible or ineligible
- Applies only to the patient care programs under the Department of Health (DOH), HIV/AIDS Section, in conjunction with [Chapter 64D-4, F.A.C.](#)
- Does not preclude local, state, or federal programs from adopting the requirements and procedures referenced in this document

Programmatic qualifications and requirements can be found in each program's respective manual or guidelines.

Statutory and Programmatic Authority

The statutory authority for the HIV/AIDS Section eligibility requirements, process, and procedures is stated in [Chapter 381, Florida Statutes \(F.S.\)](#), and [Chapter 64D-4, F.A.C.](#), hereinafter referred to as the "eligibility rule."

This manual is developed in conjunction with the statute and the eligibility rule requirements.

HIV/AIDS patient care programs include the following:

- Ryan White Part B Consortia
- Ryan White Part B AIDS Drug Assistance Program (ADAP)
- Ryan White Part B ADAP Premium Plus Insurance
- State Housing Opportunities for Persons With AIDS (HOPWA) Program
- Patient Care Networks (PCN) and county health departments (CHD)

Not included under the eligibility rule authority are the HIV/AIDS services provided by other local, state, or federal HIV/AIDS patient care programs, such as:

- Ryan White Part A (Eligible Metropolitan Areas)
- Ryan White Part C
- Ryan White Part D
- Ryan White Part F
- Medicaid, Project AIDS Care (PAC) Waiver, and Medicare
- City HOPWA
- Local indigent programs

Florida Statutes

[Chapter 381, F.S., Public Health](#) establishes DOH's responsibility for the state's public health system, which shall be designed to promote, protect, and improve the health of all people in the state. [Chapter 381, F.S.](#), is often referred to as Florida's Public Health Law, which provides the statutory authority for the DOH HIV/AIDS Section to establish the eligibility requirements and procedures developed through the administrative rulemaking process for the HIV/AIDS patient care programs.

HIV/AIDS Statutes

- Section [381.0042, F.S.](#) - Patient Care for Persons with Human Immunodeficiency Virus Infection. This section provides the authority for the DOH to establish HIV patient care networks to plan for the care and treatment of persons with HIV/AIDS.
- Section [381.0037, F.S.](#) - This section is specific to HIV/AIDS, and addresses the unique nature of the disease by establishing programs and requirements related to HIV/AIDS. Care and treatment programs must balance medical necessity, the right to privacy, and protection of the public from harm.

Florida Administrative Code

[Chapter 64D-4, F.A.C.](#), Eligibility Requirements for HIV/AIDS Patient Care Programs, is the "eligibility rule" for the patient care programs; and was developed through a process that included statewide input, workshops, public hearings, and notification to the affected parties. An administrative rule or code is a legal binding document based on statutory authority. The eligibility rule can be found at the following link:

<https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64D-4>.

It is important that all staff read Chapter 64D-4, F.A.C., in its entirety.

**State/Federal
Laws/Regulations**

Other laws and regulations affecting the patient care programs under the DOH, HIV/AIDS Section, include the Ryan White Treatment Extension Act of 2009 and the AIDS Housing Opportunity Act.

**Allowable
Services
(Attachment A)**

- The HIV/AIDS patient care programs are eligibility programs and not entitlement programs, such as Medicaid; therefore, the services provided by these programs are subject to accessibility, availability, and funding statewide. Local areas have the authority to determine funding priorities, limitations, and resources. Consequently, services vary widely across the state.
- The services provided are listed in the 2014 Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual and have been adapted to only include only those service categories which are allowable in the Florida Ryan White Part B HIV/AIDS Program. (refer to Attachment A).

Please Note: Core eligibility is a prerequisite for enrollment in the specialty programs of ADAP, ADAP Premium Plus Insurance, or State HOPWA; however, there are additional program-specific qualifications and requirements.

SECTION 2: Confidentiality

Staff must take prudent and reasonable steps to protect applicant/client confidential information. This section provides minimum criteria regarding the security of records and the management of confidential information.

Authority

Section [384.29](#), [392.65](#), and [455.667, F.S.](#), Health Insurance Portability and Accountability Act (HIPAA).

This section provides the minimum criteria regarding security of records and the management of confidential information. Florida Statutes, Florida Administrative Code, and HIPAA are the guiding authorities for DOH security policies.

The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement the requirements of HIPAA. The Privacy Rule addresses the use and disclosure of individuals' health information (called "protected health information") by organizations subject to the Privacy Rule (called "covered entities"). The rule also ensures that individuals understand and control how their health information is used.

Policy and Procedure

All written and verbal communications with applicants during and after eligibility must be maintained in strict confidence as required by law. These procedures are the same for eligibility and case management agencies.

The DOH has written security policies, protocols, and procedures to ensure the security of information; and to protect confidentiality, data integrity, and access to information in accordance with the Florida Statutes.

- These policies are entitled "Information Security Policy DOHP 50-10-10." To request a copy of DOHP 50-10-10, lead agencies may contact the local DOH contract manager.
 - Contracted and subcontracted providers for DOH HIV/AIDS programs may create their own security policies, protocols, and procedures; however, they must be consistent with the DOHP 50-10-10.
 - All employees and volunteers with access to client information must receive annual training on confidentiality, the proper exchange of information, and required consent. Documentation of training must be maintained in personnel records.
-

Forms

The following forms have been developed by the DOH for the purpose of securing confidential information. Eligibility staff is required to use the following DOH forms.

DH 1120, Acceptable Use and Confidentiality Agreement (Attachment B)

- Must be completed by the employee and their supervisor after review of each section, and must be included in the employee's personnel record.
- Should be completed within the first 30 days of employment.
- Should be modified to meet the needs of the agency.

If modifying form DH 1120, the agency should submit to the contract manager for approval and address, at a minimum, the following subjects:

- An internal and external response to a breach of confidentiality, including the understanding by the employee that they can be prosecuted
- Review the use of DOH software and hardware (Section B of form DH 1120 covers this), if applicable
- Review and access to the agency policies and procedures
- Review and access to the agency personnel handbook
- Review and access to the Florida Statutes and Administrative Rules pertaining to HIV/AIDS services and confidentiality, which can be accessed on the Internet by going to www.MyFlorida.com
- Procedures to ensure that the protection and confidentiality of all confidential materials shall be consistent with the DOHP 50-10-10

DH 3204, Initiation of Services (Attachment C)

- Completed by the client
- Allows the agency to obtain or provide necessary information related to the client's treatment, payment, and health care operations
- Is in effect indefinitely unless the client revokes the form

DH 150-741, Notice of Privacy Practices (Attachment D1)

- Given to the client when they sign DH 3204 upon initial enrollment or if requested by the client
- Describes how medical information about the client may be used and/or disclosed, and how the client gets access to this information

DH 150-741, Notice of Privacy Practices Acknowledgment Form (Attachment D2)

- Completed by the client when they receive the Notice of Privacy Practices upon initial enrollment or when requested by the client
 - Establishes written documentation that the client received a copy of the
-

Notice of Privacy Practices

DHOGC-3203-06-13, Authorization to Disclose Confidential Information
(Attachment E)

- Establishes written documentation that the client has given permission to disclose protected health information for purposes other than treatment, payment, or health care operations.
- Examples of individuals that information can be disclosed to include: attorneys, caregivers, spouses, and partners. Information provided to the person on the release should be on a “need to know” basis and be pertinent to the client’s care.
- **Need to know** is defined as:
 1. The legitimate requirement of a person or organization to know, access, or possess sensitive or classified information that is critical to the performance of an authorized, assigned mission.
 2. The necessity for access to, or knowledge or possession of, specific information required to carry out official duties.
- This release must be renewed annually unless a specific date is inserted.

Phone Calls

All phone calls in which confidential information is discussed must be made from an area that ensures confidentiality is maintained.

- The employee must determine the identification of the caller and what information may be disclosed.
- Cell phones and BlackBerry devices are not considered secure, and should not be used for confidential phone calls unless the client consents.
- Cell phone calls regarding confidential information must be limited to the minimum information.
- The call recipient must be informed the call has been initiated from a cell phone.

Mailing

A secured mail intake site must be used to receive incoming confidential information.

- Mailrooms and mailboxes must be secured to prevent unauthorized access to incoming and outgoing mail.
- Double-enveloping is required for mailing confidential information. The outside envelope is addressed to the recipient. The inside envelope specifies “Confidential” and the recipient’s name.

Faxes

Confidential information may be faxed in a medical emergency or with the written consent of the client.

- The fax machine must be in a secured area.
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- Fax cover sheets must have the appropriate language and state “Confidential.” This language must include: ***“This transmission may contain material that is confidential under Federal law and Florida Statutes, and is intended to be delivered to only the named addressee. Unauthorized use of this information may be a violation of criminal statutes. If this information is received by anyone other than the named addressee, the recipient shall immediately notify the sender at the address or telephone number above and obtain instructions as to the disposal thereof. Under no circumstances shall the material be shared, retained, or copied by anyone other than the named addressee.”***
 - Medical information that is faxed must have a permanent copy in the record and documentation in the progress notes.
-

Email

- Per the DOH policy, email to a client is not allowable.
 - CHDs are not allowed to email clients.
 - Clients should be informed that email is not secure, especially from a CHD where all emails are considered public record for three years.
 - Email usage by staff in community based agencies as a method of communication is at the discretion of each agency regardless of a consent form. The agency’s policies and procedures manual should provide guidance on agency-specific limitations regarding email.
-

Field Security

Job descriptions must document the authority to transport confidential information into the field. In addition:

- All confidential information taken into the field must be tracked, including who, what, when, why, where, and expected date of return.
 - Information taken into the field is limited to what is needed to perform responsibilities.
 - Prior permission must be obtained from the supervisor if information is not to be returned by close of business.
 - Information must be safeguarded from unauthorized access.
-

Work Space

- Eligibility staff must be provided with office space that allows business to be conducted in a timely and confidential manner.
 - If private office space with a door is not available, the provider must ensure all communications remain confidential.
-

Storage

- Offices and staff must maintain confidentiality of all data, files, and records, including client records related to the services; and shall comply with state and federal laws, including, but not limited to, Sections [384.29](#), [392.65](#), and [455.667, F.S.](#)
-

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- Appropriate storage systems for hard copy client records are required.
 - Storage systems must include, at a minimum, file folders that are kept in locked file cabinets.
-

Client File Retention

- File retention must follow the Florida Department of State, Bureau of Archives and Records Management, storage and disposition procedures as mandated in Chapters [119](#) and [257, F.S.](#)
 - File retention schedule for agencies contracted with the DOH is six years from the date of termination of a provider (contract) with the DOH or closure of the file.
 - Upon completion or termination of the contract, the provider will cooperate with the DOH to facilitate the duplication and transfer of any said records or documents during the required retention period.
 - In the event that a client file is closed, the file is retained at the agency for the minimum six years before disposing of said record.
 - Documents must be shredded.
-

Electronic Files and Computers

The use of electronic files to gather and collect client information requires specific precautions to avoid a breach of confidentiality and protect the client's right to privacy. DOHP 50-10-10 includes, but is not limited to, the following guidance concerning electronic files and information:

- Computer monitors must be positioned to prevent unauthorized viewing.
 - All computers, including laptops, that access and store confidential information must be password protected; and the data must be encrypted in accordance with DOH Information Security policies, protocols, and procedures.
 - Laptops may be used for storing and accessing HIV/AIDS information with client identifiers if they adhere to the specific requirements in DOHP 50-10-10.
 - Laptops containing confidential information must be returned to the secured area at the end of the working day and never stored in an unsecured, unauthorized area. This directive includes storing laptops in the employee's car, car trunk, or home unless there is prior supervisory approval.
 - Deleting files from a computer hard drive is not necessarily sufficient if the computer is to be stored. Hard drives must be wiped clean. If you are unsure how to do this or what it means, consult with your Information Technology staff.
-

**Additional
Information**

- Agencies need to document that positions have “need to know” access in their written job descriptions.
 - Unauthorized persons shall not be left unattended in areas where confidential or sensitive information is maintained.
 - All visitors must sign in on a security log.
-

SECTION 3: Eligibility Personnel

This section describes personnel activities, responsibilities, training, and documentation required for eligibility staff.

Eligibility Staff

Eligibility staff is authorized by the DOH to determine core eligibility for the HIV/AIDS patient care programs.

Staff Responsibilities

Responsibilities of eligibility staff include, but are not limited to:

- Determining and re-determining eligibility in conjunction with this manual and [Chapter 64D-4, F.A.C.](#)
- Documenting all activities related to the eligibility process and providing accurate information
- Providing referrals for services as appropriate and documenting in CAREWare
- Preparing and participating in fair hearings as necessary (see Section 6 for more information)
- Having knowledge of federal, state, and other local programs in order to refer clients for needed services

Please note: Many CHDs and case management agencies have blended staff responsibilities to include core eligibility and case management for more than one program. All staff completing core eligibility must follow the established procedures in this manual, regardless of other roles.

Supervisory Oversight

All eligibility staff must have an immediate supervisor for oversight of the eligibility process. Eligibility staff must have access to supervisors to ensure the final determination is completed in accordance with the established procedures.

Supervisor Responsibilities

Supervisor responsibilities include, but are not limited to:

- Providing oversight to the overall eligibility process
 - Monitoring staff performance, and complete annual performance evaluations
-

Training Requirements

Eligibility staff, including supervisors, must complete the DOH “Core Eligibility Training.” A Certificate of Completion must be maintained in the personnel file.

Training schedules are posted on the HIV/AIDS Section web page. To register, go to the following link:
<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/core-eligibility-registration.html>.

SECTION 4: Eligibility Requirements

Following are the core eligibility requirements for all clients seeking services for HIV/AIDS patient care programs under [Chapter 64D-4, F.A.C.](#), including Consortia, ADAP, ADAP Premium Plus Insurance, and State HOPWA.

Who May Apply for Services

The following may apply for services:

- Any individual seeking services
- The individual's legal guardian
- A person designated in the individual's medical power of attorney (i.e., their court appointed representative or legal representative)

Proper documentation must be collected at initial determination and re-determination to verify guardianship or medical power of attorney.

Minors Seeking Services

Minors (under 18 years old) may receive HIV/AIDS services without parental consent or notification. Please see [Chapter 384.30, F.S.](#), for more information.

Eligibility Requirements

The following are the requirements that must be met for all clients seeking services under [Chapter 64D-4, F.A.C.](#):

- Proof of HIV (see Section 7).
- Living in Florida (see Section 8).
- Not participating in local, state, or federal programs where the same types of services are provided or available. This means a client can not have duplication in services (see Section 9).
- Low-income, which means a gross income less than or equal to four hundred percent (400%) of the Federal Poverty Level (see Section 10).
- Must submit a completed and signed DH 150-884, Application to Receive Allowable Services for HIV/AIDS Patient Care Programs, (Attachment G); be willing to cooperate with eligibility staff during the eligibility process; and initial and comply with the Rights and Responsibilities stated in the application (see Section 5).

Additional information regarding each program requirement can be found in the specific sections listed above.

SECTION 5: Eligibility Brochure and Application

Eligibility requirements for the HIV/AIDS Patient Care Programs are listed in the Core Eligibility Requirements brochure (Attachment F). DH 150-884, the Application to Receive Allowable Services for HIV/AIDS Patient Care Programs (Attachment G), is the official application for patient care services that is incorporated by reference in the eligibility rule.

Brochures and applications are available at every CHD, and can be made available at other local venues such as lead agencies, case management agencies, and community-based organizations. The back of the brochure provides space for local addresses and phone numbers.

Core Eligibility Requirements Brochure

The brochure is in a question and answer format, and provides the following information:

- Eligibility requirements
- Services covered
- Program qualifications for ADAP, ADAP Premium Plus Insurance, and State HOPWA
- Required documentation
- Eligibility process
- Client's recourse if determined ineligible
- Rights and responsibilities

Application

The application is divided into the following sections:

- Applicant Information
- Living Arrangements
- Medicaid Insurance and Other Programs
- Household Monthly Income
- Rights and Responsibilities
- Client Signature
- For Eligibility Staff Only (optional)

Frequency

- Completion of an application is only required once upon initial enrollment, unless the client's file has been closed for more than one year.
 - An additional application must be completed if a client has not received services in excess of one year.
-

**Interpreters/
Illiteracy**

- The application is available in English only. The Core Eligibility Requirements brochure is available in English, Spanish, and Creole.
- Interpreters must be provided as needed.
- Eligibility staff must provide assistance to persons unable to read.

CAREWare

- The application must be completed, signed by the client, and scanned into CAREWare.
 - This is done once, unless the client file is closed for one year or more; then, a new application should be completed.
-

SECTION 6: Eligibility Determination and Re-Determination

This section describes the activities for initial determination of a new applicant, and re-determination every six months or sooner if necessary.

Initial Contact

A new client's first contact with the eligibility office or process may be through:

- A referral from another social service program
- A referral from the AIDS Hotline 1-800-FLA-AIDS (1-800-352-2437)
- An inquiry by mail or phone
- A walk-in to the eligibility office
- A referral from a friend or another client

Initial contact procedures may vary among eligibility providers; however, at a minimum, the following information should be provided:

- Eligibility requirements as stated in the Core Eligibility Requirements brochure
- Where to obtain the brochure and application
- Policies regarding walk-ins
- An individual may complete an application prior to or during the face-to-face eligibility interview, with or without staff assistance
- The services available from programs under Chapter [Chapter 64D-4, F.A.C.](#)
- Time limits

Please note: Confidentiality issues could be a factor if other individuals in the client's household are unaware of the client's HIV status. It is very important to contact a client only in the manner instructed in Part 2 of the application.

Initial Eligibility Requirements

Eligibility determination requires the following documentation:

- Completed application (Attachment G)
- Completed Eligibility Staff Assessment Worksheet (Attachment H) at initial application or if the file has been closed for more than one year
- Insurance Waiver Form (Attachment L), if applicable
- Required documentation (see Section 4)

Application Requirement

Eligibility staff must have a face-to-face encounter with the client to determine eligibility. Circumstances may prevent face-to-face contact, and this must be documented in the client's file with supervisory approval.

Time Limits

- The application must be processed and a determination of eligibility made within 30 days from the date the application was received/dated.
 - Mail-in applications are dated when received at the eligibility provider.
 - Walk-in clients who submit a completed or partially completed application will have their application dated the same day.
 - If the requested information has not been received within 30 days, the time limit can be extended with supervisory approval and documentation.
-

**Referrals and
Linkage**

The primary tasks of eligibility staff after a determination of eligibility include referrals and/or linkage to the following:

- Local available case management services.
- A choice of case management service providers in the area (if available) and make the appropriate referral. If the staff completing the eligibility process works at a case management agency, the client is still provided a choice of case management agencies in the service area.
- Allowable services based on availability, accessibility, and funding of the service in the client's local area.

Referrals may be made directly to the HIV/AIDS patient care programs when indicated.

**Eligibility Staff
Assessment
Worksheet
(Attachment H)**

The Eligibility Staff Assessment Worksheet (Attachment H) is required for all initial determinations and is completed by a staff member. The form must be:

- Included in each client's eligibility file or established client record
 - Used to ensure all eligibility requirements are included
 - Used in preparation for a fair hearing
-

**Required
Documentation In
Eligibility Chart**

The following documentation must be included in the file and scanned into CAREWare under the Unique IDs tab, attachment hyperlink:

- Original eligibility application signed and dated by client (see Section 5)
- Proof of HIV (see Section 7)
- Proof of living in Florida (see Section 8)
- Documentation of income (see Section 10)
- Copies of any third party insurance card and/or policy, such as Medicare, Medicaid, private insurance, etc. (see Section 9)
- Releases and consents signed by the client

The following forms must be completed in CAREWare under the Forms tab (eligibility staff completes forms):

- Eligibility Staff Assessment Worksheet (Attachment H) at initial enrollment only
-

- Six Month Recertification Review Form (Attachment I) once every six months
- Notice of Eligibility (NOE; Attachment J) or Notice of Ineligibility (NOI; Attachment K) every six months (once completed, form must be printed, signed, and scanned into the Unique IDs tab)
- Insurance Waiver Form (Attachment L), if applicable

**Re-Determination
(Attachment I)**

- Clients must be re-determined for eligibility at least every six months or sooner if circumstances have changed.
- Clients will need to provide current information, especially as it relates to changes in income.
- Eligibility staff must complete a Six Month Recertification Review Form (Attachment I) and provide client with NOE (Attachment J), which is valid for six months.

**Eligibility Staff
Requirements for
Re-Determination**

Staff must remind the client of their responsibility to advise eligibility staff of any circumstances that could impact their eligibility status.

**Appointment
Reminders**

Eligibility providers are encouraged to provide appointment reminders for clients who have consented to accept mail, at least two weeks prior to the scheduled re-determination time.

**Location of
Eligibility File**

- Only one eligibility/re-determination file per client is required.
- A list of agencies responsible for eligibility and re-determination must be provided to the contract manager, made available to all area providers, and updated as needed.

Ineligible

- A client may be deemed ineligible at any point during the eligibility process.
- Supervisory review is required for all cases determined ineligible prior to issuing the NOI.

The following documentation will be reviewed for accuracy to determine ineligibility:

- Completed application (Attachment G).
- Completed Eligibility Staff Assessment Worksheet (Attachment H).
- Required documentation.

**Notice Of
Ineligibility (NOI)**

The NOI is reviewed with the client preferably during a face-to-face interview, and a copy is provided to the client. The NOI may be mailed only if a face-to-face interview is not possible (certified mail only). All efforts are made to assist the client with understanding the reason for the decision.

- The client is advised to contact the eligibility provider for a re-determination if circumstances change.
- Referral information (name, address, and phone numbers) is provided to the client for possible assistance from other programs.
- Clients are advised of their right to a fair hearing if denied eligibility (see application Part 5, Rights and Responsibilities).

The client can choose to pursue the fair hearing instructions provided in the NOI; however, the eligibility office may not assist the individual with the appeal process other than possible referrals to legal aid or other legal counsel.

If the client chooses to appeal the decision, the agency where the client's eligibility was determined will be contacted by the local CHD or DOH legal counsel since the request for a fair hearing is submitted to the agency clerk in Tallahassee, Florida. Copies of the application (Attachment G), the Eligibility Staff Assessment Worksheet (Attachment H), and other documentation may be required. No further action is required by eligibility staff unless instructed by legal counsel.

**Hearing
Procedures**

An administrative hearing may be conducted when a client requests to appeal the determination of eligibility.

- Requests are sent to and reviewed by the agency clerk in Tallahassee, Florida.
 - The agency clerk may request more information about the case before granting or denying the request. A hearing officer in Tallahassee, Florida, will be assigned the case, and the local DOH attorney will represent the program.
 - The local DOH attorney will work closely with the program or eligibility staff for more information and clarification of the case as the appeal process progresses.
-

Closing the File

All active eligibility files must remain open until such a time circumstances change; for example, the client:

- Moves out of state or to another area
- Is deceased
- Has been incarcerated for six months or longer
- No longer needs services

The file is closed when all documentation is assembled and the determination completed. All closed files must follow the record retention

policy located in Section 2.

**CAREWare
Instructions**

- If applicable, the NOI must be completed under the forms tab. Once completed, it must be printed and signed by the eligibility staff member.
 - If applicable, the NOE must be completed under the forms tab. Once completed, it must be printed and signed by the eligibility staff member and the applicant/client.
 - The signed NOE must be scanned with an identifying name; use the drop down box to select “Notice of Eligibility.”
 - The comment box is not required, but encouraged if needed.
-

SECTION 7: Proof of HIV

An applicant is required to have documentation of a medical diagnosis of HIV disease with a laboratory test documenting confirmed HIV infection for their initial determination of eligibility.

Acceptable Proof

For the purposes of core eligibility, staff must have a copy of a test approved by the U.S. Food and Drug Administration (FDA) for diagnosis of HIV infection.

This may include, but is not limited to:

- A positive HIV Immunoassay (IA) test result from an initial antibody or combination antigen/antibody (Ag/Ab) test followed by a positive (reactive) HIV-1/2 type-differentiating test (Supplemental IA), qualitative Nucleic Acid Test (NAT), Western Blot or Immunofluorescence Assay (IFA).
- A positive qualitative HIV NAT (DNA or RNA) or HIV-1 p24 antigen test.
- A detectable (quantitative) HIV viral load (undetectable viral load tests are NOT proof of HIV).
- An HIV nucleotide sequence (genotype).

Use of PRISM

- PRISM (Patient Reporting, Investigation, and Surveillance Manager) is a web-based application used by the Sexually Transmitted Disease Program.
- PRISM has been designed to receive electronic lab results from the public labs of the State of Florida.
- Lab results from PRISM are considered acceptable documentation for proof of HIV when presented by an applicant/client.

Exposed Infants

- Exposed infants of HIV-positive mothers can be served with documentation of the mother's HIV-positive status up to the age of 12 months.
- Children 12 months or older must meet the same criteria for proof of HIV as listed above to continue services.

Not Acceptable Proof

The following are not considered acceptable as proof:

- A physician's or nurse's statement of HIV-positive status on a prescription or letterhead
 - Any point of care rapid test not approved by the FDA for confirmatory purposes (i.e., OraQuick, Clearview, UniGold, Insti)
-

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- Anonymous test results, or a test result with the applicant/client name missing or name of the testing laboratory missing
 - An undetectable viral load test
 - A Project AIDS Care (PAC) Physician’s Referral Form (effective February 2015)
-

**CAREWare
Instructions**

- Proof of HIV must be scanned and attached under the Unique ID tab, attachment hyperlink.
 - Document must have an identifying name; use drop down box to select “Proof of HIV.”
 - The comment box is not required, but is encouraged if needed.
 - Proof of HIV only needs to be collected and scanned during the initial enrollment.
-

SECTION 8: Living in Florida

A client must be living in Florida.

Living in Florida Definition

- For purposes of eligibility, living in Florida refers to clients who make Florida their home.
- A specific number of weeks or months in Florida are not required to be considered as living in Florida; however, a client's intent to remain in Florida is of interest, particularly for medical and treatment services.
- Clients can have unusual circumstances, such as the unpredictability of migrant work, that require consideration.

Documentation

Documentation to show current proof of living in Florida is documented by at least one of the following:

- Current state or local Florida photo identification (includes driver's license)
- Utility bill with name and street address
- Housing, rent/mortgage agreement in client's name
- Recent school records
- Bank statement with name and street address
- Letter from person with whom the client resides
- Property tax receipt or IRS W-2 Form for previous year
- Unemployment document with street address
- Current voter registration card
- Official correspondence (recently postmarked)
- Prison records (if recently released)
- Current documentation from the Florida Medicaid Management Information System (FLMMIS) or the Medical Eligibility Verification System (MEVSNET) showing that the client is currently receiving Medicaid or assistance from the Supplemental Nutritional Assistance Program (SNAP), formally known as food stamps
- Florida Department of Corrections offender search website photo print out
- Declaration of Domicile (Section 222.17, Florida Statutes)

Please note: Photo identification (photo ID) is not required, but encouraged (photo ID can be an old document if it is being used just as a way to visually identify a client; it must be current if you are also using it to show current living status). Photo identification should not be considered the only form of proof of living in Florida, especially if it is not current.

Homeless

If homeless, proof of living in Florida can include:

- A statement from the shelter in which the client resides or visits.
 - Physical observation from eligibility staff.
 - A written statement from the client describing living circumstances; it must be signed and dated by the client. Eligibility staff may provide assistance with this.
 - A statement from a social service agency attesting to the homeless status of the client.
-

Immigration Status

- Citizenship of the United States and immigration status are not required as a condition of eligibility.
 - Clients who are undocumented aliens do not have Social Security numbers and are identified using alternate pseudo numbers.
 - Eligibility providers are not required to report undocumented aliens to the U.S. Citizenship and Immigration Services, formerly the U.S. Immigration and Naturalization Service (INS).
-

Use of Social Security Number

A Social Security number (SSN) should be collected for eligibility determination and entered into CAREWare. It is imperative for the performance of the Ryan White Part B Program's duties and responsibilities as prescribed by the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (reauthorized in 2006 and 2009). This Public Health Service Act states that Ryan White grant funds may not be used to pay for items or services that are eligible for coverage by other federal, state, or private health insurance. This provision is commonly referred to as the "payer of last resort" requirement (see Section 9 for more information on payer of last resort). SSNs are used as client identifiers when cross-referencing FLMMIS with CAREWare to identify individuals who may be receiving Medicaid services while receiving Ryan White services, thus ensuring that providers and/or their subcontractors can make reasonable efforts to ensure the Ryan White Part B Program is the payer of last resort.

If documenting a pseudo identification number, this can only be done under the following circumstances:

- Undocumented aliens
 - Non-citizen residents who do not have a SSN
 - Children 12 months or under whom do not have a SSN
-

Creating Pseudo Identification Numbers

If an individual is not eligible to receive a SSN, staff must create a pseudo identification number using the following format for consistency among all programs:

- First letter of client's first name, followed by
 - First letter of client's middle name (or "X" for persons with no middle
-

name), followed by

- First letter of client's last name, followed by
- Client's six digit date of birth using the format MM-DD-YY

Example: If a client's name is Joe Edward Smith and he was born October 5, 1945, his alternate pseudo identification number would be JES100545.

**CAREWare
Instructions**

- Proof of living in Florida must be scanned and attached under the Unique IDs tab, attachment hyperlink.
 - Document must have an identifying name; use drop down box to select "Proof of Living in Florida."
 - The comment box is not required but encouraged, especially if there is one type of document being used for various types of proof.
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SECTION 9: Screening for Other Programs

Screening for other available programs is a required step in the eligibility process. Determining whether an applicant/client is already participating in local, state, or federal programs is necessary to eliminate duplication of services and adhere to federal requirements associated with the funding of the programs. This section provides a brief description of some common programs and information relating to specific circumstances that may arise during the applicant interview for this requirement.

Payer of Last Resort

Ryan White HIV/AIDS Program (RWHAP) funds may not be used “for any item or service to the extent that payment has been made, or can reasonably be expected to be made...” by another payment source. See HRSA’s Policy PCN 13-01:

<http://hab.hrsa.gov/manageyourgrant/pinspals/1301pcnmedicaideligible.pdf>

For additional Policy Notices from the Health and Human Services Administration (HRSA), HIV/AIDS Bureau (HAB), see:

<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>.

A client may not access Ryan White Part B or other HIV/AIDS patient care programs when the client is receiving or is eligible to receive the same services in another local, state, or federal program. This requirement does not preclude an individual from receiving allowable services not provided by other local, state, or federal programs, or pending a determination of eligibility from these other programs. The services provided by Ryan White Part B and the other HIV patient care programs may be used for HIV-related services only when no other source of payment exists.

In order to ensure Ryan White Part B or other HIV/AIDS patient care programs are the payers of last resort, eligibility providers are required to print proof (at a minimum) from the Florida Medicaid Management Information System (FLMMIS), ACCESS Florida, or other Medicaid verification systems, which shows a client is not eligible for such services.

Please note: Payer of last resort includes after Medicaid payment.

Exception: HRSA has allowed an exception for those persons able to access services under the U.S. Department of Veterans Affairs (VA). See further details under the section regarding VA.

Screening for Health Insurance

Ask the client if they currently have health insurance. Determine if they are eligible for insurance.

If the client has insurance:

- Obtain a copy of the insurance card (front and back) and policy coverage, and maintain a copy in eligibility file.
- Determine if the coverage is viable, including pharmaceutical coverage (seek assistance from ADAP Premium Plus Insurance staff or the lead agency for assistance as needed).
- Determine the premium cost to the client, and if help is needed with their portion to maintain coverage (not everyone needs assistance with premium payments).
- If assistance with premium payments is needed, refer the client (once determined eligible) to the ADAP Premium Plus Insurance provider.

If the client (or spouse) is employed and insurance is available through the employer, take the following steps:

- Determine if the client will have access to insurance, and when access will be available (usually there is an open enrollment period).
- If open enrollment is not immediate, complete the Insurance Waiver Form (Attachment L) stating the client will have access to insurance during open enrollment and document timeframe. Complete eligibility and issue a NOE until open enrollment can be completed or for six months, whichever comes first.
- The client must access insurance during open enrollment and provide insurance documentation as specified above.
- Refusal to access employer-based insurance is justification to deny eligibility.
- Clients who are not eligible for ADAP wrap-around assistance and meet all other Ryan White Part B eligibility requirements will not be denied services based on potential eligibility for the Health Insurance Marketplace.

If the client has no insurance:

- Document steps taken to ensure insurance is not available.
- If the client is employed but without insurance, the client will need to provide proof that they have no access to insurance from their employer. This can be done in various ways. For example:
 - Letter from employer.
 - Personnel handbook that describes benefits.

Please note: Proper documentation is required. It is not acceptable to take a client's word they have no access to insurance when employed.

Additional Considerations

- Clients who are in the process of completing the COBRA application may have a lapse in health insurance coverage for a period of 30 to 60 days
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(during the application process). The application for COBRA should be completed as soon as possible since this option is time limited.

- Local consortia dollars may be used to pay for the drugs in the interim. ADAP does not provide interim drug coverage. Interim coverage for a premium payment may be accessed through Part B in the Health Insurance Premium/Cost Sharing line item. Please contact your lead agency for more information.

Medicaid

Medicaid is a state and federally-funded entitlement program. The Florida Department of Children and Families (DCF) and/or the Social Security Administration (SSA) determine Medicaid recipient eligibility. Individuals who might be eligible for Medicaid include:

- Single parent household with children under age 18
- Two parent household unemployed or underemployed
- Individuals with a disability as determined by the SSA or DCF

Clients who are Medicaid eligible will not be eligible for HIV/AIDS patient care services/benefits where the same service is covered by Medicaid. Eligibility staff must have access to FLMMIS or other Medicaid software in order to verify current Medicaid enrollment. This is a requirement. Individuals denied Medicaid due to withholding information will also be deemed ineligible for Ryan White Part B services. Additional information on Medicaid can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/florida.html>.

Medicaid Screening

All individuals potentially eligible for Medicaid benefits and not currently accessing some form of insurance must be pre-screened for Medicaid eligibility using the ACCESS Florida website.

Procedure for Pre-Screening Clients:

1. Visit the following link: <http://www.myflorida.com/accessflorida/>.
2. Under "Access Your Benefits," click "Am I Eligible?"
3. On the ACCESS Florida page under "Get Started Now," click the "Am I Eligible?" link.
4. Click the "Next" button to move through and answer each page of questions.
5. Verify the information, and click "Next" to submit.

If the pre-screening process determines the client is possibly eligible for Medicaid services, the client **must** apply for Medicaid. The results page must be printed, the client's name and date of pre-screening must be written on the printout, and the document must be scanned into CAREWare.

Clients who are deemed ineligible based on the pre-screening also must have the results page printed, the client's name and date of pre-screening

must be written on the printout, and the document must be scanned into CAREWare.

Please note: Medicaid screening must be completed at each six month re-determination. Documentation must be scanned into CAREWare to ensure that the most current proof of screening is available.

**Medically
Needy (Share
of Cost
Medicaid)**

- A client's Medicaid plan only provides full benefits if the cost of treatment (including medications) exceeds the share-of-cost amount. The Medicaid approval/denial for a "share of cost" client is determined on a monthly basis. To find additional information about this program, visit <http://www.myflfamilies.com/faq/what-medically-needy-program>.
 - To find additional information about wrap-around assistance through the ADAP Premium Plus insurance services, see the ADAP Policy and Procedures Manual.
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**Medicaid
Project AIDS
Care (PAC)
Waiver
Program**

- The Project AIDS Care (PAC) Waiver Program is a home and community-based program through Medicaid that includes a wide range of authorized services for clients.
 - Clients must have a medical diagnosis of AIDS, be determined disabled according to the SSA (or in the process of applying for or appealing disability decision), and have income less than 200% of FPL.
 - All clients participating in the PAC Waiver Program must have a case manager.
 - PAC case managers are the primary and lead case managers, and are responsible for accessing Ryan White Part B or other services.
 - Documentation of PAC participation waives the income eligibility requirement.
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Medicare

Individuals who are eligible for Medicare must enroll in all coverage that is available before accessing Ryan White Part B services.

- Medicare is a federally-funded entitlement program administered by the Centers for Medicare and Medicaid Services.
 - Medicare is health insurance for people aged 65 or older, under age 65 with certain disabilities, or at any age with end-stage renal disease.
 - Persons with disabilities are eligible for Medicare after two years of being determined disabled by the SSA.
 - Most people receive Medicare health coverage in one of two ways: an original Medicare plan (Part A Hospital Insurance or Part B Medical Insurance), or a Medicare Advantage Plan (sometimes referred to as Part C or MA Plans). Medicare Advantage Plans may offer extra coverage, such as
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vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).

- Medicare Part A and B recipients are required to enroll in a drug plan under Part D before accessing ADAP services.
 - Medicare recipients who are below 152% of FPL also are required to be enrolled in the Low-Income Subsidy (also called "Extra Help") before accessing ADAP services.
 - Monthly premium costs vary depending on the plan selected.
 - There are two ways to get Medicare Part D prescription drug coverage:
 - Join a Medicare Part D prescription drug plan that adds drug coverage to the original Medicare plan; or
 - Join a Medicare plan (like an HMO) that includes prescription drug coverage as part of the plan.
 - Additional information can be found at <http://www.medicare.gov/default.aspx>.
 - To find additional information about wrap-around assistance through ADAP Premium Plus insurance services, see the most recent guidance from ADAP.
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Other Types of Medicare

- Qualified Medicare Beneficiary (QMB) – individuals who are eligible to have Medicaid pay for Medicare premiums (Parts A and B), Medicare deductibles, and Medicare co-insurance within limits.
 - Specified Low-Income Medicare Beneficiary (SLMB) – individuals eligible to have Medicaid pay Medicare directly for Medicare Part B premiums.
-

ADAP Premium Plus Insurance Services

The ADAP Premium Plus insurance services is a component of the ADAP designed to assist eligible ADAP clients with their out-of-pocket costs. ADAP Premium Plus clients have private or government-sponsored health insurance coverage that contains prescription drug coverage equivalent to the ADAP formulary drugs.

To be referred to ADAP, a client must:

- Be determined eligible for HIV/AIDS patient care programs.
- Meet ADAP program qualifications.
- Have a current health insurance policy.
- Be willing to participate by providing their health insurance benefits package and explanation of benefits.

ADAP Premium Plus insurance services requirements referenced in this section may be updated after the release of this manual. Determining program qualifications for ADAP Premium Plus Insurance is not a part of the Ryan White Part B Core Eligibility process. Clients should be referred to ADAP for program qualification determination.

Co-Pays and Deductibles

Clients who are enrolled in the ADAP wrap-around assistance are eligible to receive co-pay and deductible assistance for medical services and other medications not covered under the ADAP formulary.

As local Health Insurance Premium/Cost Sharing line item funding allows, clients who are not eligible for the ADAP wrap-around assistance and meet all other Ryan White Part B eligibility requirements may have certain co-pays and deductibles paid. Please contact your lead agency for more information regarding funding availability.

Temporary Cash Assistance for Needy Families (TANF)

- Temporary Cash Assistance for Needy Families (TANF), which was previously called Aid to Families with Dependent Children (AFDC), provides assistance to needy families with children so that they can live in their own home or the homes of relatives.
 - Clients can apply for TANF through the Florida Department of Children and Families (DCF).
 - Visit the following link for more information:
<http://www.tanf.us/florida.html>.
-

Supplemental Nutrition Assistance Program (SNAP), Previously Food Stamps

- Supplemental Nutrition Assistance Program (SNAP) benefits are intended to supplement other household income and may only be used to purchase food. Other household items, such as cleaning supplies, paper goods, clothes, and alcohol or tobacco products, may not be purchased with SNAP benefits.
 - To receive SNAP benefits, a household must meet certain conditions. Everyone in the household who is applying must have or apply for a Social Security number; and be a U.S. citizen, U.S. national, or have status as a qualified alien (documented alien with a permanent resident card, or "Green Card").
 - All those applying for or receiving Supplemental Security Income (SSI) payments must take or send their SNAP application to the local DCF office or to any Social Security office where a SNAP representative works, or online at ACCESS Florida.
 - When interviewed, a client should have:
 - Identification, such as a driver's license, state identification, birth certificate, or alien card;
 - Proof of income, such as pay stubs, Social Security, SSI, or a pension for each member of their household;
 - Proof of how much is spent for child care;
 - Rent receipts or proof of mortgage payments;
 - Proof of utility costs; and
 - Medical bills for those members of the household age 60 or older, and for those who receive government payments, such as Social Security or SSI, because they are disabled.
 - Visit the following link for more information:
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<http://www.dcf.state.fl.us/programs/access/>.

Please note: Proof of a client receiving SNAP benefits waives the income eligibility requirement for HIV/AIDS patient care programs. However, income is still required for ADAP.

Veterans Affairs (VA)

- The U.S. Department of Veterans Affairs (VA) is a federal agency created to assist all former members of the Armed Forces of the United States and their dependents in preparing claims for and securing compensation, hospitalization, and other medical benefits for eligible persons.
 - Veterans will be issued documentation of VA eligibility or denial.
 - Enrollment in VA services is not required in order to be eligible for patient care services funded by the HIV/AIDS Section. However, VA services provide comprehensive health care coverage for veterans while the HIV/AIDS Section only provides coverage for HIV-related services.
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Children's Medical Services (CMS) Network

- Effective August 1, 2014, Children's Medical Services (CMS) Network became a specialty health plan under [Managed Medical Assistance \(MMA\)](#).
 - The statewide network includes over 5,000 doctors, hospitals, university medical centers, and other health care providers.
 - Approved CMS providers and physicians can be found using the [CMS Provider Search](#).
 - Medical care is provided at community doctors' offices and hospitals, local specialty medical clinics, and at university medical centers. Services are coordinated through one of the 22 CMS Area Offices or 15 Local Early Steps (early intervention) Offices around the state.
 - Visit the following link for more information:
http://www.floridahealth.gov/alternatesites/cms-kids/families/health_services/cms_network_home.html.
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Florida KidCare

Florida KidCare is the state's health insurance program for uninsured children from birth to age 18, and includes four different parts/programs (MediKids, Healthy Kids, CMS Network, and Medicaid). When an individual applies, Florida KidCare will identify which program a child may be eligible for based on age and family income. Some of the services Florida KidCare covers are:

- Doctor visits, check-ups, shots, hospital, and surgery.
- Prescriptions.
- Emergencies.
- Vision, hearing, dental, and mental health.

Visit the following link for more information: <http://floridakidcare.org/>.

Supplemental Security Income (SSI)

- A cash assistance program administered by the Social Security Administration (SSA).
- Provides financial assistance to aged, blind, or disabled individuals who have little or no income.
- Provides cash to meet basic needs for food, clothing, and shelter.
- To be eligible a person must be a U.S. citizen, and have resources and income that do not exceed the program maximum.
- Persons eligible for at least \$1 in SSI automatically receive Medicaid.
- To apply for SSI or find more information, visit: <http://www.ssa.gov/ssi/> or <http://www.dcf.state.fl.us/programs/access/medicaid.shtml>.

Social Security Disability Insurance (SSDI)

- A payroll tax-funded federal government insurance program managed by the SSA.
- Provides income to people who are unable to work due to a disability.
- To qualify, individuals must have a physical or mental condition that prevents them from engaging in “substantial gainful activity,” the condition is expected to last at least 12 months or result in death, and they are under the age of 65 and have worked 40 quarters (at least 10 years).
- To apply for SSDI or find more information visit: <http://www.ssa.gov/disability/>.

Prescription Discount Card Program

- This plan is not insurance; it is a prescription discount program provided by various pharmaceutical companies.
- The card provides immediate discounts at the pharmacy. Upon the client presenting their card to the pharmacist, the client will pay the lower of a discounted price or the pharmacy’s regular retail price.
- There are no claim forms to fill out, and no limit to the number of times clients can use the card. These discounts are available only at participating retail pharmacies.
- Apply online at: <http://www.nacorx.org/>.

Patient Assistance Program (PAP)

- A Patient Assistance Program (PAP) provides for electronic claims adjudication and electronic payment of client cost-sharing, such as co-pays and deductibles for prescription drug coverage available through an insurance plan.
 - PAPs are available through pharmaceutical companies to provide access to free or discounted medications to people with limited income.
 - Qualification guidelines vary among pharmaceutical companies.
 - Further information can be found at: <http://www.needymeds.org/index.htm> and <https://www.pparx.org/>.
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Expanded Access Program (EAP)

- Expanded Access Program (EAP) refers to the use of investigational drugs outside of a clinical trial by patients with serious or life-threatening conditions who do not meet the enrollment criteria for the clinical trial in progress. The Food and Drug Administration (FDA) has established medical criteria for enrollment. The drugs are provided free of charge and are only available to patients through participating physicians.
 - Clients seeking assistance through EAPs should communicate with their physician.
 - For more information, visit: <http://www.aidsinfo.nih.gov/default.aspx>.
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Clinical Trials

- Clinical trials are research studies that follow pre-defined protocols.
 - Guidelines for all clinical trials can be researched at: <http://www.aidsinfo.nih.gov/default.aspx> and <http://clinicaltrials.gov/>.
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Local Assistance Programs

- Areas may have additional locally-funded assistance programs that individuals/applicants should be referred to.
 - If a client is eligible for or participating in locally-funded assistance programs, documentation verifying the client's eligibility for these programs must be scanned into CAREWare.
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CAREWare Instructions

- A copy of Medicare and/or Medicaid eligibility must be scanned into CAREWare every six months for those currently on Medicare and/or Medicaid to show current enrollment status.
 - Proof of third party insurance and/or screening for Medicare/Medicaid must be scanned and attached under the Unique IDs tab, attachment hyperlink.
 - Documentation must have an identifying name; use drop down box to select "Proof of Third Party Insurance."
 - The comment box is not required but encouraged if needed, especially if there is one type of document being used for various types of proof.
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SECTION 10: Income

For the patient care programs within the HIV/AIDS Section, the income eligibility requirement is defined as a gross household income (before taxes and deductions) at or below 400% of the Federal Poverty Level (FPL).

Gross Income versus Net Income

Gross income is commonly defined as the amount of a company's or person's income before any deductions or taxes are taken. Section 61 of the Internal Revenue Code defines gross income as "all income from whatever source derived."

Net income for an individual is gross income minus taxes, allowances, and deductions. An individual's net income is used to determine how much income tax is owed.

- In business, net income is what remains after subtracting all the costs (business, depreciation, interest, and taxes) from a company's revenue. Net income is sometimes called the bottom line, and also called earnings or net profit.

Gross income is the amount used when determining eligibility, except where the client reports he/she is self-employed.

Federal Poverty Guidelines

The Federal Poverty Guidelines provide a measure of poverty. The FPL is used by the HIV/AIDS Section to determine the maximum amount of income allowed for eligibility. The FPL is updated annually in the Federal Register by HHS. The guidelines are a simplification of the poverty thresholds when determining financial eligibility for certain federal programs. For general questions about the FPL, visit: <http://aspe.hhs.gov/poverty>.

Automatic Income Eligibility

A client is automatically income eligible if they have current documentation of eligibility (less than six months old) for one of the following programs:

- Medicaid (not Medically Needy) - a copy of the Medicaid card (front and back) is acceptable as proof when validation is current (checked through MEVSNET, FLMMIS, or other verification systems)
 - Medicaid Project AIDS Care (PAC) Waiver Program
 - Supplemental Nutrition Assistance Program (SNAP; formerly food stamps)
 - Supplemental Security Income (SSI)
 - Specified Low-Income Medicare Beneficiary (SLMB)
 - Qualified Medicare Beneficiary (QMB)
 - Qualified Individual-1 (QI-1)
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- Low-Income Subsidy (LIS; also called "Extra Help")
 - Temporary Cash Assistance to Needy Families (TANF)
 - Women, Infants, and Children (WIC)
 - Local indigent programs (with income requirements that are more stringent than Ryan White Part B)

For a comprehensive list of SSI-related programs available in Florida, visit: <http://www.myflfamilies.com/service-programs>.

Declaring No Income

Clients that declare no income must verify other means of support. This includes:

- If a client is eligible for or participating in locally-funded assistance programs, documentation verifying the client's eligibility for these programs must be scanned into CAREWare.
- The final determination of eligibility is based on compliance with the other eligibility requirements.

Please note: Clients who declare no income are required to self-report the amount and source of their household support. Zero income is not allowable, unless they actually have no income. In this circumstance, clients must provide a letter of support from the person(s) providing in-kind support to the client. See the No Income section below.

No Income (Including Documentation)

- In cases where the client declares no income, documentation is required to verify his/her status.
- A discussion of no income and unemployment is covered in this document when determining the household size.

The below list of questions reflects subject areas that can be explored on a case-by-case basis. Not all questions will be applicable.

- How does the client support himself/herself without income or employment?
 - How are food, clothing, shelter, and utilities being managed?
 - How long has the client been unemployed?
 - What is the client's previous work experience?
 - What are the client's educational qualifications?
 - Is the client underemployed?
 - Could the client find better employment?
 - Is the client currently looking for employment?
 - What is the reason for unemployment (medical, voluntary)?
 - If medical, what is the status of disability/SSI determination?
 - If voluntary, has payer of last resort been discussed?
 - Has there been any effort to find a job?
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- Is the client receiving unemployment compensation?

For clients declaring no income, at least one of the following is required:

- A statement provided as to how the client receives food, clothing, and shelter (also known as a letter of support)
- A recent Summary Earnings Query (SEQY) printout, or Work and Gain Economic Self Sufficiency (WAGES) printout or an income tax return from the previous year
- Federal Insurance Contributions Act (FICA) to establish prior work year income

Please note: While SEQY or FICA printouts may verify only prior year income, such information can be useful in helping to support the factual establishment of current income or claims of no income.

**Step 1:
Determining
Household Size**

A household includes the client, members of his/her family, and certain other adults who live together as a unit. The size of the household used in determining the client's FPL will not necessarily include everyone in the household unit.

Counted

Only specific individuals are counted when determining the household size for purposes of determining the client's FPL. Those counted in the household size are:

- Client (always)
 - Spouse (always, if married in a state that legally recognizes the marriage)
 - Client's minor children (under 18 years old)
 - Adults who live with the client, and meet one or more of the following:
 - Claims the client as a dependent on a tax return
 - Has legal custody, or other legal arrangement or guardianship of the client
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Not Counted

Not counted in household size are:

- Roommate(s) with separate finances who share only in the cost of room and board. Room and board includes household expenses, such as utility, cable, phone, rent or mortgage, and meals.
 - Adults, such as parents, adult siblings, adult children, significant others, and partners who live with the client but have separate finances and/or share only household expenses.
 - Live-in aides who receive payment for their services.
 - Children who are not financially dependent on the client.
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**Step 2:
Determining
Household Income**

- Household income is defined as income received by the client from all sources.
 - Adults living outside of the household who provide money to the client on a daily, weekly, or monthly basis are not included in the household size, but the amount of financial support (allowance) is counted and documented on the Eligibility Staff Assessment Worksheet (Attachment H) under “Other.”
 - Income includes items that generate funds, which may be counted as income. For example, a second home rented out generates income.
 - A list of items counted as income is included in this section.
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**Income Counted
(Including
Documentation)**

The total amount of income from all counted household members is calculated on an annual basis.

Earned income is compensation earned from participation in a business, including wages, salary, tips, commissions, bonuses, earnings from self-employment, and royalties or honoraria.

Earned income documentation:

- Pay stubs showing income before taxes and deductions may be used. Enough pay stubs should be collected to reasonably determine a person’s annual income to be able to project forward. Generally, at least two paycheck stubs (eight weeks, if available) would suffice.
- A signed and dated employer statement on company letterhead may be used. It must state the name of client, rate and frequency of pay, a phone number, and whether the client is currently receiving or is eligible to receive health benefits from the employer.
- IRS 1040 Form or IRS W-2 Form for the most recent year.
- If self-employed:
 - IRS 1040 Form for the most recent year with corresponding attachments (Schedule C or Schedule SE)
 - Most recent IRS W-4 Forms
 - Company accounting books showing business revenue and expenses
 - Self-Employment Tracking Sheet (Attachment M); extenuating circumstances may call for supervisory approval

Unearned income is all income that is not earned, such as Social Security benefits, pensions, disability payments, unemployment benefits, interest income, property rental income, and cash contributions from relatives.

Unearned income documentation:

- Retirement income statement from Social Security
 - Old-Age and Survivors Insurance (OASI) statement
 - Retirement pension statement from private or public fund
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- Trust fund income documentation
 - Military/veteran pension benefits statement
 - A recent Third Party Query (TPQY) printout from Social Security
 - IRS 1040 Supplemental Income and Loss (Schedule E) for property rental income (net income is counted in this circumstance)
 - Unemployment benefit statement
 - Alimony payments
 - Benefits from dependent children (i.e., survivor's benefits)
 - Child support payments
 - Cash assistance by relatives and other individuals (included in letter of support)
 - Monthly income from welfare agencies (public and private)
 - Interest on investments

Deemed income is all earned and unearned income from the client's spouse if married (including legally recognized same sex marriages), and from the adults living in the home who are counted in the household size.

Income Not Counted

Income that is not counted includes grants, scholarships, fellowships, value of SNAP benefits, 401K if not accessed, and any other non-accessible income, such as trust funds.

Self-Employed (Including Documentation)

Self-employment income includes, but is not limited to:

- Small businesses, including proprietorships and partnerships
- Paid professional, paraprofessional, or occupational services such as lawn care, domestic work, handyperson, landscaping, farming, or salesperson
- Royalty or honoraria from intellectual property or authorship

Eligibility for a self-employed client is based on net income. Net income is obtained from the federal income tax return (IRS Form 1040), and all applicable schedules and attachments:

- Schedule SE (titled "Self-Employment Tax")
 - Section A, Line 4; or Section B, Line 6, as applicable
- Schedule C (titled "Profit or Loss From Business"), Line 31

If this is not available or if the client has not been self-employed long enough to have filed taxes, the client can submit records of their monthly self-employment income for at least the past three months. The Self-Employment Tracking Sheet (Attachment M) may serve as proof of income in these cases. Extenuating circumstances may call for supervisory concurrence.

In such cases, subtract from gross self-employment income any allowable

business expenses necessary and directly related to producing goods or services. Allowable self-employment expenses include, but are not limited to:

- Purchasing inventory.
- Space rental and utilities.
- Salaries for employees other than the client.
- Transportation expenses required for employment.
- Interest on loans for capital assets or durable goods.
- Income reinvested in a business (except for the purchase of real estate); this includes the purchase of capital equipment, payment on the principal of loans, and other expenses needed to produce goods and services.

Please note: Capital equipment is equipment needed to produce self-employment goods (e.g., a printing press, copy machines, farm machinery, tools, sewing machines, tractors, tow trucks). If the expenses exceed the gross receipts, the self-employment income will be zero.

How To Calculate Income

Below are some examples of how to calculate income (review the “Income Counted” subsection above for details).

WEEKLY

- Weekly gross amount X 52
- Example: $\$600.32 \times 52 = \$31,216.64$ (annual income)

BI-WEEKLY (every two weeks/26 paychecks)

- Bi-weekly gross amount X 26
- Example: $\$1417.92 \times 26 = \$36,865.92$ (annual income)

BI-MONTHLY (twice per month)

- Bi-monthly gross amount X 24
- Example: $\$1325.28 \times 24 = \$31,806.72$ (annual income)

MONTHLY

- Monthly gross amount X 12
- Example: $\$1,288.52 \times 12 = \$15,462.24$ (annual income)

Circumstances may vary based on the availability of documentation.

- If a client’s weekly income fluctuates greatly (e.g., day labor), determine the total weekly income of each week worked by adding the gross income for each day the client worked in the week. Add the weekly totals together, and then divide by the number of weeks worked to determine the average weekly gross amount. Once the average weekly gross amount is determined, use the weekly income calculation above to determine the annual income. For example, a client comes in and
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provides two weeks of income information. The documentation shows the client worked only two days in one week earning \$75 on Monday and \$50 on Wednesday for a total weekly income of \$125. The following week the client worked four days earning \$50 on Monday, \$120 on Tuesday, \$35 on Wednesday, and \$75 on Friday for a total weekly income of \$280. The two weekly totals (\$125 and \$280) are added together (\$405), which is divided by the number of weeks provided (two) to equal the weekly gross amount of \$202.50. Multiply \$202.50 by 52 to equal an annual income of \$10,530 ($\$125 + \$280 = \$405 / 2 = \$202.50 \times 52 = \$10,530$).

- Year to Date (YTD) information can be used if only one paycheck stub is available. For example, a June 30, 2015, pay stub reflects YTD \$19,055; and the client is paid bi-weekly. Calculate the income by dividing the YTD income (\$19,055) by the number of pay periods to date (13) to determine bi-weekly pay (\$1,465.77), and then multiply by 26 pay periods to get an annual income of \$38,110 ($\$19,055 / 13 = \$1,465.77 \times 26 = \$38,110$).

Step 3: Calculating the Federal Poverty Level (FPL)

The FPL should be calculated to a specific number rather than a range by doing the following:

- Calculate total annual household income.
- Calculate total household size.
- Calculate the FPL using the most current FPL information and the household size total.
- Document this on the Eligibility Staff Assessment Worksheet (Attachment H).

Example: If a client's income is \$24,000 annually and their spouse's income is \$22,000 annually, add the total incomes together. Divide the total (\$46,000) based on a family size of two using the amount in the corresponding FPL chart to determine the specific FPL (visit <http://aspe.hhs.gov/poverty> for the most current FPL data). So $\$24,000 + \$22,000 = \$46,000 / \$15,930$ (2015 poverty guidelines data) $\times 100 (\%) = 289\%$ FPL.

Final Income Determination

- The total amount of income from all counted household members is calculated on an annual basis.
 - All of the earned and unearned income is documented on the Eligibility Staff Assessment Worksheet (Attachment H), and the grand total for the household income is tallied.
 - This amount cannot exceed the client's FPL dollar amount, which is determined in Step 3 above.
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State HOPWA Exception
(this information has been included to alert staff of the potential for some clients to be eligible for State HOPWA even if over 400% FPL)

- Clients seeking housing assistance from the State HOPWA Program must be determined eligible under [Chapter 64D-4 F.A.C.](#)
- Clients who are not core eligible for HIV/AIDS patient care programs based on the FPL limit should be assessed for a housing need.
- The State HOPWA Program qualification allows clients to be at 80% of the median income, which in some instances is greater than 400% of FPL.
- Under these circumstances if all other criteria except FPL are met, clients who might have a housing need should be given a NOE with a notation for **HOPWA only** and referred to the State HOPWA Program.
- Clients receiving a NOE exception for HOPWA services are not guaranteed to receive HOPWA services. Additional programmatic requirements will need to be determined.
- The State HOPWA Program will assess for 80% of the median income.
- Not all clients who seek core eligibility will have a housing need.

Refusal to Divulge

- Clients who refuse to divulge or document income will not be able to complete the financial eligibility assessment, and will therefore be determined ineligible.
- This includes spouses and household members counted in the household size who refuse to provide the appropriate information.
- Under these circumstances, clients must be given a NOI with an explanation.

CAREWare Instructions

- All forms of income/in-kind support must be scanned and attached under the Unique ID tab, attachment hyperlink.
 - Documentation must have an identifying name; use drop down box to select “Proof of Income.”
 - The comment box is not required but encouraged if needed, especially if there is one type of document being used for various types of proof.
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Section 11: State CAREWare Instructions For Eligibility

This section provides instructions on use of State CAREWare for the purpose of core eligibility. All-inclusive data entry requirements for CAREWare can be found in the CAREWare User Manual and the Patient Care Program Administrative Guidelines.

Entering Into CAREWare

All eligibility forms and information under [Rule 64D-4, F.A.C.](#), must be entered into CAREWare, the statewide client level information database. The most recent State CAREWare documents can be found online at: <http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/ware.html>.

Database Access Restrictions

Access to CAREWare for eligibility will be determined by the lead agency that contracts with providers. All personnel entering into CAREWare will have user accounts.

Information Security Requirements

All eligibility staff must attend confidentiality training annually; and adhere to the rules established in DOHP 50-10-10, Information Security and Privacy Policy. To request a copy of DOHP 50-10-10, lead agencies may contact the local DOH contract manager.

Domains and Sharing of Eligibility Data

Agency staff enters client information for eligibility into their unique domain (agency name). Clients may seek services from multiple providers (agencies). Clients can exist under multiple domains and this does not prevent different agencies from using CAREWare for that client.

The only shared data between agencies are the following tabs:

- Demographics
- Annual Review
- Unique IDs

Each area is unique, so domains (name of agency as listed in CAREWare) may vary. Lead agencies determine local domains, except for ADAP. All ADAP staff domains are their CHDs.

Paper Enrollment

Eligibility staff may use paper forms to determine eligibility for new clients if:

- The CAREWare database is not available due to server/network issues.
- You are conducting eligibility off site, and do not have access to the CAREWare database.

All handwritten paperwork and data must be entered and/or scanned into CAREWare once service or access to the database has been restored.

CAREWare Forms

The following documents must be completed in CAREWare under the "Forms" tab:

1. Eligibility Staff Assessment Worksheet (Attachment H; once at initial appointment or if the file is closed for more than a year)
2. Six Month Re-certification Review Form (Attachment I; every six months after initial certification)
3. NOE or NOI (Attachment J and Attachment K, respectively; every six months)
4. Insurance Waiver Form (Attachment L; if applicable)

All forms are custom sub-forms. This means these forms are kept each time they are completed and will provide a history over time. Check the box in the top left corner of the form to fill it in and save. When it is time to complete any of the documentation on the "Forms" tab, a new form will need to be added. **Do not edit any previous forms.**

No signatures are required on the Eligibility Staff Assessment Worksheet (Attachment H), Six Month Re-certification Review Form (Attachment I), and Insurance Waiver Form (Attachment L).

The NOE must be printed for signatures (client and staff), scanned, and saved into CAREWare. The NOI must be printed for signature (staff only), scanned, and saved into CAREWare.

Complete a new form for each six month re-certification. Do not edit existing forms. Doing so deletes the original form and the history provided.

Deleting Forms

Although forms completed under the "Forms" tab can be deleted, this should not occur unless a form is completed for the wrong client, under a different client's name, or other unusual circumstance.

Forms will save by date, and should be kept for tracking and auditing purposes.

Scanning Documents (Located under the Unique IDs Tab)

The following items must be scanned into CAREWare as proof of documentation (see each applicable section in the manual for acceptable proof/documents):

1. Copy of the completed and signed Eligibility Application (Attachment G)
 2. Copy of the signed NOE or NOI (Attachment J or Attachment K,
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- respectively)
3. Proof of HIV (Section 7)
 4. Proof of living in Florida (Section 8)
 5. Proof of any third party insurance, such as Medicaid, Medicare, private insurance, veterans benefits (Section 9)
 6. Proof of income (Section 10)
 7. Copy of the signed releases/consent forms (Attachments C,D2, and E)
 8. Other identified documents as part of file, if applicable.

When scanning documents, you must select an item from the drop down menu. Specifics about the document should be noted in the “Comments” section. All documents should be saved individually rather than combining them, even if they represent one category (e.g., proof of living in Florida, such as driver’s license and utility bill).

Example: A copy of a client’s utility bill may be used as proof of living in Florida. Select from the drop down box “Living in Florida,” and in the comment box type “utility bill.” You are not able to type free text in the drop down menu.

Please note: File uploads (scanning) are limited to 1 MB or smaller. Anything larger will cause problems with the system.

Deleting Scanned Documents

Documents scanned and saved in the “Attachment” section under the tab “Unique IDs” should not be deleted, except under the following circumstances:

- The document is scanned under a different client name.
- The wrong type of document was scanned by accident.

Any deletions will not be allowed at the user level. Documents needing deletion will require a call to your agency’s local CAREWare administrator, or the DOH IT Help Desk at (850) 922-7599.

Confidential or client-specific information must not be transmitted electronically. Following assistance from the DOH IT Help Desk, Reporting Unit staff will contact the requestor if additional information is required.

Scanning for Six Month Re-certification

Updated information must be scanned during EACH six month re-certification. Certain documents do not need to be re-scanned.

1. Proof of HIV: Do not re-scan. This only needs to be done during the initial enrollment.
2. Proof of living in Florida: If the client has moved or has new living circumstances, the new documentation must be scanned. If there are no changes, do not re-scan any documents.
3. Proof of income: Verification of earned income (e.g., pay stubs) are

always required at the six month re-certification. All other documents only need to be scanned if there is a change, such as award letters for SSI, SSDI, VA, etc., where there has been an increase in benefits. If there is no change, do not re-scan any documents.

4. Proof of third party insurance (Medicaid, Medicare, private insurance, veterans benefits, etc.): Any new information on insurance must be scanned.
 5. Copy of the signed NOE: Scan every six months.
 6. Copy of the updated signed releases/consent forms (Attachments C, D2, and E): Do not re-scan.
 7. Other identified documents as part of file, if applicable: Do not re-scan.
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Saving/Storing Scanned Documents

Scanned documents attached in CAREWare should be deleted from networks or desktops routinely, at least at the end of each day.

Agencies should determine a central location where all scanned documents are stored. It is preferable that these documents all be scanned to one file/location, and then be deleted each night for security purposes.

Display Settings

If you have issues viewing and/or printing a form, you might need to adjust your display settings. Please look at your DPI by going to "Control Panel," "Display," "Settings," "Advanced," "DPI Setting." Make sure your setting is at normal size (96 DPI).

Attachments

Attachment	Name	Requirement
Attachment A	Ryan White Program Definitions of Eligible Services	N/A
Attachment B	DH 1120, Acceptable Use and Confidentiality Agreement	Required
Attachment C	DH 3204, Initiation of Services	Required
Attachment D1	DH 150-741, Notice of Privacy Practices	Required
Attachment D2	DH 150-741, Notice of Privacy Practices Acknowledgment Form	Required
Attachment E	DHOGC 3203, Authorization to Disclose Confidential Information	Required
Attachment F	Core Eligibility Requirements Brochure (English, Spanish, and Creole)	N/A
Attachment G	DH 150-884, Eligibility Application	Required
Attachment H	Eligibility Staff Assessment Worksheet	Required
Attachment I	Six Month Recertification Review Form	Required
Attachment J	DH 8000-PHSPM, Notice of Eligibility	Required
Attachment K	Notice of Ineligibility	Required
Attachment L	Insurance Waiver Form	Required
Attachment M	Self Employment Tracking Sheet	Required