2025

BOSTON PUBLIC HEALTH COMMISSION

FY 2025 Service Standards Ryan White Part A Boston EMA

BOSTON PUBLIC HEALTH COMMISSION

RYAN WHITE SERVICES

Contents

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) provides funding for Ryan White Services in the Boston EMA. The contents of this manual are those of the Boston Public Health Commission Ryan White Services, developed to ensure compliance with the legislative and programmatic requirements of the RWHAP Part A program, and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Service Standards

Section I: Universal Standards

The Service Standards are the minimum requirements that programs are expected to meet when providing HIV services funded by Ryan White Part A. Subrecipients are encouraged to exceed these standards. The Service Standards ensure that agencies best meet the needs of their clients and are consumer-focused on the design and implementation of services. **Service Standards apply equally to services provided in-person and via telehealth.** The objective of the Universal Service Standards is to help achieve the goals of each service type by ensuring that programs:

- Have policies and procedures in place to protect clients' rights and ensure quality of care for both in person and telehealth services;
- Have Emergency Preparedness and Response Policies and Procedures services in place to guide service provision during emergencies such as the COVID-19 Public Health Emergency;
- Provide clients with access to the highest quality services through experienced, trained, and when appropriate, licensed staff;
- Provide services that are culturally and linguistically appropriate;
- Meet federal and state requirements regarding safety, sanitation, access, public health, and infection control;
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of grievance review and advocacy;
- Comprehensively inform clients of services, establish client eligibility, and collect and store client information through an established process;
- Effectively assess client needs and encourage informed and active client participation;
- Address client needs effectively through coordination of care with appropriate subrecipients and referrals to needed services;
- Are accessible to all people living with HIV in the designated 10 counties that constitute the Boston EMA;

1.0 Eligibility, Insurance & Recertification

RWS Description:

Ryan White legislation requires that individuals receiving services through Ryan White Part A funding must have a diagnosis of HIV, reside in the Boston EMA and be income eligible as detailed in this section. Subrecipients must demonstrate that all other funding sources available are fully exhausted before Ryan White funds are utilized. Funded subrecipients are responsible for screening clients for eligibility for Medicaid (MassHealth and NH Medicaid), other third-party insurance, and other funding sources as appropriate. Ryan White Part A funds may not be used for any item or service "for which payment has been made or can reasonably be expected to be made" by another payment source[1].

Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements:
PCN 16-02 https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1302clienteligibility.pdf

Standard	Measure
1.1 Eligibility Agencies must establish eligibility of clients at intake and recertify clients for eligibility annually. Activities include: • Complete an intake *(**See Standard 2.1 -Intake)*** • Screen patients for eligibility • Maintain intake and eligibility documentation in client file and e2Boston	Record of eligibility in the client file and e2Boston, including: • Client name, home address and mailing address • Documentation of HIV Status • Proof of Boston EMA residency • Verification of income eligibility • Documentation of health insurance
1.2 HIV Status Documentation required for the initial eligibility determination includes: • Diagnosis letter signed by a licensed medical professional • Positive test result consistent with HIV diagnosis.	Record of HIV status evident in client's file and e2Boston Providers only need to collect this documentation one time at the initial determination of eligibility and do not need to update after initial submission.
1.3 Income Must have an income of 500% or less of the most current FPL. Documentation includes at least one of the following: • State/Federal Tax Return • Current pay stub • Bank statement indicating direct deposited income • Disability award letter • Self-employment affidavit • Support affidavit • MassHealth Verification (i.e. screen shot of EHR face sheet or Virtual Gateway verification) • NH Medicaid Verification • HDAP approval letter • Written letter signed by client attesting to not income	Client files and e2Boston must have updated documentation to verify income eligibility once a year.
1.4 Boston EMA Residency The client must reside within the 10 counties of the	Client files and e2Boston must have updated documentation to verify EMA residency once a year.

Boston EMA. Documentation includes at least one: • Utility Bill • Lease/Mortgage Statement • Support affidavit • Letter from Shelter • MassHealth Verification (i.e. screen shot of HER face sheet or Virtual Gateway verification) • Driver's License/State Issues ID • Bank Statement • Paycheck or Benefits Statement Written letter signed by client attesting to residency	
1.5 Health Insurance The client must be enrolled, or in the process of enrolling into health insurance. Documentation includes at least one of the following: • Insurance Verification document • Recent Explanation of Benefits • Recent Explanation of Payment • Recent Premium Bill • MassHealth letter • Patient Medical Information (PMI) Form HDAP approval letter	Client files and e2Boston must have updated documentation to verify insurance coverage for eligibility once a year.
1.6 Recertification Providers must recertify Ryan White Part A eligibility every 12 months.	All eligibility documentation must be collected at least once annually.
1.7 Electronic Tracking of Eligibility Status Providers must enter client eligibility status and upload the required back-up documentation, as listed above in **Standards 1.1-1.6**, for all clients into e2Boston.	Record of agency tracking client eligibility status and back-up documentation in e2Boston
1.8 Eligibility Data Sharing When agencies refer a client to another Part A agency in the Boston EMA, they must: 1. Ensure eligibility status is current and that eligibility documentation is uploaded into e2Boston (either full documentation or self- attestation, whichever is most recent); 2. Upload completed client **Consent to Receive Services Form,** which is agency specific and collected at intake (**see Standard 2.1-Intake**); and 3. Complete and upload the **Consent and Authorization to Share Information Form** developed for the Data Sharing and Eligibility Module. Please note that if the client declines to authorize sharing, the information cannot be shared, and each agency will have to verify eligibility through a separate process or through another method of information sharing. 4. The purpose of this **Consent and Authorization to Share Information Form** is to allow the sharing of	Records in e2Boston of agency uploading consent forms and sharing eligibility data with Part A agencies/services

individual data when seeking services at two or more agencies; or to revoke sharing of data if the client no longer wishes to share eligibility data with those agencies. **This consent will remain valid for one year or until revoked by the client.** If the client wishes to revoke their consent form, they must do so in writing and must resubmit the consent form indicating their revocation to an agency within the system.	

[1] Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1) and 2671(if) of the Public Health Service (PHS) Act

2.0 Intake, Discharge, Transition & Case Closure

RWS Description:

Providers are responsible for educating clients of their rights and responsibilities, confidentiality policies, and informing clients of the agency's grievance policy for all Ryan White Part A funded services at the time of intake and on an annual basis thereafter. Additionally, all clients must receive a general needs assessment 14 business days from the initial engagement. If a client is discharged or a case closure occurs, the provider must reasonably attempt to contact the client to inform the client of their pending discharge/case closure.

Standard	**Measure**
2.1 Intake Within 14 business days of initial contact with a client, the agency must perform an intake. Intakes must include the collection of identifying information and the review and completion of the Confidentiality Policy and Client Grievance Procedures forms, the Client Rights and Responsibilities form, and the Consent to Receive Services form. Intakes must also include an assessment of client language needs and a plan to ensure client access to all services, materials, and communication in the client's preferred language. Agencies must work with clients to determine the best mode of service delivery for the client, based on client preference, at the time of scheduling appointments. **If the agency does not offer in-person services in a given period due to an emergency, staff will work to support client access to services via alternative service modalities.*	Record of intake completed, including all required components, within 14 business days of initial contact of the client
2.2 Confidentiality Policy Confidentiality Policy and Release of Information will be discussed and signed.	Confidentiality Policy and Release of Information policy reviewed, signed, and dated by client annually, and placed in file
2.3 Rights and Responsibilities and Grievance Policy Rights and Responsibilities and Grievance policy signed and dated by client annually and placed in file. All major grievances should be reported to the Ryan White Services Team at BPHC within 30 days	Rights and Responsibilities and Grievance policy signed and dated by client annually, and placed in file
2.4 Discharging, Transferring or Case Closures The agency must have policies and procedures in place to discharge, transition and/or close cases when the client: • Relocates out of the service area • Has no direct program contact in the past 6 months (becomes inactive) despite provider contact to engage in care. • No longer needs the service • Discontinues from the services • Is incarcerated for a year or longer	Record of discharge, transition and/or case closure within the client file Written policies and procedures about discharge process on file at the agency Record of at least 3 attempts to contact clients before discharge and to communicate about case closures

• Exhibits threatening behavior that prevents the provision of a service or that prohibits another client from receiving services. • Has passed away Policies and procedures for discharge must include at least three (3) attempts to contact the client before discharge. The agency must inform the client of discharge with information about how they can access services in the future if needed.	

3.0 Client Retention, Re-Engagement, and Linkage and Access to Care

RWS Description:

Ryan White Part A funded agencies must have policies and procedures in place to promote client retention, re-engagement, and linkage to care. Funded agencies should also have policies and procedures in place that ensure clients' access to care.

Standard	Measure
3.1 Client Retention and Re-Engagement Policies and Procedures Providers will develop and implement policies and procedures to support retention of clients in care and re-engagement if they fall out of care. These should include staff protocols to follow-up with clients to determine and mitigate barriers to accessing services and continuity of care. **Note:** Service delivery models that are medium to large group interventions must assess participation.	Written policies on file at the provider's agency Record of at least 3 attempts to re-engage clients that fall out of care Record of reason for individual falling out of care
3.2 Linkage to Care (referrals) Providers must provide appropriate referrals to resources and services to fully address client needs and mitigate barriers to continuity of care. Providers must follow **Standard 1.8** regarding eligibility data sharing, when making referrals to another Part A funded service in the Boston EMA	Documentation of referrals evident in client file that correspond to identified client needs Records in e2Boston of agency uploading consent forms and sharing eligibility data with Part A agencies/services in Boston EMA
3.3 Accessibility of Facility Services at provider agency are accessible to clients according to ADA requirements, and are equipped with accessible elevators, ramps, TTY, etc.	Observations made by RWS staff upon visiting provider sites
3.4 Accessibility of Setting to Income-eligible Individuals Services delivered by provider are available in settings that are readily accessible to income-eligible individuals.	Observations made by RWS staff upon visiting provider sites Interviews with staff
3.5 Service Delivery Space Provider makes deliberate effort to ensure that facilities are welcoming and comfortable to the populations served. Provider must configure physical spaces and establish/follow protocols that ensure services provided are private, whether in-person or telehealth modalities.	Observations made by RWS staff upon visiting provider sites Interviews with staff
3.6 Collection & Utilization of Client Input Provider develops and implements policies and procedures to regularly obtain client input and utilize the input to inform service delivery.	Written policies and procedures on file at the provider's agency Documentation that indicates utilization of client input Interviews with staff

3.7 Refusal of Services Policies & Procedures Documentation of each client that has either refused a service themselves or has been refused a service with the rationale for refusal.	Written policies and procedures on file at the provider's agency Documentation of each client that has been refused a service with the rational for refusal
3.8 Engagement of Income-eligible Clients Provider conducts specific activities and/or maintains promotional materials that are used to engage income-eligible clients and to promote awareness of Ryan White services.	Interviews with staff Review of the percentage of provider's clients that are income-eligible

4.0 Staff Credentials, Training, & Supervision

RWS Description:

Providers are responsible for delineating administrative and direct service costs in accordance with PCN 15-01. The licensure, credentials, experience and training of staff on Ryan White Part A budgets must reflect requirements of the service-specific standards set forth within this document or reflect internal policies set by the agency. Generally, all staff must meet minimal qualifications to administer and/or deliver services, including:

- Provision of appropriate care to people living with HIV
- Documentation of the services delivered to people living with HIV
- Administration of the required fiscal or programmatic components of service delivery

Furthermore, all direct service staff must receive administrative supervision. Administrative supervision addresses issues relating to staffing, policy, distribution of vouchers, scheduling, training, quality improvement activities and overall communication. One hour per month of clinical supervision must be provided for Health Education & Risk Reduction, Non-Medical Case Management, Medical Case Management and Psychosocial Support direct staff. Clinical supervision can occur in a group or individual setting and must be provided by a third part who is not associated with the funded Ryan White Part A service. The clinical supervisor may be employed by the agency but must be impartial to the service(s) provided.

All agencies must maximize third-party billing for staff with the proper credentials and/or licensure to bill third-party payers for services render to clients by credentialed and/or licensed staff member. They must bill for the services rendered to clients. Income earned from the Ryan White program must be tracked and reported to RWS.

Source: PCN 15 – 01 Treatment of Cost Under the 10% Administrative Cost
https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1501.pdf

Source: PCN 11 - 04 Use of Ryan White HIV Program Funding for Staff Training
https://hab.hrsa.gov/sites/default/files/hab/Global/habpl1104.pdf

Standard	Measure
4.1 Training and Onboarding The agency must develop and execute training according to PCN 11-04.	Training and onboarding materials on file
4.2 Cultural Competency The agency's recruitment, onboarding and training policies must reflect an intention to provide accessible services in a manner most appropriate to the population served.	The agency will provide documentation, in the form of a cultural competency policy or other document, that reflects a commitment to provide appropriate services to the service population.
4.3 Supervision of Funded Services All staff will receive relevant supervision of services rendered under the funded service category.	The supervision structure will be defined and documented in a policy by the subrecipient.

5.0 Staff Safety Standards

RWS Description:

The Ryan White Part A funded agency must establish policies and procedures to protect the physical safety of staff and clients, both on-site and in the community. Ryan White Part A staff must be protected and supported by an agency to ensure crises can be properly managed and de-escalation protocols are in place to prevent harm to both clients and staff members.

Standard	**Measure**
5.1 Safety Protocol for Staff and Clients Agency must have a safety policy/protocol that is reviewed and signed by Part A staff members.	A written safety policy/protocol is on file at the agency location
5.2 Anti-bullying, Discrimination, and Sexual Harassment The agency must have a policy with language that protects staff and clients, regardless of how they identify their gender, sexual orientation and ethnicity.	A written safety policy/protocol for anti-bullying, discrimination and sexual harassment is on file at the agency location
5.3 Staff Safety on Community and Home Visits The agency must have policies in place to ensure the safety of staff and clients during community and home-visits.	A written safety policy/protocol for staff safety on community and home visits is on file at the agency location
5.4 Protocol for Incident Reporting The agency must have policies in place for staff to report incidents. Policies must contain a timeframe of when the incident occurred to when the follow up report is expected to happen. All major incidents should be reported to the Ryan White Services Team and BPHC within 30 days.	A written safety policy/protocol for incident reporting is on file at the agency location All major incidents should be reported to the Ryan White Services Team and BPHC within 30 days

6.0 File Maintenance & Data Security

RWS Description:

The Ryan White Part A funded agency must meet all mandatory file maintenance and data security requirements and standards. These requirements include the documentation of engagements between the client and provider both in-person and via telehealth, policies pertaining to electronic and paper file security, and quality assurance activities related to the maintenance of files and the archiving of files.

Standard	**Measure**
6.1 File Security Client records maintained by the agency must be locked or password protected. Access to records must be limited to relevant staff.	Security measures observed during monitoring activities
6.2 Data Entry Data entry and reporting requirements for recipient and HRSA are completed according to the required schedule and with complete and accurate data.	Verified through e2Boston
6.3 Archiving Subrecipient will archive client files that meets the minimum requirements in accordance with state, federal, and other legal regulations.	Policy must be documented and may include use of Iron Mountain or other archive systems

Section II: Core Medical Services

HRSA Definition: Essential, direct, health care services for HIV care.

7.0 ADAP

HRSA Description:

The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to income-eligible clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV. HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:

- HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.
- See PCN 07-03: The Use of Ryan White HIV Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services
- See PCN 18-01: Clarifications Regarding the use of Ryan White HIV Program Funds for Health Care Coverage Premium and Cost Sharing Assistance
- See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Ensure that all people living with HIV have access to and are able to adhere to HIV and other prescribed medical regimens.

Objective*:* Ease the financial burden of medical costs for people living with HIV by providing financial assistance for prescription medication.

Standard	Measure
7.1 Pricing ADAP agency has a process to secure best prices available for all medications, including 340b pricing or better and a policy to determine the cost effectiveness of purchasing insurance for clients.	Record of medication purchases and policy to determine cost effectiveness of purchasing insurance
7.2 File Maintenance ADAP files will be kept in accordance with Massachusetts and/or New Hampshire code of regulations.	Files compliant upon RWS staff review during monitoring visits

7.3 Formulary ADAP services must include a medication formulary that meets the minimum requirements of all approved classes of medications according to HHS treatment guidelines. Decisions about medication costs must be inclusive of the medicine regimen and the way the medication is procured and delivered.	A record of the medication formulary on file

8.0 Medical Case Management

HRSA Description:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes variety of encounters including face-to-face, phone contact, or via another form of telehealth, etc.

Key activities include:

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

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

Program Guidance:

- Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.
- Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Engage clients who face significant challenges to enter and maintain treatment for their HIV.

Objective: Assess client needs and develop a Comprehensive Treatment Plan (CTP) that provides guidance and assistance in improving health care outcomes for people living with HIV.

Standard	Measure
8.1 Medical Case Management Needs Assessment A client needs assessment must be completed within 30 days of intake and include a wide range of topics to identify the client needs and address potential barriers to retention in care. The following topics, at minimum, should be assessed: • Healthcare • Mental Health • Transportation • Health Education & Risk Reduction • Sexual Health Assessment • Legal • Support systems • Nutrition • Housing • Insurance	8.1 Medical Case Management Needs Assessment A client needs assessment must be completed within 30 days of intake and include a wide range of topics to identify the client needs and address potential barriers to
8.2 Medical Case Management Reassessment of Needs A reassessment of needs must be completed every six months from the previous completed assessment. The reassessment can be adapted to reflect a more narrow focus than the initial assessment based on the clients ongoing needs.	Record of reassessment completed six months after the previous assessment in the client file
8.3 Comprehensive Treatment Plan (CTP) Medical case management staff must develop a medically oriented Comprehensive Treatment Plan with a client-centered approach that is informed by the client needs assessment. The Comprehensive Treatment Plan must be updated every six months, or more often as needed.	Record of the Comprehensive Treatment Plan completed within six months, or less, from the initial or previous comprehensive service plan
8.4 Client Monitoring The provider must regularly monitor the efficacy of the Comprehensive Treatment Plan (CTP). This includes the ongoing assessment of adherence to the Comprehensive Treatment Plan.	Record of regular contact with client within client's file to monitor progress with the CTP
8.5 Treatment Adherence Screening Medical case management staff must routinely perform treatment adherence screenings to ensure adherence to medication.	Record of treatment adherence screening within client files

8.6 Coordination of Care Medical case management staff must coordinate services being provided to the client. Activities may include, but are not limited to: • Scheduling medical and/or behavioral health appointments. • Ordering labs • Providing referrals • Completing supported referrals • Case conferences Coordination of care must be appropriate to the client's needs, as identified by the Needs Assessment and/or the comprehensive service plan. These activities must be tracked. Coordinating care with external agencies requires the consent of the client. Consent must be obtained in accordance with state and federal code of regulation.	Record of services detailed and maintained within client files Completed Authorization Forms for communication with external agencies in accordance with HIPAA Written Referral Policies and Procedures on file at the agency
8.7 Clinical Supervision Medical case management staff must receive at least one hour of clinical supervision per month.	Record of medical case management staff attendance in clinical supervision
8.8 Caseload Case load determination should be based on client characteristics and the intensity of case management activities.	Written policy on file and procedures for staffing ratios

9.0Medical Nutrition Therapy

HRSA Description:

Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:

- All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.
- See also Foodbank/Home Delivered Meals

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Optimize immunity, reduce weight loss and nutritional deficiencies, and improve the overall wellbeing for people living with HIV.

Objective: Identify and treat nutritional deficiencies in people living with HIV through the provision of medical nutrition therapy which includes nutritional counseling and the prescription of dietary regimens by a physician or licensed nutritionist or registered dietician.

Standard	Measure
9.1 Medical Provider Referral Clients receiving services under the MNT service category must be referred by a medical provider.	Record of medical provider referral in client file
9.2 Nutrition Assessment, Screening and Dietary Evaluation A licensed nutritionist or registered dietician must perform a nutritional assessment, screening or evaluation of the dietary needs of the client.	Record of an assessment, screening and/or dietary evaluation in clients file
9.3 Nutritional Plan A nutritional plan must be developed in accordance with the nutritional assessment and screening. The nutritional plan must include (but not limited to) the following items: • Recommend services and course of MNT to be provided, including types and amounts of nutritional supplements and food. • The signature of the referring medical provider and each registered dietician who rendered services. Date of the initiation and/or termination of MNT services • Recommendations for follow-up	Record of nutritional plan in client file Record that nutritional plan is updated every six months in client file

• Planned number and frequency of sessions. The nutritional plan must be updated every six months.	
9.4 Food and/or Nutritional Supplements Food and nutritional supplements can be provided to the client based on the nutritional plan completed by the registered dietician or licensed nutritionist.	Record of food and nutritional supplements provided to the client
9.5 Nutrition education and/or counseling All clients receiving a food and/or supplement for the first time will receive appropriate education/counseling. This must include written information regarding the health benefits of the prescribed nutritional plan and recommended strategies to promote adherence to the nutritional plan.	Record of nutritional education and/or counseling in client file
9.6 Provider Licensure Services must be provided by a nutritionist or registered dietician.	Record of licenses and credentials maintained in employees Human Resources file

10.0 Oral Health Services

HRSA Description:

Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Prevent and control oral and craniofacial diseases, conditions, and injuries, and improve access to preventive services and dental care for eligible people living with HIV.

Objective: Increase awareness of the importance of oral health to overall health and well-being, increase the acceptance and adoption of effective preventive interventions and reduce disparities in access to effective preventive and dental treatment services. (Healthy People 2020).

Standard	Measure
10.1 Clinical Decisions and Treatment Guidelines Dental providers must provide oral health care in accordance with HIV treatment guidelines released by state and federal regulatory bodies. Additionally, clinical decisions must be supported by the American Dental Association Dental Practice Parameters.	Written policies and procedures that reflect the most up-to-date treatment guidelines and American Dental Association Dental Practice Parameters
10.2 Contractor Licensure All dental staff must have appropriate license, credentials and expertise to administer oral health care.	Record of licenses and credentials maintained by the dental provider and submitted to the program for review
10.3 Leadership Training The program director must have training experience in clinical aspects of oral hygiene, dental treatment planning and dental care	Record of demonstrated experience within personnel files
10.4 Wait List Policy The program must have a policy to manage a wait list for eligible RWHAP, Part A clients.	Written wait list policy on file
10.5 Appeal Process The program must have a process in place in the event a client's treatment plan is not approved and the client wishes to appeal the denial of the treatment plan. The client must be informed of the appeals process upon denial.	Written policy and procedures on file at the agency Record that appeal forms are accessible to the clients
10.6 Contractor Recruitment & Training The program must routinely recruit and train dental providers to ensure gaps in service delivery are addressed.	Written policies and procedures to recruit and onboard dental providers on file at the agency
10.7 Treatment Plan A treatment plan must be developed by contracted dental providers that is based on an initial examination of the client. Treatment plans must be reviewed and	Contracted dental providers must record treatment plans in client file

approved by the dental program director.	
10.8 Treatment Plan Review and Update The treatment plan must be reviewed and updated routinely by the dental provider and/or dental program director.	Record of treatment plan review and update in client files

Section III: Support Services

HRSA Definition: Services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV.

11.0 Emergency Financial Assistance

HRSA Description:

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

Program Guidance:

- Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category.
- Direct cash payments to clients are not permitted.
- If EFA is being used for emergency housing support, mortgage and rental deposits are not permitted and all other housing services standards must also be followed.
- Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Assist clients with meeting a short-term urgent need for an item or service that is essential to their HIV care and treatment. Services and items could include, but are not limited to, the following:

- Utilities (*may include household utilities including gas, electricity, propane, water, and all required fees*)
- Housing (*may include as rent or temporary shelter and recommended to not exceed no more than 6 months. EFA can only be used if HOPWA assistance is not available*)
- Food (i.e., groceries or food vouchers)
- Transportation (Taxi vouchers, Uber Health, Lyft Health, bus passes)
- Prescription medication assistance (i.e., short term or one-time assistance for any medication and associated dispensing fee as a result or component of a primary medical visit, and not to exceed a 30-day supply)
- Other RWHAP allowable costs needed to improve health outcomes
- Vision Care to pay the cost of corrective prescription eye wear for eligible clients

AGENCIES FUNDED FOR EFA MUST BE ABLE TO MAKE AN EXPLICIT CONNECTION BETWEEN ANY SERVICE SUPPORTED WITH EFA FUNDS AND THE INTENDED CLIENT'S HIV CARE AND TREATMENT, OR CARE-GIVING RELATIONSHIP TO A PERSON LIVING WITH HIV.

Unallowable EFA Expenses:

- Mortgage payments and security deposits for rental housing
- Direct cash payments to clients
- Clothing
- Court fees
- Maintenance expense (tires, repairs, etc.) of a privately-owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees, towing or

impound fees, excise tax. This restriction does not apply to vehicle operated by organizations for program purposes.

- Local or state personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and burial expenses

Objective: Agencies funded for EFA will assess client's emergency needs related to food security, housing, utilities, transportation and cost of medication, as well as provide appropriate assistance.

Standard	**Measure**
11.1 Emergency Financial Assistance Assessment An assessment of the presenting emergency must be completed by the provider. Providers must demonstrate an urgent need resulting in client's inability to pay their utility bills or prescriptions without financial assistance for essential items or services necessary to improve health outcomes. For example, demonstrated need may be demonstrated by, but not limited to the following: • A significant increase in bills that prevents a client from addressing both basic needs to maintain positive health outcomes and the increased cost of bill(s) • A recent decrease in income • Unexpected event that hinders ability to meet housing, utility, food or medication need • High unexpected expenses on essential items • Client is unable to provide for basic needs and shelter • A failure to provide EFA will result in danger to the physical health of client or dependent children • Other emergency needs as deemed appropriate by the provider	Record of assessment of need evident in the client file
11.2 Tracking EFA The provider must track dispersal of EFA. This includes creating a tracking system that clearly indicates the date of distribution, client code and purpose and link to HIV care outcome of EFA provided.	Development of a tracking mechanism and a record of EFA provision within 3 business days of approval of request
11.3 EFA Voucher All payments made on behalf of clients or vouchers distributed, of any kind, to clients, is/are consider an EFA Voucher. EFA Vouchers ***cannot be provided in the form of direct cash payment*** to a client. The use of store cards/gift cards with the Mastercard/Visa/American Express logo are ***considered cash payments and cannot be distributed*** to the client. Payments must be made to another agency or vendor.	Program/agency fiscal records

11.4 Payer Anonymity Payment for assistance made to service providers will protect client confidentiality by ensuring the source of payment cannot be identified as a HIV service provider. Use of checks, envelopes, credit cards, or other forms of payment that de-identify agency as an HIV/AIDS provider.	Program/agency fiscal records
11.5 Processing EFA All completed requests for assistance shall be approved or denied within three (3) business days.	Record of EFA voucher distributed within three (3) business days of application
11.6 Drugs/Medication Drugs distributed under EFA must be included in the State formulary.	Record of the type of medication purchased, the cost of the medication, and evidence that the medication is/are on the approved formulary
11.7 Third-Party Payer & Benefits Applications The provider must take steps to enroll the client into HDAP, MassHealth, housing supports, SNAP, or other third party to continue support for the client.	Record of third-party payer applications/screenings maintained in the client files
11.8 Multiple Funding Sources & Payor of Last Resort All other sources of funds for Housing, Food Bank/Home Delivered meals or other funding sources that can address the urgent needs of the client, must be exhausted prior to the use of EFA. Prior approval can be made for special circumstances.	Program/agency fiscal records Documentation of referrals to other resources as relevant
11.9 EFA Limitation & Agency Controls The delivery of EFA must be a one-time or short-term financial support. The provider must have approved policies for the distribution of EFA and only distribute EFA in accordance with the defined terms within the scope of services. The policy must detail fiscal and programmatic controls and define the limitations of each type of EFA awarded to provide. Policies must include: • EFA Duration & Frequency • Limitation of Unit Distribution **NOTE:** RWS recommends agencies awarded with EFA to narrow the definition of emergency for each type of EFA service.	Written policy, approved by RWS, on file

12.0 Food Bank/Home Delivered Meals

HRSA Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:

- Unallowable costs include household appliances, pet foods, and other non-essential products.
- See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Prevent hunger and malnutrition among people living with HIV.

Objective: Improve access to food sources and to improve nutrition for people living with HIV with identified food security needs.

Standard	Measure
12.1 Documenting Service Delivery The agency must document the provision of food items, hot meals, food vouchers and/or allowable non-food items. Documentation must include: • Service provided • Amount of food, vouchers, and/or non-food items distributed • Number of clients served • Date of services	Record of service delivery in the client file
12.2 Food Safety The agency must meet all requirements of the local and state health department for food handling and storage.	Record of certifications and licenses on file
12.3 Agency Drivers All drivers delivering meals must hold a valid driver's license and automobile insurance consistent with state minimum requirements.	Personnel files of paid and volunteer drivers contain documents indicating valid driver's licenses

13.0 Housing

HRSA Description:

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, and fees associated with these activities.

Program Guidance:

- HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.
- HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.
- Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards. RWHAP funding may be used to pay for a client's security deposit if the subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not to the RHWAP client.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Assist a client to gain or maintain medical care by reducing the barriers to permanent shelter and provide linkages to permanent housing.

Objective: Eligible clients will receive assistance in the form of individual sessions with a housing search advocate, or in the form of financial assistance, within the parameters listed below.

Standard	Measure
13.1 Rental Assistance Services Agencies funded to provide rental assistance services must have policies that define: • Use of funds • Maximum/minimum financial assistance a client can have per fiscal year • Reapplication periods • Appeals process The agency must collect documents that validate the housing conditions of the client.	Written policy on file at agency location Lease Agreement/Rental Agreement on file

13.2 Payment Policies The agency must have detailed payment policies and procedures. These policies must include, at minimum: • Rental Assistance Application Approval Process • Payment Timelines • Payment Tracking and Payment Return to the subrecipient if money is used for a security deposit. **NOTE:** Ryan White ***cannot pay more*** than the Fair Market Rent as set by the U.S. Department of Housing & Urban Development (HUD). Fair Market Rent amounts are available at: https://www.huduser.gov/portal/datasets/fmr.html Additionally, payments cannot be made for mortgage payments and/or directly to clients.	Written policy on file at agency location
13.3 Program Application (Rental Assistance) The agency must implement an application for clients to formally request rental assistance. The provider must support all clients in the completion of the application. The program application, at minimum, must include the following: • Date of the Request Reason for the Request	Record of completed application in client file
13.4 Rejected Applications (Rental Assistance) If an application has been rejected, the client must be informed of the rejection within 24 hours of the decision.	Record of contact (or attempts to contact) in client file
13.5 Payor of Last Resort (Rental Assistance) Alternative rental assistance must be used prior to the use housing rental assistance. Reasonable efforts to explore and apply for alternative rental assistance programs must be performed. **NOTE:** If the clients housing stability will be affected by pending housing application, the use of housing funds to ensure a client is not evicted will be appropriate use of funds.	Record of application and rejection from alternative rental assistance programs
13.6 Housing Search & Advocacy Services Agencies funded to provide Housing Search & Advocacy services must have tools in place to track placement of clients and provide referral to services that will lead to permanent housing.	Record of Supported Referral and Client Housing Placement on File
13.7 Housing Assessment The agency must assess the housing needs of the clients. The assessment must include, but not limited to: • Resources • Projected Barriers • Strength/Weakness The housing needs assessment must include a detailed client budget that is completed with the provider.	Record of assessment in clients file Record of client's budget on file

13.8 Individual Housing Plan Informed by the client's needs assessment, an individual housing plan must detail tenancy goals. If a client receives rental assistance, a client must agree to maintaining communication with housing provider for up to 6 months after rental assistance has been provided.	Record of Individual Housing Plan on file

14.0 Medical Transportation

HRSA Description:

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

Program Guidance:

Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Volunteer drivers (with insurance and other liability issues specifically addressed)

Voucher or token systems Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Maintain clients connected to core medical and support services that contribute to positive health outcomes.

Objective: Provide allowable transportation resources to eligible clients who otherwise could not access the core and support services to meet medical and support needs.

Standard	Measure
14.1 Approved Transportation Methods The use of transportation funds can include; • Volunteer driver system • Purchase/Lease of a Vehicle (Prior Approval required) • Voucher System (for taxi or public transportation etc.) • Rideshare • Uber Health • Lyft Health • Mileage Reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)	Record of method of transportation in client's file Contract with transportation services Tracking mechanism for the distribution of vouchers (i.e. GATRA Pass or Charlie Cards) Receipts of Rideshare Utilization (i.e. Circulation, Uber, Lyft) Written policies and procedures for a volunteer driver system

Standard	Measure
14.2 Agency Vehicle All vehicles must be registered and properly insured.	Record of Registration and Insurance
14.3 Agency Drivers All drivers transporting clients must hold a valid driver's license and automobile insurance consistent with state minimum requirements. All drivers must be aware of their responsibility in the event of an accident.	Personnel files of paid and volunteer drivers contain documents indicating valid driver's licenses Written Accident policy on file
14.4 Mobility Accommodations and Ride Accessibility All clients must be accommodated under the medical transportation funds. The agency must seek alternative methods for transporting clients who cannot be accommodated with the agency's primary transportation service delivery method.	Record of service delivery in the client file
14.5 Documenting Service Delivery The agency must document transportation of all approved methods. Documentation must include: • Method • Destination/origin • Type of Appointment (Reason) • Date of Service(s) • Units of Service (One Way/Two Way) • Cost A log system must be developed to track transportation services on a monthly basis. **NOTE:** For Volunteer Systems/Agency Vehicle, documentation must include: • Drivers Name • Mileage For Taxi, Public Transportation & Rideshare Services: • Receipts	Record of service delivery in the client file Completed tracking log for transportation services maintained at agency location Receipts and vouchers maintained at the agency
14.6 Payor of Last Resort Alternative transportation methods (i.e. Medicaid) must be used prior to the use of Medical Transportation funds.	Record of application in client file

15.0 Non-Medical Case Management

HRSA Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance with accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes a variety of types encounters including (but not limited to) face-to- face, telehealth, phone contact, etc. Key activities include:

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

Program Guidance:

- NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Enhance access to and retention in essential medical and social support service for people living with HIV. This is a human service approach that supports engagement and retention into medical care.

Objective: Assess client needs and develop an Individual Service Plan (ISP) that provides guidance and assistance in improving access to needed services.

Standard	Measure
15.1 Non-Medical Case Management Needs Assessment The assessment must be administered within 30 days of intake and include a wide range of topics to identify the client needs to access medical and support services. The following topics, at minimum, must be assessed: • Healthcare • Mental Health • Transportation • Health Education & Risk Reduction • Legal • Support systems • Nutrition • Housing • Insurance • Vocational	Record of needs assessment in client file completed 30 days after the completion of the intake

15.2 Non-Medical Case Management Reassessment of Needs A reassessment of needs must be completed every six months from the previous completed assessment. The reassessment can be adapted to reflect a more narrow focus than the initial assessment based on the clients ongoing needs.	Record of reassessment completed six months after the previous assessment in the client file
15.3 Assistance with Benefits Non-medical case managers may assess status of benefits (HDAP, MassHealth, SNAP, WIC, Section 8, PT-1 etc.…) and assist clients in the maintenance of benefits.	Completed benefit applications within client file
15.4 Individual Service Plan Non-Medical Case Management staff must develop an Individual Service Plan (ISP) with a client-centered approach, using SMART goals, that is informed by the client needs assessment. The ISP must be updated at minimum every six months and as needed to respond to changes in client needs.	An Individual Service Plan (ISP) completed within six months, or less, from the initial or previous comprehensive service plan within client file
15.5 Client Monitoring The provider must continuously monitor the efficacy of the individual service plan. This includes the ongoing assessment of key family member needs and the client's personal support system. If circumstances of the client changes, the Individual Service Plan must be adapted to meet changing needs.	Record of regular contact with client within client file
15.6 Caseload Case load determination should be based on client characteristics and the intensity of case management activities.	Written policy on file at agency regarding staffing ratios

16.0 Other Professional Services (Legal)

HRSA Description: Other Professional Services (OPS) allows for the provision of professional and consultant services rendered by members of professions licensed and/or qualified to offer such services by local governing authorities.

Under OPS, legal services may be provided to, and/or on behalf of, the HRSA RWHAP-eligible people living with HIV, involving legal matters related to or arising from their HIV disease, including

- Assistance with public benefits
    - Unemployment compensation
    - Social Security Disability Insurance (SSDI)
    - Supplemental Nutrition Assistant Program (SNAP)
    - Supplemental Security Income (SSI)
    - Medicare & Medicaid

- 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:
    - Durable Power of Attorney for Healthcare
    - Living will
    - General/Financial Power of Attorney
    - Last Will & Testament or Trust
    - 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:
        - Drafting of wills or delegating powers of attorney
        - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption

- Legal Consultation Services (*not representation*) may also be available in these areas:
        - Debt collection and judgment process
        - Bankruptcy
        - Garnishment

Providers must be able to make an explicit connection between the legal service and the intended client's HIV care and treatment. They must be able demonstrate that the service is necessary to improve the client's health outcomes.

Program Guidance: Legal services exclude criminal defense, OUI, immigration, and class action lawsuits. A class action lawsuit may be considered if related to access to services eligible for funding under the RWHAP.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Provide clients with access to legal services necessary to improve client health outcomes.

Objective: Reduce the effects of HIV discrimination; assist with access to and maintenance of medical care; remove barriers to accessing care, treatment, and services.

Standard	Measure
16.1 Professional Services Staff Qualifications All legal counsel services must be performed by trained professional staff. Attorneys must be current members of the Massachusetts Bar by the Board of Bar Overseers or other similar body in the relevant state. Licensed volunteer attorneys, law students, law school graduates and other legal professionals (acting under the supervision of a member of the bar) may be used to expand program capacity. Paralegal Staff must be supervised by a member of the bar. Paralegal staff or other employees must be qualified to hold the position in which they are employed. Non-licensed staff must be supervised by a licensed attorney.	Certifications and Licenses of all staff funded through Ryan White Part A on file at the agency
16.2 Service Documentation and Legal Assessment The provider must have a written policy that identifies allowable and unallowable legal services funded by Ryan White Part A. Any provider that sub-contracts for Ryan White Part A legal services must ensure the contract includes assurances from the agency providing legal services that it will not bill the provider for legal services that are unallowable under Ryan White Part A legal services. Client file must include a documentation of the need for legal services to support HIV care, treatment and health outcomes. Service agreements will be developed and signed by both the attorney and the client. Documentation for legal services provided must include attorney name, client name, duration of service, rate, type of service provided, (for example, legal consultation, in-person representation of client, developing written legal documents, phone call etc.). The legal matter addressed does not need to be included in this documentation.	Written policy and contracts (if applicable) with assurances regarding billing for services that are unallowable through Ryan White Part A funds on file for RWS staff review Documentation of the need for legal services to support HIV care, treatment and health outcomes included in client file Services agreements, signed by both the attorney and client, in client file Written documentation including the required information about the legal service provided in the client file
16.3 Written Criteria for Services The provider must have an established fee structure, intake process, and case closure policies. Clients must be informed of these criteria before receiving services and related documentation must be included in the client's chart.	Written policies for intake process and case closure procedures on file at the agency Fee schedule readily available An acknowledgement signed by the client that they have been advised/informed of fee schedule, intake process, and case closure process prior to receiving services

16.4 Caseloads & Waiting List Staff must have reasonable caseloads and cases must be accepted on priority basis. If the provider uses a wait list, they must have a policy in place that ensures that the wait list is appropriately managed and updated; and that they communicate the client's place on the wait list regularly.	Written policies and procedures for caseload management and case closures on file at the agency

17.0 Psychosocial Support

HRSA Description:

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible people living with HIV to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:

- Funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home Delivered Meals) or client incentives.
- HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.
- HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.
- Psychosocial Support staff are not required to be people living with HIV.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Psychosocial support services will decrease isolation for people living with HIV and support the wellbeing of people living with HIV.

Objective: Through one-on-one interactions and in small groups, psychosocial support promotes clients' engagement in health care and emotional support in a respectful setting. Subrecipients of psychosocial support assist in the development of coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, to help improve quality of life for participants.

Standard	Measure
17.1 Psychosocial Assessment The agency must assess the psychosocial support needs of the client. The assessment can include the following topics: • Alcohol and drug use • Violence risk • Family • Social support • Occupational history • Education • Legal history • Financial • Development history • Spiritual • Cultural • Coping skills	

• Nutrition • Interests and abilities • Mental Health	
17.2 Psychosocial Support Counseling One-on-one and group counseling can include a wide range of topics, including, but not limited to: • Child abuse and neglect • Bereavement counseling • Pastoral *(must be available to clients from all faiths/religions)* • Domestic violence • Newly positive • Nutritional education *(must be performed by a non-registered dietician)* ***RWS does not require Psychosocial Support staff to be people living with HIV.***	Record of counseling and topics evident in the client file or group notes
17.3 Psychosocial Groups Group sessions are defined as three or more participants (not including the facilitator). Additionally, all support groups must have a topic and attendance must be documented. ***RWS does not require Psychosocial Support group facilitators to be people living with HIV.***	Records of group sessions must include of name of the facilitator, dates, topics, duration and attendance by client code and be available in agency files.