

AIDS INSTITUTE

Ryan White Part B HIV/AIDS

Behavioral Health Education Initiative

Guidelines

NEW YORK STATE DEPARTMENT OF HEALTH
AIDS INSTITUTE
DIVISION OF HIV AND HEPATITIS HEALTH CARE
BUREAU OF COMMUNITY SUPPORT SERVICES
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I. PURPOSE, BACKGROUND AND INTENT

The Ryan White Part B HIV/AIDS Behavioral Health Education Initiative Guidelines describe the New York State Department of Health AIDS Institute’s (NYSDOH AI) expectations and recommendations for awarded contractors who provide behavioral health education for persons living with HIV/AIDS (PLWH/A) under the Ryan White Part B HIV/AIDS Behavioral Health Education Initiative (RFA#13-0003).

The NYSDOH AI is committed to improve and maintain the mental, emotional, and behavioral health of PLWH/A in New York State. The Ryan White Part B HIV/AIDS Behavioral Health Education Initiative supports the NYSDOH AI’s priorities of increasing linkage to and retention in care and treatment as a mechanism to achieving viral suppression among PLWH/A. Funded services through this initiative strengthen the comprehensive continuum of HIV prevention, health care, and supportive services in New York State. This is accomplished by educating clients about the benefits of engaging in mental health and substance abuse treatment, helping to address stigma or related anxiety that may impact a client’s willingness to engage in, adhere to, and be retained in their HIV medical and behavioral health care and treatment.

President Obama released the first comprehensive National HIV/AIDS Strategy in July 2010¹. The HIV Care Continuum Initiative², released July 2013, continues the blueprint set forth by the National HIV/AIDS Strategy by calling for coordinated action in response to recent data showing only a quarter of people living with HIV in the United States have achieved the treatment goal of controlling the HIV virus. The National HIV/AIDS Strategy and the HIV Care Continuum Initiative acknowledge significant gaps along the entire HIV care continuum – from being diagnosed to suppressing the virus – including how behavioral health issues can directly impact on PLWH/A’s ability to engage in HIV treatment.

HIV/AIDS continues to pose a threat of unprecedented magnitude to gay men in the United States, especially for gay men of color.³ Despite available services, gay men and men who have sex with men (MSM) continue to be disproportionately affected by HIV/AIDS. As of December 2011, New York State surveillance data suggests that persons with MSM or injection drug using MSM (MSM/IDU) transmission risk make up one third of all living HIV cases, and half of the living male cases. In contrast, cases with MSM or MSM/IDU transmission risk make up half of all new diagnoses and two-thirds of new male diagnoses. This is particularly true for gay men and MSM of color in that the number of new diagnoses within Black, Hispanic and White MSM was roughly equal. Community based prevention and treatment efforts should continue to focus on this population. Improving access to care, retention in care, and treatment adherence among MSM will increase viral suppression and decrease transmission as well.

According to the National Institute of Mental Health (NIMH), nearly a quarter of all adults have some form of mental health disorder, but only a third of those individuals seek treatment, and less than half complete the course of treatment recommended. These numbers may be substantially higher for those living with HIV/AIDS due

¹ The White House. (2010). *National HIV/AIDS Strategy for the United States*. Retrieved from <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>

² The White House. (2013). *Accelerating Improvements in HIV Prevention and Care in the United States through the HIV Care Continuum Initiative*. Retrieved from <http://www.whitehouse.gov/the-press-office/2013/07/15/executive-order-hiv-care-continuum-initiative>

³ The Foundation for AIDS Research (AMFAR). (2012). *Ending the HIV Epidemic among Gay Men in the United States*.

to the presence of multiple factors (i.e. a stigmatizing chronic illness, substance abuse, and other psychosocial stressors).

The National Council for Community Behavioral Healthcare, using data collected from the World Health Organization (WHO), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control (CDC), the National Alliance on Mental Illness (NAMI) and the NIMH, indicate that 49% of Medicaid beneficiaries with disabilities have a mental illness. Up to two-thirds of homeless adults suffer from chronic alcoholism, drug addiction, mental illness or some combination of all three. Of individuals treated in the public system, those with serious mental illness die 25 years sooner than the general population – men at about age 53, and women at age 59. Approximately 90% of people receiving behavioral health treatment recover; however, two-thirds go without treatment because of stigma and inability to access care.⁴

Some persons with HIV/AIDS are diagnosed with mental health or substance use disorders after being diagnosed with HIV, or are dealing with issues of anxiety, depression associated with the challenges and difficulties of being HIV positive, disclosure and stigma. Rüsçh, et.al., (2005) stated, “Persons with mental illness often have to struggle to cope with the symptoms of the disease itself [i.e.] anxiety, or mood swings, [as well as] the misunderstandings of society about mental disorders [resulting] in stigma. Many persons living with mental illness can be significantly improved by various psychiatric and psychosocial treatments. Unfortunately, persons likely to benefit from that kind of treatment either choose to never start treatment or opt to end it prematurely.”⁵

Others may have had a mental illness or substance use issues prior to being diagnosed with HIV. There are numerous factors that affect persons who are diagnosed with HIV and have behavioral health issues. These include: 1) diminished access to and utilization of health and mental health care, 2) reduced adherence to psychotropic medication leading to increased risk of harm to self and others, 3) reduced adherence to antiretroviral therapy, 4) inadequate treatment of other medical conditions, and 5) increase in drug and alcohol use. Swendeman, et.al., (2009) stated, “Similar to other chronic diseases, HIV requires lifetime changes in physical health, psychological functioning, social relations, [and] requires a self-management model in which patients assume an active and informed role in healthcare decision making to change behaviors. It requires developing and supporting a framework that promotes healthy behaviors, adherence to treatment, forming collaborative relationships with healthcare providers, and managing stigma [which] is a significant barrier to HIV service utilization.”⁶ Mental illness can also impact disclosure of HIV status to others and may exacerbate risk behaviors that could lead to increased risk of transmission.

In January 2013, President Obama directed Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services and Secretary Arne Duncan of the U.S. Department of Education to launch a national conversation on mental health to reduce the shame and secrecy associated with mental illness, encourage people to seek help if they are struggling with mental health problems, and encourage individuals whose friends or family are

⁴ National Council for Behavioral Health. (2012). *Mental Health Infographic*. Retrieved from: <http://www.thenationalcouncil.org/expert-buzz/2012/01/mental-health-infographic>

⁵ Rüsçh, N., Angermeyer, M.C., & Corrigan, P.W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry*, 20, 529–539

⁶ Swendeman, D., Ingram, B. L., & Rotheram-Borus, M. (2009). Common elements in self-management of HIV and other chronic illnesses: An integrative framework. *AIDS Care*, 21(10), 1321-1334. doi:10.1080/09540120902803158

struggling to connect them to help. Misperceptions, fears of social consequences, discomfort associated with talking about these issues with others, and discrimination all tend to keep people silent.⁷

Behavioral health education and engagement services are short term mechanisms advocating treatment by “[empowering PLWHA] through education regarding HIV and [behavioral health that] help engage [individuals] into care and support their adherence.” (Mutchler, et.al, 2011)⁸ With many funding options available for behavioral treatment, including provisions through the Affordable Care Act broadening access to health care, a shift in focus to education and treatment engagement is essential. The services funded through this initiative include community based behavioral health education and engagement, and training and technical assistance. These services are intended to strengthen engagement and retention efforts by focusing on the benefits of early and ongoing behavioral health services, including mental health and substance use treatment, that address the various biological, psychological and social factors impacting client willingness and readiness to engage in treatment and care.

Community Based HIV/AIDS Behavioral Health Education and Engagement (BHEE) Service Providers are expected to provide behavioral health screenings, referrals, and psycho-educational interventions to PLWH/A. These short term mechanisms identify clients and promote treatment readiness for linkage to and engagement in behavioral health treatment.

BHEE contractors are expected to make services available to all PLWH/A in their geographic region and not limit services to their clients only. Community based HIV/AIDS behavioral health education and engagement services will serve community needs by allowing access to services for eligible individuals. It is expected that contractors collaborate with other regional providers and develop a system for making all services available through referral networks. They are expected to identify and leverage other community resources that: 1) enhance the provision of service delivery, 2) assist clients to overcome personal or cultural barriers that prevent them from accessing care and treatment, and 3) address issues that may compromise their behavioral and medical health status.

The HIV/AIDS Behavioral Health Education Training & Technical Assistance Center (TTAC) will provide HIV/AIDS focused behavioral health education training and technical assistance services that further advance provider capacity. Services are intended to increase the number of BHEE staff who are educated and motivated to perform behavioral health education, screening, engagement, and linkage services to PLWH/A with behavioral health needs. The TTAC will make these training and technical assistance services available to funded providers statewide through the use of a variety of techniques, including in-person and technology based formats (e.g., webinars).

⁷ Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). *Community Conversations about Mental Health – Information Brief*. Retrieved from <http://store.samhsa.gov/shin/content//SMA13-4763/SMA13-4763.pdf>

⁸ Mutchler, M. G., Wagner, G., Cowgill, B. O., McKay, T., Risley, B., & Bogart, L. M. (2011). Improving HIV/AIDS care through treatment advocacy: Going beyond client education to empowerment by facilitating client-provider relationships. *AIDS Care*, 23(1), 79-90. oi:10.1080/09540121.2010.496847

II. DEFINITIONS: BEHAVIORAL HEALTH EDUCATION AND ENGAGEMENT

The following definitions are meant to provide the framework for the services provided by the **Community Based HIV/AIDS Behavioral Health Education and Engagement Service Providers (BHEE)** and the **HIV/AIDS Behavioral Health Education Training & Technical Assistance Center (TTAC)**:

Behavioral Health - A state of mental or emotional being, or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicidal behavior, and mental and substance use disorders. (SAMHSA, 2012)

Behavioral Health Care – A continuum of services for individuals at risk of, or suffering from, mental, behavioral, or addictive disorders and includes clinical services provided by licensed professionals: social workers, counselors, psychiatrist, psychologists, neurologists, and physicians.

Mental Health and Substance Use – There are many definitions of mental health, mental illness, and substance abuse. Behavioral Health Educators and Peer Navigators are not acting as licensed behavioral health professionals and NOT doing diagnostic assessments for the scope of this initiative. The following definitions can provide the foundation for all education interventions, referrals and linkage and retention efforts:

Mental or emotional issues can be viewed on a spectrum of severity from mild (coping or adjustment problems) to severe (emotional or psychological disturbances). According to the American Psychiatric Association (APA) Diagnostic and Statistical Manual (DSM-5), a mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

Substance-related issues are the problematic use of alcohol or drugs occurring when an individual's use of alcohol or drugs interferes with basic work, family, or personal obligations. With higher severity it can become a clinical diagnosis when an individual using alcohol or illicit drugs meets the criteria set forth in the DSM-5, including a strong desire to use the substance, a higher priority given to use than to other activities and obligations, impaired control over its use, persistent use despite harmful consequences, increased tolerance, and a physical withdrawal reaction when use is discontinued.

Stigma, Resistance and Denial – Often people with behavioral health issues report that they experience **stigma** which is a mark of shame or humiliation that sets a person apart from the mainstream. They can sometimes feel like they are being stereotyped or being treated poorly due to the negative attitudes of society, family, or their social circle. Some have even experienced discrimination. The disgrace, hopelessness, distress, and isolation experienced can lead to a **resistance** to seek or accept necessary professional help. These negative experiences may also contribute to **denial** which is a commonly referred to defense mechanism where an individual is unable to admit or recognize that something is occurring. Denial can temporarily protect individuals from anxiety or pain but requires a substantial investment of emotional and physical energy.

Behavioral Health Education (BHE)- Behavioral Health Education, for this initiative, is short term mechanisms for identifying clients, screening for mental and substance abuse treatment readiness; educating on the effectiveness and benefits of treatment while decreasing misperceptions and stigma; linking and referring to mental health and substance abuse treatment providers; and assisting in retention to behavioral healthcare while promoting overall health and supporting adherence to medical treatment. The ultimate goal of behavioral health education is for a client to self-manage his/her own behavioral health issues and HIV/AIDS related care, while working in partnership with their medical and behavioral healthcare providers. Behavioral health education improves health outcomes through the identification of behavioral health goals and the development of a plan that supports those goals.

III. PROGRAM REQUIREMENTS AND GUIDING PRICIPLES FOR COMMUNITY BASED HIV/AIDS BEHAVIORAL HEALTH EDUCATION AND ENGAGEMENT SERVICES	
1) RYAN WHITE GUIDANCE FOR PART B DIRECT SERVICE CONTRACTORS	
OBJECTIVE	STRATEGY
<p>BHEE contractors will implement programs in compliance with AIDS Institute and Ryan White Part B Requirements regarding payer of last resort, client eligibility and allowable costs.</p>	<p>All BHEE contractors will be review and be in compliance with Appendix 1: Attachment B – Program Specific Clauses – AIDS Institute and Appendix 2: Attachment “B-1” – Ryan White Guidance for Part B Direct Service Subcontractors.</p> <p>Ryan White contractors are expected to provide documented, fundable services to eligible clients and to clearly define the scope and nature of such services in the contract workplan. Ryan White funding may only be used for services that are not reimbursable by Medicaid, ADAP Plus or other third-party payers. This funding cannot support the provision of reimbursable behavioral health services, including diagnostic assessments.</p>
2) COLLABORATION BETWEEN BHEE CONTRACTORS AND THE TTAC	
OBJECTIVE	STRATEGY
<p>BHEE contractors will recognize and support the collaboration between BHEE staff and the Training and Technical Assistance Center (TTAC)</p>	<p>BHEE contractors are required to work closely with the HIV/AIDS Behavioral Health Education Training & Technical Assistance Center (TTAC): 1) during start up for a comprehensive needs assessment for core training and ongoing technical assistance, and 2) during all phases of program implementation and the duration of the funding cycle. Only BHEE contractors funded through this initiative will be targeted for training and technical assistance. All services provided under the program, as well as all training needs, are limited to the provision of behavioral health education services designed to promote client linkage to and engagement in behavioral health treatment.</p> <p>Once established, Behavioral Health Educators and Peer Navigators are required to attend the core trainings provided by the TTAC and ongoing facilitated learning opportunities. Program staff is also required to attend and participate in provider meetings of all Ryan White Part B HIV/AIDS Behavioral Health Education Initiative contractors.</p>

3) PROGRAM OVERSIGHT	
OBJECTIVE	STRATEGY
<p>BHEE contractors will demonstrate that systems and administrative support are in place to support capacity to receive funds and administer them in conformance with the intent of the funding.</p>	<p>BHEE contractors should demonstrate they have resources in place to provide:</p> <ul style="list-style-type: none"> ▪ Fiscal operations; including but not limited to timely submission of budgets, budget modifications, and monthly vouchers; ▪ Appropriate time and effort reporting ▪ Human resources; including best practice hiring standards, discipline processes, staff evaluation processes, and provision of job descriptions; <ul style="list-style-type: none"> ○ Personnel files should contain: <ul style="list-style-type: none"> • Application for employment and/or resume • Job descriptions that include: position title, responsibilities, lines of supervision, education/training, work experience and other qualification for the positions • Evidence that staff on contract meet job qualifications • Signed confidentiality statement • Evaluation signed by supervisor and employee • Timeframes for evaluations are consistent with agency policy • Salary adjustment information • Attestation of receipt of Agency Policy and Procedure Manual • Information systems technology, including usage of updated methods for appointment tracking. • Resource development
<p>BHEE contractors will provide programmatic and administrative support to ensure deliverables are met with the intent of the funding.</p>	<p>BHEE contractors will provide/demonstrate:</p> <ul style="list-style-type: none"> ▪ Strategic Planning and clear involvement of a Board of Directors <ul style="list-style-type: none"> ○ Board of Directors members should receive an orientation, be encouraged to attend Board development trainings, and communicate on a regular basis with program management ▪ Effective usage of client advisory groups ▪ Oversight of the overall operation of the BHEE Initiative; including data and narrative reporting with respect to implementation, client recruitment, success in identifying and linking PLWH/A to behavioral health treatment, significant accomplishments achieved, and barriers encountered and plans to address noted problems; ▪ Supervision of the BHEE program professional staff, and ensure BHEE program goals and objectives are being met; ▪ Required training for BHEE staff; ▪ Development and implementation of the work plan; ▪ Adherence to AIDS Institute BHEE Initiative Guidelines; ▪ Communication and collaboration with AIDS Institute staff and timely and appropriate responses to all requests; ▪ Attendance all AIDS Institute required meetings and trainings; ▪ Proficiency in AI data reporting requirements (AIRS) and assurance that computer systems are adaptable as changes occur.

4) POLICIES AND PROCEDURES	
OBJECTIVE	STRATEGY
BHEE contractors will recognize and support the BHEE program as an integral part of HIV care.	<p>Program policies and procedures should address the following:</p> <ul style="list-style-type: none"> ▪ Client eligibility (see Section VI) which includes screening clients for eligibility to receive services through other programs (e.g., Medicaid, ADAP); ▪ HIV confidentiality and other appropriate training of behavioral health education program staff; ▪ Security and confidentiality of client information; ▪ Documentation of services provided; ▪ Client rights, consent, responsibilities, grievances, noncompliance, and loss to follow-up; ▪ Coordination of behavioral health and other services with other HIV service providers; ▪ Processes to facilitate client retention in, and adherence to HIV medical care and treatment; ▪ Quality management and data reporting; and ▪ Protocols specific to the provision of BHEE services.
5) PROGRAM SAFETY AND ACCESSIBILITY	
OBJECTIVE	STRATEGY
Services should be provided in settings that ensure the well-being and safety of clients and staff. Facilities should be easily accessible by all, clean, comfortable and free of hazards.	<ul style="list-style-type: none"> ▪ Program promotes and practices Universal Precautions. ▪ Program is Americans with Disabilities Act (ADA) compliant for physical accessibility; and services are accessible to target population. ▪ Program will develop and enforce a policy to respond to emergencies and crises.
6) CULTURAL AND LINGUISTIC COMPETENCE	
OBJECTIVE	STRATEGY
The TTAC and BHEE will design programs with an understanding of the differences that derive from language, culture, race-ethnicity, religion, age and developmental characteristics. Programs will recognize that clients may participate in one or more subcultures, including those related to gender, income, region or neighborhood, sexual orientation, substance use, homelessness, the deaf and hard of hearing or other disabled populations.	<ul style="list-style-type: none"> ▪ The TTAC and BHEE contractors will promote training and educational opportunities for program staff that increase cultural and linguistic competence and strengthen their ability to provide quality services to all PLWHA including those of special and underserved populations (e.g., immigrants and migrants, MSM, MSM/IDU of color). ▪ All materials will be in languages spoken or read by clients and in a format that promotes health literacy.

7) HEALTH LITERACY UNIVERSAL PRECAUTIONS GUIDING PRINCIPLE	
OBJECTIVE	STRATEGY
The TTAC and BHEE contractors will ensure that program operations and client level services are sensitive to health literacy universal precautions.	<ul style="list-style-type: none"> ▪ Health literacy impacts all levels of the health care delivery system. Improving health literacy is critical to achieving the objectives set forth in Healthy People 2020 and, more broadly, key to the success of our national health agenda⁹. ▪ Limited health literacy affects people of all ages, races, incomes, and educational levels. Even people who have adequate health literacy may experience difficulty processing and using information when they are sick, frightened, or otherwise impaired. Evidence shows that health information and the complexity of the health care system can overwhelm people regardless of their literacy or health literacy skill level. With this realization has come the recognition that health care professionals have a responsibility to improve patients' understanding of what they have been told and what they need to do to care for themselves. Health care professionals need to assume that <u>all</u> patients are at risk for <u>not</u> understanding information relevant to maintaining or improving their health. As such, a universal precautions approach to health literacy is essential to improve health outcomes, reduce disparities and reduce costs. Health literacy universal precautions is defined as an approach that 1) assumes <u>everyone</u> could use help with health information, 2) considers it the responsibility of the health care system to make sure patients understand, 3) focuses on making health care environments more literacy friendly and training providers to always communicate effectively. For more information on health literacy universal precautions, see the following journal articles. <ol style="list-style-type: none"> 1. "Ten Attributes of Health Literate Health Care Organizations" - full article 2. "A Proposed 'Health Literate Care Model' Would Constitute A Systems Approach To Improving Patients' Engagement In Care" – abstract The full journal article is available on the AIDS Institute website: http://www.health.ny.gov/diseases/aids/health_literacy/index.htm ▪ The AIDS Institute recognizes the importance of health literacy universal precautions to improve quality, reduce costs and to reduce health disparities. Funded providers will integrate health literacy universal precautions into their funded program policies, staff training requirements, care models, and quality improvement activities to ensure patient understanding at all points of contact. Best practice recommendations for health literacy universal precautions include the expansion of these guiding principles agency wide.

⁹ US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). National Action plan to Improve Health Literacy.

8) AIRS DATA REPORTING AND MONTHLY NARRATIVE REPORTS	
OBJECTIVE	STRATEGY
<p>All BHEE services are reported on a monthly basis using the AIDS Institute Reporting System (AIRS).</p> <p>The AIDS Institute requires the maintenance and reporting of unduplicated client level data, including demographics and service histories. Statistical reports on clients served and other data reflecting program operations should be submitted using AIRS.</p>	<ul style="list-style-type: none"> ▪ AIRS data extracts are submitted electronically within 30 days of the end of each month. AIRS data should be checked for completeness and accuracy prior to submission. ▪ Copies of aggregate AIRS reports are submitted with the narrative reports; and annual data is to be submitted in the required AIDS Institute format. ▪ BHEE services are to be recorded in the appropriate mapped areas. ▪ For each service provided, whether individual or group, the encounter should be recorded in AIRS. ▪ All client referrals and referral outcomes are tracked in AIRS. <p>See VI. Service Requirements, 13) AIRS Data Entry for more information</p>
<p>Monthly narrative reports are required to accompany AIRS data and fiscal vouchers.</p>	<ul style="list-style-type: none"> ▪ Monthly reports should be submitted monthly and adhere to the prescribed format. ▪ At a minimum, monthly reports should highlight the progress towards meeting program goals.
9) SUPERVISION, TRAINING, AND NETWORKING	
OBJECTIVE	STRATEGY
<p>Programs will hire qualified staff and ensure that appropriate orientation, supervision and professional development opportunities are available.</p> <p>Programs will collaborate with the NYSDOH AI and the TTAC for ongoing training and networking with other BHEE providers.</p>	<ul style="list-style-type: none"> • New BHEE staff are appropriately oriented to the agency and BHEE Initiative and receive HIV/AIDS confidentiality training upon hire; • Programs will show evidence of administrative support for professional development through supporting time off for educational activities, scheduling of professional education sessions outside of regular office hours; and ensuring availability and access to educational training resources and materials. • BHEE staff participates in all meetings and trainings as required by the NYSDOH AI. • BHEE program staff participates in TTAC events, which may include face-to-face meetings, full day trainings, workgroups, conference calls, web-based meetings, etc. • BHEE program staff will share and elicit best practices from other BHEE providers at networking meetings organized by the NYSDOH AI.
10) EVALUATION AND QUALITY MANAGEMENT	
OBJECTIVE	STRATEGY
<p>Programs should develop and implement evaluation activities in all phases of the program planning and design process as well as a</p>	<p>The program design should include sound evaluation practices and incorporate planned activities that measure and assess goals, objectives, outcomes and processes of the initiative. The evaluation plan and design should be reflected in the proposed program's overall goals and activities, and include how the results of evaluation activities will be utilized for program development, refinement and</p>

<p>quality management (QM) plan for BHEE services that monitors and evaluates program processes, quality of care and outcomes.</p>	<p>continuous improvement. BHEE contractors are expected to work with the TTAC in the development and ongoing usage of evaluation and QM activities. It is expected that clients participate in the ongoing planning, and development of the service model.</p> <p>The QM plan:</p> <ul style="list-style-type: none"> ▪ Defines measurable outcomes; ▪ Uses data to measure progress toward established benchmarks and program objectives; ▪ Guides the continuous quality improvement process; ▪ Is reviewed and updated as needed by the contractor’s quality management team and approved by the Executive Director and BHEE staff; ▪ Includes program objectives, quality management team composition, quality management indicators, and quality improvement methods; and ▪ Involves client satisfaction and feedback
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<p>V. STAFFING QUALIFICATIONS AND RESPONSIBILITIES</p>		
<p>Staff Title</p>	<p>Minimum Qualifications</p>	<p>Responsibilities</p>
<p>1. Behavioral Health Educator</p> <p>This position is required and must be a 1.0 Full Time Equivalent (FTE) position. Splitting the position across multiple funding sources will not be permitted.</p> <p>Additional 1.0 FTE Behavioral Health Educator(s) may be added if the program’s caseload and geographical coverage supports it.</p>	<ul style="list-style-type: none"> ▪ B.A. or B.S. with 2 years of experience working in the field of HIV/AIDS, behavioral health, or other chronic illness; ▪ 1 year of experience providing health education; ▪ Possess an understanding of community level work and the importance of collaborating and coordinating with other organizations; and ▪ Effective communication and documentation skills ▪ Licensed professionals (e.g. LMSW or CAC) can serve in the capacity of a Behavioral Health Educator as long as they are full time in that role and not performing any clinical interventions. 	<p>Funding will support 1.0 Full Time Equivalent (FTE) HIV/AIDS Behavioral Health Educator(s) to perform short-term, non-clinical behavioral health education services. Behavioral Health Educators will:</p> <ul style="list-style-type: none"> ▪ Incorporate best practices regarding confidentiality into all job duties and communications in accordance with Article 27-F, contractor policies and procedures and other applicable regulations; ▪ Conduct targeted outreach to PLWH/A needing behavioral health treatment through structured education and awareness activities; ▪ Conduct behavioral health screenings to identify PLWH/A in need of behavioral health services; ▪ Provide individual behavioral health education sessions (maximum of three) to de-stigmatize behavioral health related issues, increase health literacy on the benefits and purpose of treatment, present options for care, address basic questions about the benefits of psychotropic medications, encourage the importance of wellness as it relates to comprehensive HIV care, and encourage engagement into appropriate treatment; ▪ Incorporate the Transtheoretical Model of Behavioral Change, as applicable, into all aspects of programming. ▪ Provide systems navigation and addresses barriers to behavioral health care by coordinating with care management programs; ▪ Track, coordinate, and communicate behavioral health referral activities with other service providers as

		<p>applicable until clients have successfully attended three behavioral health treatment appointments;</p> <ul style="list-style-type: none"> ▪ Accompany clients to appointments as needed; ▪ Complete necessary documentation and maintain client records that document attendance, participation, progress, accomplishments, and additional needs, referrals and goals; ▪ Participate in behavioral health education program quality improvement activities; ▪ Communicate and collaborate with NYSDOH AI staff and respond timely and appropriately to all requests; ▪ Attend required meetings, trainings, and supervision to stay updated on HIV care, relevant issues in behavioral healthcare and education, and be aware of community options for referrals and linkages.
<p>2. Peer Navigator</p> <p>The peer navigator position is optional and can be a paid full time or part time position.</p>	<ul style="list-style-type: none"> ▪ High School diploma or GED ▪ Familiarity of life issues facing the target population(s) 	<p>The role of the Peer Navigator is to assist the Behavioral Health Educator with short term engagement and education to ensure successful linkage to behavioral health treatment. They can assist with monitoring services until clients are successfully established into behavioral health care. Peer navigation services should be short term and in line with the intent of the Initiative – successful linkage to behavioral health care – measured by the completion of three behavioral health treatment appointments. Peer Navigators will:</p> <ul style="list-style-type: none"> ▪ Incorporate best practices regarding confidentiality into all job duties and communications in accordance with Article 27-F, contractor policies and procedures and other applicable regulations; ▪ Conduct follow up activities including reminder phone calls and appointment accompaniment; ▪ Assist with targeted outreach to PLWH/A needing behavioral health treatment through structured education and awareness activities; ▪ Provide support to persons in need of behavioral health services; ▪ Assist with making referrals to care management and other services as needed; ▪ Document all activities as per program policies and procedures.
<p>Other types of positions may be considered if they directly support the provision of HIV/AIDS Behavioral Health Education. This Initiative is not intended to fund ongoing care coordination services. Linkages are encouraged to other sources for the ongoing provision of behavioral health and medical care coordination.</p>		

VI. SERVICE REQUIREMENTS

1) COLLABORATION BETWEEN BEHAVIORAL HEALTH EDUCATORS AND PEER NAVIGATORS

OBJECTIVE	STRATEGY
BHEE contractors will recognize and support the collaboration between the Behavioral Health Educator and Peer Navigators	Behavioral Health Educators are required to collaborate with Peer Navigators to identify and access available resources, provide PLWH/A referral and linkage to behavioral health treatment, accompany clients to appointments as needed, and are responsible for monitoring services until clients are successfully established into behavioral health care.

2) CLIENT ELIGIBILITY

OBJECTIVE	STRATEGY
BHEE contractors will ensure that all enrolled clients are eligible for services reimbursed through this funding.	<p>To receive BHEE services, the enrolled client must:</p> <ul style="list-style-type: none"> ▪ have documented proof of being infected with HIV/AIDS; ▪ be a NYS resident; ▪ not be engaged in or be resistant to needed behavioral health treatment; ▪ complete an intake and screening for behavioral health issues; ▪ and must meet all income and other recertification requirements as outlined in Appendix 1: Attachment B – Program Specific Clauses – AIDS Institute <p>Most clients already receiving mental health services would not be considered eligible to receive behavioral health education services.</p> <p>BHEE contractors are expected to make services available to all PLWH/A in a geographic region and not limit services to agency clients only.</p>

3) TARGETED OUTREACH

OBJECTIVE	STRATEGY
Targeted outreach may be conducted to identify new clients who may be eligible for enrollment into the BHEE program.	<p>This Initiative supports the full time Behavioral Health Educator to conduct targeted outreach to PLWH/A needing behavioral health treatment through education and awareness activities designed to reduce stigma and discrimination by addressing common fears and misperceptions about seeking behavioral health treatment. Targeted outreach may be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached.</p> <p>For those clients that are not yet enrolled into the BHEE program, a single behavioral health overview education session may be delivered as an introduction to BHEE services.</p> <ul style="list-style-type: none"> ▪ The TTAC will prepare all BHEE staff to deliver this session using an established curriculum developed by the TTAC. These sessions may be held up to four times per year, and may be distributed throughout each BHEE program's region as appropriate. The goal of these sessions is to engage new or resistant clients to enroll in the BHEE program for further education and eventual referral and engagement into needed behavioral health treatment. <p>BHEE programs are required to develop a targeted outreach plan to reach HIV positive at-risk individuals who may benefit from behavioral health education due to misinformation, lack of education, or resistance to mental health or substance</p>

	<p>use treatment.</p> <p>Education sessions for introductory sessions for non-enrolled clients must be documented in the monthly narrative report. After each targeted outreach session, the Behavioral Health Educator should record group attendance and complete a narrative summarizing the session.</p>
4) SCREENING/INTAKE	
OBJECTIVE	STRATEGY
BHEE contractors will ensure that all enrolled clients are properly screened and that intakes are performed.	<p>It is recommended that contractors use the AIRS Intake form to gather all required information at the client intake session. The BHEE Screening Form is recommended as a template for all necessary information required for this initiative. See Appendix 4 for samples of both forms.</p> <p>The purpose of BHEE Screening Form is to gather client information regarding behavioral health history (any previous mental health treatment, current substance use, and any substance use treatment experiences), administer basic screening tools (substance use, depression and anxiety), rate perceived behavioral health stigma and readiness for change prior to education sessions, to identify behavioral health education and engagement needs, and to get informed consent for program participation from the client.</p>
5) ORIENTATION	
OBJECTIVE	STRATEGY
BHEE contractors will provide and document a program orientation for all enrolled clients to the BHEE program.	<p>A face to face client orientation is required for all new clients to introduce them to program services and ensure their understanding of the need for continuous care, and to empower them to access services.</p> <ul style="list-style-type: none"> ▪ Individualized face-to-face orientation is provided to all clients ▪ Orientation includes information on the following: <ul style="list-style-type: none"> ○ Services available ○ Office hours and procedures for after-hours emergency situations ○ Directory of behavioral health education staff and contact numbers ○ Scheduling appointments and reminder system (i.e. text messages, phone calls, etc.) ○ Client responsibilities for receiving program services and the BHEE program's responsibilities for delivering them ○ Patient rights including the grievance process ▪ BHEE staff provides written orientation materials to the client that supports this information and is culturally sensitive and linguistically appropriate.
6) INDIVIDUAL BEHAVIORAL HEALTH EDUCATION	
OBJECTIVE	STRATEGY
BHEE contractors will provide and document individual behavioral health education sessions given to enrolled clients.	The Behavioral Health Educator will provide individual behavioral health education sessions (maximum of three) to de-stigmatize behavioral health related issues and encourage engagement into appropriate treatment. These are short term mechanisms for identifying clients and promoting treatment readiness for linkage to and engagement in behavioral health treatment. Experience with support services has suggested that three interventions is best practice and individuals in need of further services should be referred to a long term program. This funding

	<p>cannot support the provision of mental health and substance abuse counseling.</p> <p>After each individual session, the Behavioral Health Educator should document an individual progress note that summarizes:</p> <ul style="list-style-type: none"> ▪ Topics, goals and objectives of the education session(s) ▪ In what manner education occurred – face to face or telephone ▪ Duration of the education session(s) ▪ The client’s level of participation, progress, accomplishments, further needs and referrals in client’s record ▪ How the education session promoted and supported client access to care, adherence to treatment and improved medical outcomes <p>Individual behavioral health education sessions should occur face-to-face but may take place over the phone if there is HIV confidentiality, transportation, or security concerns.</p>
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7) SINGLE SESSION GROUP BEHAVIORAL HEALTH EDUCATION

OBJECTIVE	STRATEGY
<p>BHEE contractors will provide and document single session group behavioral health education sessions given to enrolled clients.</p>	<p>For clients enrolled in the BHEE program, the Behavioral Health Educator may conduct single session group awareness activities designed to reduce stigma and discrimination by addressing common fears and misperceptions about seeking behavioral health treatment. These events should be pre-planned by the Behavioral Health Educator and should contain the following:</p> <ul style="list-style-type: none"> • Goals and objectives of the education session • Expected number of individuals to be served • Duration of the session • Topic outline • How the education session will be structured to support client access to care, adherence to treatment and improved medical outcomes <p>BHEE staff will be expected to utilize the TTAC for guidance in curricula development designed for single session awareness activities. BHEE providers will also be expected to share “best practices” about these sessions at NYSDOH AI meetings and webinars.</p> <p>After each outreach and single session group education, the Behavioral Health Educator should record group attendance and complete a narrative summarizing the session. Using pre and post- tests or other evaluation mechanisms, the degree to which session goals were met should be determined.</p> <p>Funding may not be used to support ongoing support groups.</p>

8) ENROLLMENT TIME FRAMES AND CASE CLOSURE

OBJECTIVE	STRATEGY
<p>BHEE programs should establish policies and procedures for enrollment time frames and case closure, and</p>	<p>A maximum 6 month enrollment period will be utilized by all BHEE programs. Six months allows time for engagement, education, referral, linkage and follow up activities. If enrollees are not successfully linked to behavioral health treatment after this time period, they should be closed. Clients may be re-enrolled at a later time should their readiness level change.</p>

<p>will ensure that enrolled clients are disenrolled from the BHEE program within the specified time period.</p>	<p>All attempts to contact the client and notifications of case closure should be documented in the client record, including the reason for case closure. Common reasons for case closure include:</p> <ul style="list-style-type: none"> ▪ Client is no longer eligible for or requires services; ▪ Client has successfully been connected to a program that provides comparable services; ▪ Client decides to discontinue the service; ▪ Client relocated out of the service area; ▪ Client is lost to care or does not engage in service; ▪ Client is non-adherent to program requirements; ▪ Client is deceased.
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9) LINKAGES AND COORDINATION	
OBJECTIVE	STRATEGY
<p>BHEE contractors will demonstrate capacity to form and maintain linkages and coordinate care with medical, behavioral health and care management providers.</p>	<p>BHEE programs are required to establish a clear bi-directional process with care coordinators as well as medical and behavioral health providers for the receipt and provision of relevant information on the medical and psychosocial status of enrolled clients. These formal linkages are essential to facilitating referrals and ongoing communication.</p> <p>BHEE programs are required to maintain and expand behavioral health provider contacts throughout their service region to expedite referrals and decrease wait times for enrollees needing to engage in treatment. Information about new linkage agreements and expansion of referral networks should be included in each monthly narrative report. Customized referral libraries in AIRS should be created by each individual program based on the region’s resources.</p>

10) REFERRAL ACTIVITIES	
OBJECTIVE	STRATEGY
<p>BHEE contractors will make appropriate referrals for behavioral health treatment and other services as needed.</p>	<p>In conjunction with successful behavioral health education interventions, BHEE staff should make facilitated referrals for behavioral health treatment that expedite linkages to care and result in minimal delays. Referrals may be made to:</p> <ul style="list-style-type: none"> ▪ Internal or external licensed mental health treatment providers ▪ Article 28 or 31 facilities ▪ Substance use treatment providers and rehabilitation programs <p>Program staff should obtain a completed and client signed Release of Information (see Appendix 3: Authorization for Release of Health Information and Confidential HIV Related Information Form) before any referrals can be made. All referral activities and the outcomes should also be included within the client record. See AIRS data entry (pages 20 and 22) for more info on referrals and referral tracking.</p> <p>BHEE programs may identify other needs during their behavioral health education activities (i.e. housing, medical adherence issues, childcare needs etc.). Considering the multiple factors that contribute to behavioral health issues, along with co-morbidities that affect persons living with HIV/AIDS, a continuum of services is essential to meet the multitude of complex and varied needs that present barriers to positive medical outcomes. Community coordination activities serve to enhance</p>

and promote client adherence with and retention in care and treatment services. Linkages and clearly defined referral agreements with care coordinators are essential to remove barriers to care, treatment, and support services for clients. Client identified needs should be documented and communicated to their care coordinator. In the absence of care coordination services, BHEE staff may make referrals for care coordination to ensure that enrolled clients have access to additional resources that address their needs, promote general health and wellness, and facilitate adherence to and retention in medical care and treatment. In certain circumstances BHEE staff may be invited or be part of care coordination case conferencing meetings with other providers.

11) CRISIS INTERVENTION

OBJECTIVE	STRATEGY
<p>Clients may present with emergencies or severe symptoms that require immediate attention (i.e. severe depression, anxiety attacks, suicidality etc.). BHEE contractors are required to have a crisis intervention plan in place to address these needs.</p>	<p>BHEE contractors should demonstrate:</p> <ul style="list-style-type: none"> ▪ There is a documented procedure for clients to follow if they need after-hours assistance. ▪ This procedure is included in the client orientation process. ▪ There are written policies and procedures for staff to follow in psychiatric or medical emergencies. ▪ Policies and procedures define emergency situations, and the responsibilities of key staff are identified. ▪ There is a procedure in place for training staff to respond to emergencies.

12) DOCUMENTATION

OBJECTIVE	STRATEGY
<p>Records for all clients enrolled in the program must be maintained and made available for review by NYSDOH AI staff.</p>	<p>Client records contain the following:</p> <ul style="list-style-type: none"> ▪ BHEE enrollment date ▪ BHEE Intake and Screening forms (see Appendix 3) which includes: <ul style="list-style-type: none"> ○ AIRS Intake form ○ Ryan White Part B Eligibility for behavioral health education (HIV status, residency, income, insurance status) ○ Other status histories (HIV/AIDS status change, HIV/AIDS Risk Behavior, Housing Status, Household Data) ▪ BHEE Screening form <ul style="list-style-type: none"> ○ Baseline CD4 and VL ○ Screenings for Substance Use, Depression, Anxiety ○ Perceived Behavioral Health Stigma Screen ○ Behavioral Health Readiness Screen (MH & SA) ○ Stage of Change Screen ▪ Referrals to/from service providers ▪ Individual and group health education sessions ▪ Progress notes ▪ Individual behavioral health education and engagement sessions ▪ Follow-up activities to address referrals from behavioral health education and engagement sessions ▪ Disenrollment date and status

	<p>Whether an electronic medical record (EMR) or paper file, the above information needs to be present (including the Behavioral Health Educator’s Intake/Screening form). AIRS encounter forms with progress notes added can be used for documentation.</p> <p>All necessary and appropriate <i>Authorization for Release of Health Information and Confidential HIV Related Information</i> forms need to be completed and signed by the client. http://www.health.ny.gov/diseases/aids/forms/informedconsent.htm</p>	
13) AIRS DATA ENTRY		
BEHAVIORAL HEALTH EDUCATION (304)		
Behavioral Health Educators are expected to use, document and track the following services in AIRS:		
Service #	Service	Description
436	Intake	The Behavioral Health Educator is expected to conduct an intake for each client identified and enrolled into the program. The AIRS intake form will be provided by the AIDS Institute and should be completed within 2 weeks of the initial meeting with the client. The intake should include all required eligibility information (outlined above) as well as the Ryan White status histories. The Behavioral Health Education and Engagement Screening form should also be completed during the intake session. If the client elects to enroll in the program, the steps outlined under “orientation” should be carried out counted as part of the intake. All relevant information should be entered in AIRS from both the AIRS intake form as well as the scores on the BHEE screening form.
1231	Behavioral Health Education - Individual	The Behavioral Health Educator may provide individual behavioral health education sessions (maximum of three) to de-stigmatize behavioral health related issues and encourage engagement into appropriate treatment. These sessions are in addition to the intake and can be provided at any time during the enrollment (up to 180 days).
1230	Behavioral Health Education – Group	The Behavioral Health Educator may provide single session education and awareness activities to enrolled clients designed to increase behavioral health knowledge and reduce stigma and discrimination by addressing common fears and misperceptions about seeking behavioral health treatment.
1105	Coordination with Primary Care Provider	The Behavioral Health Educator is expected to communicate with the enrollee’s primary care provider regarding progress, challenges, and referrals made to behavioral health providers. In many cases the client may be referred to the Behavioral Health Educator by the primary care provider and it is the responsibility of the Educator to keep the provider apprised of relevant activities. The Behavioral Health Educator is required to notify the primary care provider of intake and enrollment and document the mode of notification (i.e. phone call). Relevant updates are expected but communication of outcome at disenrollment is required and should be documented. In person conferencing with primary care provider is recommended but not required.

1234	Coordination with Behavioral Health Provider	Once the enrollee is willing to accept a referral for behavioral health treatment, the Behavioral Health Educator will acquire appropriate consents, make necessary referral(s) and track ongoing coordination with the behavioral health provider with this service category. BHE should have ongoing communication with the behavioral health provider as necessary to discuss concerns or interventions (i.e. transportation issues, emergencies or client crisis). This “service” <u>is not used</u> for verification of attending appointments (708 Referral verification and follow up) although it may be used in conjunction with that service for the same encounter.
1235	Coordination with Care Manager	The Behavioral Health Educator is expected to coordinate with or link client to care manager(s) and communicate updates regarding progress in education activities and to identify any issues that may create a barrier to ongoing care requiring follow up (i.e. chronic transportation issues, housing issues, childcare issues etc.).
705	Referral	The Behavioral Health Educator will be responsible for making referrals to behavioral health providers (which may include mental health treatment providers, substance abuse providers, inpatient rehabs, and detox units). This “referral” service (705) will only be used one time for the initial referral to a behavioral health provider. The referral tracking mechanism within AIRS will be initiated when the referral is agreed upon and made. This service can also be used for other referrals (i.e. care manager, housing, ongoing peer support etc.) although will be used primarily for behavioral health related referrals.
708	Referral Verification and Follow Up	The Behavioral Health Educator will verify that the enrollee attended or didn’t attend the established referral and do appropriate follow-up with the individual. Each follow up activity will be entered as separate encounters. Any barriers to care will be identified, documented and communicated to the appropriate care manager for follow-up. The outcome of the first behavioral health session referral (i.e. counseling apt, psychiatric consultation etc.) which was created/initiated in a prior AIRS encounter will be tracked under this service (#708) for subsequent encounters. When the first session is ‘received’ a subsequent second and third appointment will be made and added in the new encounter with this service identified. The referral service (#705) is NOT used for 2nd and 3rd appointments although they are added into referral tracking as individual appointments. Upon successful completion of the third behavioral health session, the referral status “attended third behavioral health session” should be selected. BHEE contractors are encouraged to use technology to creatively promote appointment adherence (including the use of smart phone apps and text messaging with clients for appointment reminders etc.)
704	Re-engagement efforts	The Behavioral Health Educator will work with the peer navigator in re-engaging enrollees that were lost to follow-up or closed for unsuccessful referrals through phone calls, letters, and actual community outreach.
72	Case Closure /	The Behavioral Health Educator will close the case after the enrollee

	Discharge	has successfully completed three behavioral health appointments, chooses not to continue in the program, or is lost to follow up. Upon closure, the client should be disenrolled in the AIRS program for Behavioral Health Education. Cases should not be open for more than 180 days.
Screenings: Behavioral Health Educators will use an established screening tool to assess stigma, readiness, and stage of change. This tool must be used at intake and case closure. AIRS service categories have been established to capture scores for:		
Service #	Service	Description
1237	Stages of Change Screen	This screen is a rating determined by the Behavioral Health Educator and client based on Prochaska's Transtheoretical Model of Behavior Change Theory which identifies 6 stages of change (Pre-contemplation, Contemplation, Preparation, Action, Maintenance, and Termination). The score of 1-6 based on the stage is entered as a value field. Each enrolled client will have two separate "Stage of Change screen" service entries.
1236	Perceived Behavioral Health Stigma	A quick exercise on the screening form that has the client rate 10 statements associated with stigma on a scale from 1-10. The score should be entered as a value field in this "service". The perceived behavioral health stigma screen will be administered at intake and at disenrollment and entered in AIRS. Each enrolled client will have two separate "perceived behavioral health stigma screen" service entries.
1232	Behavioral Health Readiness Screen – Mental Health	This screen is a simple self rating of how ready the client believes they are for mental health treatment on a scale from 1-10. The score will be entered as a value field. This screen will be administered at intake and at disenrollment and entered in AIRS. Each enrolled client will have two separate "mental health readiness screen" service entries.
1233	Behavioral Health Readiness Screen – Substance Abuse	This screen is a simple self rating of how ready client believes they are for substance use treatment on a scale from 1-10. The score will be entered as a value field. This screen will be administered at intake and at disenrollment and entered in AIRS. Each enrolled client will have two separate "Substance Abuse readiness screen" service entries.
BEHAVIORAL HEALTH PEER EDUCATION (305)		
Peer Navigators are expected to use, document and track the following services in AIRS:		
Service #	Service	Description
1143	Engagement	The Peer Navigator will track all client engagement activities which may include but are not limited to: waiting room activities, street/community outreach (i.e. AIDSWalk, tabling at health fairs/events etc.) if the clients are enrolled in the program.
615	Peer Education one on one	Peer Navigators may provide individual one on one sessions to encourage meeting with the Behavioral Health Educator through appropriate personal disclosure and relating of life experiences to destigmatize behavioral health treatment, and engage into care. Once the client is enrolled these sessions can be tracked in AIRS*
238	Escort	Peer Navigators may provide accompaniment services to enrollees to

		ensure that they have transportation and emotional support getting to their behavioral health sessions (i.e. mental health visit, substance abuse intake, or even detox).
705	Referral	The Behavioral Health Educator will be responsible for making referrals to behavioral health providers (which may include mental health treatment providers, substance abuse providers, inpatient rehabs, and detox units). This “referral” service (705) will only be used one time for the initial referral to a behavioral health provider. The referral tracking mechanism within AIRS will be initiated when the referral is agreed upon and made. This service can also be used for other referrals (i.e. care manager, housing, ongoing peer support etc.) although will be used primarily for behavioral health related referrals.
708	Referral Verification and Follow Up	The Behavioral Health Educator will verify that the enrollee attended or didn't attend the established referral and do appropriate follow-up with the individual. Each follow up activity will be entered as separate encounters. Any barriers to care will be identified, documented and communicated to the appropriate care manager for follow-up. The outcome of the first behavioral health session referral (i.e. counseling apt, psychiatric consultation etc.) which was created/initiated in a prior AIRS encounter will be tracked under this service (#708) for subsequent encounters. When the first session is 'received' a subsequent second and third appointment will be made and added in the new encounter with this service identified. The referral service (#705) is NOT used for 2nd and 3rd appointments although they are added into referral tracking as individual appointments. Upon successful completion of the third behavioral health session, the referral status “attended third behavioral health session” should be selected. BHEE contractors are encouraged to use technology to creatively promote appointment adherence (including the use of smart phone apps and text messaging with clients for appointment reminders etc.)
704	Re-engagement Efforts	Peer Navigators will work with the Behavioral Health Educator to re-engage enrollees that were lost to follow-up or closed for unsuccessful referrals through phone calls, letters, and actual community outreach.

VII. HIV/AIDS BEHAVIORAL HEALTH EDUCATION TRAINING & TECHNICAL ASSISTANCE CENTER GUIDELINES

1. SCOPE OF SERVICE

- A. Cicatelli Associates Inc. (“Contractor”) is funded by the New York State Department of Health AIDS Institute (NYSDOH AI) Bureau of Community Support Services (BCSS) to function as the HIV/AIDS Behavioral Health Education Training and Technical Assistance Center (TTAC).
- B. The TTAC will provide training and technical assistance to the community based HIV/AIDS behavioral health education and engagement (BHEE) services staff funded under the Ryan White Part B HIV/AIDS Behavioral Health Initiative.
- C. The Contractor will keep abreast of the latest developments in professional literature and all policy and program issues related to promoting client linkage to, engagement, and retention in behavioral health treatment. Such activities shall be documented in the monthly report and communicated to the NYSDOH AI.

2. PROVIDER NEEDS ASSESSMENT

- A. The Contractor must ensure the training and technical assistance provided to BHEE Contractors best suits the behavioral health education needs of these providers.
- B. The Contractor will be proactive in determining the need for training and technical assistance services by developing (in conjunction with the AI) and completing a standardized survey with each BHEE provider to assess basic competencies.
- C. The Contractor will develop their core curriculum and tailor their training and technical assistance plan for BHEE contractors based on the needs assessment that outlines specific areas of need.
- D. The Contractor will complete needs assessments with BHEE contractors via telephone or E-technology based meetings with optional participation by the BHEE Initiative Director, and contract managers.
- E. Needs assessments will be conducted by a qualified staff member (see staffing section) and completed with each BHEE Program.
- F. The Contractor will complete the development of an initial needs assessment with each BHEE contractor prior to the completion of the 1st quarter in the initial contract year. Needs assessments will be facilitated by the Contractor on a biennial basis following the initial assessment, but more frequently if deemed appropriate by any of the parties involved.
- G. Completed needs assessments will be sent to the NYSDOH AI contract manager for review and feedback upon completion.

3. TRAINING CURRICULA, MATERIALS AND EVALUATION TOOLS

- A. The Contractor is responsible for developing core curricula and secondary curricula (as negotiated during work plan development and budget negotiations) on topics that will improve the competencies of BHEE contractors under this initiative to provide behavioral health screenings, referrals, and psycho-educational interventions to PLWH/A. The curricula should explore mechanisms that are short in duration for identifying clients and promoting treatment readiness for linkage and engagement in behavioral health treatment. The Contractor will meet with the designated NYSDOH AI contract manager and key management staff to negotiate a specific curriculum development plan that outlines specific topics to be addressed and a timeline for curriculum development.
- B. The curriculum development process will include multiple levels of review and approval by AIDS Institute staff (Contract Manager and Initiative Director). Review and approval will take place at the following specific steps in the development process: 1) development of training goals and objectives, length of training, intended audience and timeline for curriculum development, 2) development of a training outline that defines the content and flow of specific training modules to be included in the curriculum, 3) development of training modules with all training content, 4) development of a complete trainer manual with training content as well as directions to lead trainers through all training lectures and activities, 5) development of a participant manual, 6) development of PowerPoint slides and 7) development of a handout packet including relevant references. The contractor will develop a template to track each stage of the curriculum development process. All curriculum development materials will be provided to the AIDS Institute in an electronic format.
- C. Curriculum topics developed may include, but are not limited to, evidence-based techniques such as Motivational Interviewing, Prochaska & DiClemente's Transtheoretical Model, self-management practices, client engagement and retention in behavioral health care, and conducting behavioral health screenings. Topics should address the behavioral health education needs of special and underserved populations; and must demonstrate cultural, linguistic, and health literacy competency. Trainings should address barriers to engagement in mental health and substance abuse treatment, including stigma and social deterrents of health, and provide solutions to these issues. Please see the service requirements within the guidelines for BHEE contractors for additional topic ideas.
- D. After the core curricula are developed and core trainings are delivered to new staff, the Contractor will develop and TOT (Training of Trainer) a workshop to be facilitated by each BHEE contractor entitled "Intro to Behavioral Health". The workshop should be designed to address common fears and misperceptions consumers have about seeking behavioral health treatment as well as provide an overview of behavior health in New York State. The workshop should be designed in a format that is easily tailored by BHEE contractors whom serve diverse communities across the state. The TOT should be conducted in-person and must include an opportunity for BHEE contractors to participate in "teach backs" and receive constructive feedback from the Contractor.
- E. The Contractor is responsible for the printing of all trainer and participant manuals. In addition, the Contractor is responsible for duplicating other training materials including handouts and training folders (for those trainings that do not have formal participant manuals).

- F. Contractor is responsible for all costs incurred to print and ship training materials to statewide training sites, staff travel, room rental and any other costs associated with the training.
- G. Contractor is expected to supplement training materials by ordering materials (brochures, fact sheets, videos, posters, etc.) from the NYSDOH consumer and provider materials order forms.
- H. Contractor is responsible for developing and having approved by the AIDS Institute course evaluation forms (pre/post-training questionnaires) and training related exercises. Contractor is responsible for copying these materials and distributing them to participants at the time of the training program.
- I. All additional activities or materials proposed for use or distribution by the Contractor must be submitted to the contract manager at least four weeks prior to distribution to training program participants. The AI will make the final determination on the acceptability and appropriateness of materials and respond to the Contractor in a timely fashion. Materials must be regularly reviewed and updated to reflect curriculum changes and emerging trends. It is the responsibility of the Contractor to ensure that the AI has current copies of Trainer and Participant Manuals, marketing materials and evaluation tools.
- J. Additional materials, as designated by the AIDS Institute, may be made available to the Contractor for distribution at training programs. The AIDS Institute will provide technical assistance and information updates to the Contractor as needed. The Contractor will incorporate into curricula or distribute to attendees public health messages, as directed by AIDS Institute staff.
- K. Contractor must have the ability to utilize email, including sending and receiving electronic attachments. Contractor must have the ability to utilize Microsoft Word, PowerPoint, Access and Excel.
- L. The Contractor will provide the NYSDOH AI with participant and training related data and monthly narrative reports on training programs in a format approved by NYSDOH AI.
- M. The contractor should ensure that all Technology Based Learning strategies demonstrate the attainment of a measurable competency in a given skill area. E- Technologies should accommodate multiple learning styles and should be highly interactive. They should be accessible, self-paced when appropriate, and matched to the learning needs of BHEE contractors. The Contractor should ensure that information is disseminated in a timely and up-to-date fashion via E-mediums, which are then archived.

4. TECHNICAL ASSISTANCE

- A. The Contractor may be asked to offer technical assistance services using a cost effective mix of traditional in-person methods and technology-based learning modalities such as webinars, webcasting to ensure services are convenient and accessible.
- B. For the purpose of this Initiative, the definition of technical assistance is a relationship in which an expert with specific technical/content knowledge provides information to address an identified need.

- C. The Contractor will ensure that technical assistance goals are designed to utilize recognized best practices.
- D. Technical assistance delivery is short in duration (2 or fewer contacts, with more than one person from an organization) and should be customized to meet the needs of the BHEE contractors collectively or individually, and offers prescriptive solutions to a specific issue. BHEE contractors may consult with the Contractor at any time during the year for additional technical assistance services.
- E. The Contractor will use the following skills and competencies to ensure a successful technical assistance relationship with providers. The Contractor will:
 - 1. Demonstrate expertise in applying research based knowledge and content, best practices, resources, and current technology to address the needs of BHEE contractors.
 - 2. Use observation strategies and appropriate tools to objectively assess BHEE contractors to determine capacity and to determine prescriptive changes needed.
 - 3. Analyze information from observations to guide the development of program improvement goals with measurable outcomes.
 - 4. Demonstrate flexibility and a positive attitude in delivering assistance to meet the challenges and changing needs of BHEE contractors.
 - 5. Provide a process for ongoing planning and discussion.
 - 6. Support goals that require different levels of intensity and timelines through understanding and planning for specific goals.
 - 7. Provide support and guidance to BHEE contractors in developing a network of peers working to address similar issues.
 - 8. Provide well documented assessments and reports.
 - 9. Provide timely services and follow-up that address specific needs of BHEE contractors.
 - 10. Embrace the use of a variety of approaches, techniques, strategies, resources, and innovative thinking to find solutions to challenges.

5. TRAINING DAYS AND COURSES

- A. The Contractor will offer training services using a cost effective mix of traditional in-person training methods and Technology-Based learning modalities. Emphasis will be placed on maintaining a flexible approach that can adapt to rapid changes in teaching content and well as advances in technology.
- B. In person trainings will include statewide trainings, regional training sessions, or workshops held in a central location within the region.
- C. Trainings and live webinars will be determined in collaboration with the AI. The Contractor will work with the AI to assure that trainings/ webinars are accessible to BHEE contractors throughout New York State.

6. MARKETING, AND RESOURCE AWARENESS AND ACCESS

- A. The Contractor will determine specific trainings for Behavioral Health Education and Engagement Services contractors and locations to be provided throughout New York State in consultation with the AI.
- B. Contractor must develop (or modify previous page) and maintain a web page which, at minimum, has the following:
 - 1. A link for BHEE Contractors to the current calendar of trainings that the Contractor is offering;
 - 2. The calendar of trainings web page must list the names, dates, times, locations and course descriptions of all trainings;
 - 3. BHEE Contractors viewing the webpage must be able to register on-line for trainings in a manner that is agreed upon by the Contractor and the AIDS Institute;
 - 4. The calendar of trainings web page must be updated at least biannually so that current trainings (i.e., October - March trainings or April - September trainings) are listed; and
 - 5. A contact name, number and e-mail must be listed so that BHEE Contractors with questions about trainings or the registration process can contact someone within the Contractor organization.
 - 6. An online reference library for use by BHEE Contractors that contains links to pertinent resources, materials and archived webinars on topics to be determined in collaboration with the AI contract manager.

7. REGISTRATION, SCHEDULING AND TRAINING LOGISTICS

- A. Contractor is responsible for all enrollment activities. The Contractor will notify the contract manager of the list of enrolled BHEE staff for each training and education session.
- B. The participant registration process must assess if BHEE Contractors have staff with any needs that would require the Contractor to provide special accommodations (i.e., large print materials, sign language interpreter, and assistive hearing devices). Contractor is required by law to provide accommodations when needed. Contract must reserve sufficient money to ensure compliance with the law, as needed. The Contractor must be cognizant of their responsibilities as outlined in the American with Disabilities Act and be prepared to comply fully with the law.
- C. The Contractor is responsible for securing training sites for all trainings and a user- friendly webinar software package for all webinars. All sites (including bathrooms) must be accessible to people in wheelchairs. Site information must be available to the AI staff upon request. All training spaces must be able to accommodate a minimum of 30 people.
- D. The Contractor is expected to create a training environment reflective of the diverse population of providers being trained and the communities they serve. To accomplish this, the Contractor is expected to display posters and other images showing diversity with regards to race, ethnicity, age and people with disabilities. Training centers are also expected to display Safe Zone statements indicating the center is a safe environment for gay, lesbian, bi-sexual and transgendered people.
- E. If training courses are cancelled due to insufficient registration/participation, every effort will be made by the Contractor to reschedule the course and meet the full contract deliverables. The

Contractor will notify the NYSDOH AI Contract Manager of low attendance so they can notify the appropriate Contract Manager of BHEE providers who are not attending required trainings.

- F. The Contractor will notify the NYSDOH AI Contract Manager of any cancellations at least one week prior to the scheduled delivery.
- G. The Contractor is responsible for verifying participants' attendance by having participants sign a sign-in sheet. The sign-in sheet must also include the names of the staff providing the training and the signature of the trainer authorizing the issuance of letters of attendance to participants who have completed the training. The sign-in sheet will be a tool to help the Contractor track participants' attendance for future inquiries from participants regarding letters of attendance as well feedback on attendance of BHEE Contracts to appropriate NYSDOH AI contract management staff. These sign-in sheets are to be made available to the NYSDOH AI upon request.
- H. The Contractor will publicize the availability of training by mailing a hard copy of calendars to BHEE providers and NYSDOH AI contract manager. Evidence of promotional activities and publicity must be documented and reported in the monthly report narrative section on an ongoing basis. A copy of the calendar must be submitted for review and approval prior to distribution.
- I. Contractor will determine specific trainings and locations to be provided in consultation with the NYSDOH AI.

8. MATERIALS REVIEW PROCESS

- A. The Contractor will facilitate bringing together an internal Program Review Panel as well as full communication with AI Contract Manager and BHEE Initiative Director to:
 - 1. develop a plan for training program development and delivery,
 - 2. review training materials as they are developed and
 - 3. evaluate overall impact of training programs.

9. STAFF WHO PROVIDE TRAINING

- A. The skill and knowledge of the person delivering training and technical assistance is extremely important. The following qualifications represent NYSDOH AI standards and will allow Contractors to be best prepared to successfully implement this training initiative:
 - 1. Program Manager – Master's degree and five years of professional administrative level experience in a public health or human services related field providing programmatic and fiscal oversight activities with at least three years of experience overseeing professional training programs. An effective program manager will have experience in training, coordinating activities with community-based and governmental organizations, program development and implementation, evaluation of training programs and have excellent interpersonal skills.
 - 2. Lead Trainer/ Curriculum Developer – Master's degree and at least three years of professional training and curriculum development in the fields of behavioral health education, HIV/AIDS, screening, referral, and consumer linkage and engagement strategies. A bachelor's degree may substitute for a Master's degree with five years of training and curriculum development experience. The Program Manager and Lead Trainer/Curriculum

- Developer may be the same person.
3. Trainers and consultants – the minimum standard is a Bachelor’s degree, and at least three years of training experience and expertise in behavioral health education, HIV/AIDS, screening, referral, and consumer linkage and engagement strategies. The Contractor will select professionals that demonstrate competence and expertise in a subject matter to address the technical assistance needs of the BHEE contractors.
 4. Resumes and credentials of staff and consultants are subject to approval by the NYSDOH AI.
- B. Contractor will provide qualified administrative, training, clerical staff and consultants to perform contract-related activities. If the Contractor would like to hire a staff person whose educational or professional background does not meet the above standards, the Contractor must submit a resume and justification for selection of the staff person or consultant to the AI for approval before hiring. It is the responsibility of the Contractor to notify the AI contract manager when trainers or administrative staff leave, have a change in position or are hired by the Contractor.
- C. All half-day and one day programs may be conducted by one trainer. A minimum of two trainers must conduct multi-day training programs provided by the Contractor.
- D. The Contractor is to submit to NYSDOH AI a list of trainers, the dates they are assigned to train and the courses they are prepared to deliver.
- E. The ability of Contractor training staff to successfully present the training curricula will be evaluated by the AIDS Institute during the contract period.
- F. The NYSDOH AI will provide technical assistance and information updates to the Contractor as needed. The Contractor will incorporate into curricula or distribute to attendees public health messages, as directed by NYSDOH AI staff.

10. DATA COLLECTION AND EVALUATION

- A. The overall goal is to learn how well BHEE contractors are translating knowledge into their workplace practice. The Contractor should also measure the mastery of learning content and skill advancement and periodically will measure the customer satisfaction of BHEE contractors. The Contractor will take the lead in evaluating training program content including trainers’ style, course content and the impact of training and technical assistance activities over time for individual BHEE contractors.
- B. The Contractor will provide the NYSDOH AI with summaries of pertinent evaluation data and narrative reports on training programs in the regular monthly report.
- C. Pre and post tests are required for all Technology-Based learning activities. Progress should be tracked and feedback should be provided to learners and trainers/TA providers.
- D. The NYSDOH AI expects funded training centers to conduct formal quality improvement projects to evaluate Contractor’s activities including:
1. Agency infrastructure
 2. Staffing patterns to meet all fiscal, program and administrative requirements
 3. Preparation and supervision of trainers
 4. Marketing efforts

5. Training registration process
 6. Meeting contract deliverables
 7. Ensuring availability of appropriate training space and training materials
 8. Access to training throughout New York State
 9. Responsiveness to training needs and
 10. Meeting all program reporting and fiscal vouchering requirements.
- E. The NYSDOH AI will conduct Compliance Site Monitorings, as required by the NYSDOH AI. These visits will take place at the Contractor's place of business and where trainings are performed for purposes of assessing all aspects of contract compliance. The site monitoring will use criteria established by the NYSDOH AI and will be provided to the Contractor prior to the scheduled site visit. The site monitoring may include a programmatic and fiscal component. Contractor is responsible for providing the NYSDOH AI with an electronic copy of materials prepared by the Contractor for the NYSDOH AI site monitoring.
- F. The NYSDOH AI will observe training programs being performed by the Contractor on a periodic basis throughout the contract period. A standardized evaluation tool will be used for each course observed and for following up on any needed changes/corrections noted during a monitoring visit. The NYSDOH AI will provide timely verbal and written feedback based on the training program observation using the monitoring evaluation tool.

11. DELIVERABLES AT A GLANCE

The Contractors is expected to attend and participate in the provider meetings and webinars organized and facilitated by NYSDOH AI staff for all BHEE contractors.

The total projected number of training deliverables to be provided during the contract term will be negotiated during workplan development but may include:

- A. Curriculum Development and delivery of core trainings which may include: Outreach and Engagement (How to find, engage and bring PLWHA into services), Psychoeducation (Encouraging engagement and destigmatizing behavioral health treatment), Screening Tools and Risk Assessment, Orientation to Behavioral Health Education and Engagement, Making Referrals, Networking, Linkage, etc.
- B. Curriculum Development and delivery of supervisory core training which may include: Roles and Responsibilities, Systems for Reporting, Tracking, and Coordinating, Staff Capacity and Competencies, Data, Evaluation and Performance Management.
- C. Curriculum Development for "Introduction to Behavioral Health"
- D. Webinars and technical assistance based on agency needs assessment

APPENDIX 1**Attachment B – Program Specific Clauses – AIDS Institute****1) Maximum Reimbursable Amount:**

- a) In the event that a **Maximum Reimbursable Amount** has been specified on the face page of this Agreement, it is understood and accepted by the Contractor that while the Budget attached hereto as Exhibit B is equal to the Total Contract Amount specified on the face page of this Agreement, the aggregate of all allowable costs reimbursed under this reimbursement contract ***will not exceed the Maximum Reimbursable Amount***. The Contractor may incur allowable costs in all categories as noted in the Budget Exhibit B; however, the aggregate amount reimbursed by HRI under this Agreement shall not exceed the Maximum Reimbursable Amount. In the event the Maximum Reimbursable Amount is increased by HRI, the Contractor will be notified in writing by HRI.

2) Confidentiality:

- a) CONTRACTOR understands that the information obtained, collected or developed during the conduct of this agreement may be sensitive in nature. The Contractor hereby agrees that its officers, agents, employees and subcontractors shall treat all client/patient information which is obtained through performance under the Agreement, as confidential information to the extent required by the laws and regulations of the United States Codified in 42 CFR Part 2 (the Federal Confidentiality Law) and Chapter 584 of the laws of the State of New York (the New York State HIV Confidentiality Law) and the applicable portions of the New York State Department of Health Regulation Part 63 (AIDS Testing and the Confidentiality of HIV Related Information.)
- b) CONTRACTOR further agrees that its officers, agents, employees and subcontractors shall comply with the New York State Department of Health AIDS Institute policy “Access to and Disclosure of Personal Health Related Information,” attached hereto and made a part hereof as Attachment D.

3) Evaluation and Service Coordination

- a) CONTRACTOR shall participate in program evaluation activities conducted by the AIDS Institute at the Evaluation Frequency specified in Exhibit C. These activities will include, but not be limited to, the collection and reporting of information specified by the AIDS Institute.
- b) For Direct Service Contracts Only - CONTRACTOR shall coordinate the activities being funded pursuant to this work plan with other organizations within its service area providing HIV-related services including, but not limited to: community entities that provide treatment adherence services, including treatment education, skills building and adherence support services; service providers; community based organization, HIV Special Needs Plans; and other agencies providing primary health care to assure the non-duplication of effort being conducted. The Contractor shall develop linkages with these providers in order to effectively coordinate and deliver services to the targeted population. As part of the reporting requirements, the Contractor will advise the AIDS Institute as to the coordination of efforts being conducted and the linkage arrangements agreed to.

4) Publication:

- a) All written materials, pictorials, audiovisuals, questionnaires or survey instruments and proposed educational group session activities or curricula developed or considered for purchase by the Contractor relating to this funded project must be reviewed and approved in writing by the NYS Department of Health AIDS Institute Program Review Panel prior to dissemination and/or publication. It is agreed that

such review will be conducted within a reasonable timeframe. The Contractor must keep on file written notification of such approval.

- b) In addition to the sponsor attributions required under paragraph 10, “Publications” of “Attachment A General Terms and Conditions”, any such materials developed by the Contractor will also include an attribution statement, which indicates the intended target audience and appropriate setting for distribution or presentation. Examples of statements are attached with Attachment E.

5) Fiscal Systems

- a) CONTRACTOR shall meet contracted programmatic and fiscal requirements including (i) financial reports that track expenditures as specified by HRI; (ii) financial and provider policies and procedures manual that meet HRI program requirements; and (iii) flexible fiscal reporting systems that allow the tracking of obligated balances and carryover funds and detail service reporting of funding sources.
- b) CONTRACTOR shall ensure adequacy of agency fiscal systems to generate budgets and expenditure reports including (i) accounting policies and procedures; (ii) budgets; and (iii) accounting system.
- c) CONTRACTOR shall (i) maintain file documentation of all payroll records, tax records, invoices, accounts payable and expenditure data related to this award and (ii) make the documentation available for HRI review upon request.
- d) CONTRACTOR shall provide HRI personnel access to (i) accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports; (ii) all financial policies and procedures, including billing, collection, purchasing and procurement policies; and (iii) accounts payable systems and policies.
- e) CONTRACTOR shall (i) provide timely properly documented invoices; (ii) submit invoices on time with required documentation; (iii) maintain data documenting reimbursement periods, including monthly bank reconciliation reports and receivables aging report; (iv) inform HRI of any situation that will make it impossible or unlikely to fully spend this award; (v) track and provide accurate and timely reporting of position vacancies and unspent funds to HRI; and (vi) carry out monthly monitoring of expenses to detect and implement cost saving strategies.
- f) CONTRACTOR shall maintain a file documenting all travel expenses paid under this contract.
- g) CONTRACTOR shall submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services.
- h) CONTRACTOR shall document all requests for and approval of budget revisions.

6) Documentation

- a) CONTRACTOR shall (i) develop and maintain a current, complete and accurate asset inventory list that lists purchases of equipment of a cost of more than \$1000 per unit and all computers and AIRS related equipment by funding source and make the list and schedule available to HRI upon request and (ii) implement adequate safeguards for all capital assets that assure they are used solely for authorized purposes.

- b) If applicable, CONTRACTOR shall establish policies and procedures that acknowledge the revisionary interest of the federal government over property improved or purchased with federal dollars and maintain file documentation of these policies and procedures for HRI review.
- c) CONTRACTOR shall include in personnel manual and employee orientation information on regulations that forbid lobbying with contract funds.
- d) If applicable, CONTRACTOR shall use purchasing policies and procedures that meet federal requirements.
- e) If applicable, CONTRACTOR shall establish policies and procedures to ensure compliance with all applicable federal and local statutes and regulations governing contract award and performance including (i) state law and procedures when awarding and administering subcontracts; (ii) ensure that every subcontract includes any clauses required by federal statute and executive orders and their implementing regulations; (iii) ensure that subcontract agreements specify requirements impose upon subcontractors by federal statute and regulation; (iv) ensure appropriate retention of and access to records and (v) ensure that any advances of grant funds to subcontractors substantially conform to the standards of timing and amount that apply to cash advances by federal agencies.
- f) CONTRACTOR shall prepare and provide to HRI upon request program and fiscal staff resumes, job descriptions, a staffing plan, and an organizational chart.
- g) CONTRACTOR shall maintain and review file documentation of (i) Corporate Compliance Plan; (ii) Personnel Policies; (iii) Code of Ethics or Standards of Conduct; (iv) Bylaws and Board Policies including Board Ethics; (v) business conduct practices; and (vi) file documentation of any employee or Board Member in violation of or with a complaint of violation of the Code of Ethics or Standards of Conduct and its resolution.
- h) CONTRACTOR shall have adequate policies and procedures to discourage soliciting cash or in-kind payments for (i) awarding contracts; (ii) referring clients; (iii) purchasing goods or services; and (iv) submitting fraudulent billings.
- i) CONTRACTOR shall also have employee policies that discourage (i) the hiring of persons being investigated by Medicare or Medicaid and (ii) large signing bonuses.

7) Allocations

- a) CONTRACTOR shall (i) ensure that budgets and expenses conform to federal cost principles; and (ii) ensure fiscal staff familiarity with applicable federal regulations.
- b) CONTRACTOR shall (i) make available to HRI very detailed information on the allocation and costing of expenses for services provided; and (ii) reconcile projected unit costs with actual unit costs on a yearly or quarterly basis.
- c) CONTRACTOR shall (i) have in place policies and procedures to determine allowable and reasonable costs; (ii) have in place reasonable methodologies for allocating costs among different funding and (iii) make available policies, procedures and calculations to HRI on request.
- d) CONTRACTOR shall (i) establish and consistently use allocation methodology for employee salaries and wages where employees are engaged in activities supported by several funding sources and (ii) make allocation methodology available to HRI upon request.

8) Audits

- a) CONTRACTOR shall (i) conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds); (ii) request a management letter from auditor; (iii) submit the audit and management letter to HRI; (iv) prepare and provide auditor with income and expense reports that include payer of last resort verification; (v) have in place financial policies and procedures that guide selection of an auditor; (vi) submit to HRI the CONTRACTOR's response to any reportable conditions on the audit.

9) Other

- a) CONTRACTOR shall cooperate with any federal investigation regarding funding under this contract.
- b) For Direct Service Contracts Only - CONTRACTOR shall ensure that the facility where services are provided is accessible by public transportation or provide for transportation assistance.
- c) For Direct Service Contracts Only - CONTRACTOR (i) shall maintain file materials documenting Consumer Advisory Board (CAB) membership and meetings including minutes; (ii) regularly implement client satisfaction survey tool, focus groups and or public meetings with analysis and use of results documents and (iii) maintain visible suggestion box or other client input mechanism.
- d) For Direct Service Contracts Only - CONTRACTOR shall maintain files documenting provider activities for the promotion of HIV services to low income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements.
- e) For Direct Service Contracts Only - CONTRACTOR shall to the extent possible provide services in settings that are accessible to low-income individuals with HIV disease.

10) For Direct Service Contracts Only - Client Eligibility and Recertification Requirements

- a) CONTRACTOR shall (i) document that the process for establishing eligibility, assessment and reassessment takes place within time frames established by the New York State Department of Health; (ii) document that all staff involved in eligibility determination have participated in required training; and (iii) provider client data reports are consistent with eligibility requirements specified by funder which demonstrates eligible clients are receiving allowable services.
- b) CONTRACTOR must document client eligibility immediately upon enrollment in the funded program. Client eligibility verification includes; HIV status, New York State residency, Income, and Insurance Status. Specific examples of acceptable forms of documentation are listed below.
 - i) To maintain eligibility for services, clients must be recertified at least every six months (except for HIV status, see below). The primary purpose of the recertification process is to ensure that an individual continues to meet eligibility requirements for the program.
 - ii) There is flexibility in the recertification process.
 - (1) It is required that at least once a year the recertification procedures include the collection of in-depth supporting documentation, similar to that collected at the initial eligibility determination.
 - (2) However, at one of the two required certifications during a year, contractors may accept client self-attestation, or "verification" that an individual's income, residency, or insurance status continues to comply with the eligibility requirements.
 - (3) Appropriate supporting documentation is always required for any changes in status that may occur throughout the year.

- iii) Contractors must be aware of these requirements, and contract managers must review documentation of client eligibility during monitoring.

c) HIV Status

- i) Contractors must document client eligibility immediately upon client enrollment into the program. Client files must include primary documentation of HIV positive status.
- ii) Acceptable documentation includes:
 - (1) HIV antibody test results and/or
 - (2) Documentation of detectable HIV viral load results and/or
 - (3) Physician (M.D., N.P., P.A.) signed/written statements/progress notes and/or
- iii) If documentation is not in the client's file, a reference to the primary documentation is acceptable. This may be in the form of a certified referral or a notation that eligibility has been confirmed, including the name of the person/organization verifying eligibility, date, and nature and location of primary documentation.
- iv) HIV Status must be documented in AIRS. Once a client is determined to be HIV positive and eligible, continued verification of HIV status will be required every twelve months or until such time as the client is indicated as "HIV-Positive, CDC-Defined AIDS". Once a client receives this status in AIRS, continued verification is no longer required. Providers may use the "Verify" button on the HIV Status Information screen to indicate to the AIDS Institute that proper recertification procedures were followed and the information contained in AIRS is accurate.
- v) Non-infected individuals may be appropriate candidates for services in limited situations, but these services for non-infected individuals must always benefit a person with HIV infection. Funds may be used for services to individuals not infected with HIV only in the circumstances described below.
 - (1) The service has as its primary purpose enabling the non-infected individual to participate in the care of someone with HIV disease or AIDS. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist non-infected individuals with the stresses of providing daily care for someone who is living with HIV disease.
 - (2) The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care. Examples include child care for children, while an infected parent secures medical care or support services.
 - (3) The service promotes family stability for coping with the unique challenges posed by HIV/AIDS. Examples include mental health services that focus on equipping uninfected family members, and caregivers to manage the stress and loss associated with HIV/AIDS, and short-term post death bereavement counseling.
 - (4) Services to non-infected clients that meet these criteria may not continue subsequent to the death of the HIV-infected family member, beyond the period of short-term bereavement counseling.

d) Residency

- i) Contractors must document client eligibility immediately upon client enrollment into the program. Proof of New York State residency is required, U.S. citizenship is not required. Incarcerated individuals receiving services in jails or prisons are exempt from this requirement.
- ii) Acceptable forms of documentation include:

- (1) Current lease
 - (2) Current driver's license
 - (3) Government issued ID card
 - (4) Current voter registration card
 - (5) Current Notice of Decision from Medicaid
 - (6) U.S. Immigration, naturalization or citizenship card with current address
 - (7) Fuel/utility bill (within past 90 days)
 - (8) Phone bill (within past 90 days)
 - (9) Rent receipt (within past 90 days)
 - (10) Pay stubs or bank statement with client's name and address (within past 90 days)
- iii) If the client has a PO Box where he/she receives mail, information documenting the client's physical address must be included to document New York State residency.
 - iv) If a client lives with someone and has none of the items above in the client's name, proof of their residency and a letter stating that the client lives with them will be needed.
 - v) Client's address information must be recorded in AIRS on the Agency Intake screen. Since this is not a history in AIRS, any changes to the client's address must be updated on the Intake screen. Also, there is no verification process in AIRS associated with the Intake screen. This means that documentation of the six month or annual recertification process must be recorded in the client's record.

e) Income

- i) Contractors must document client eligibility immediately upon client enrollment into the program.
- ii) Financial eligibility is based on 435% of the Federal Poverty Level (FPL): FPL varies based on household size and is updated annually. Financial eligibility is calculated on the gross income available to the household excluding Medicare and Social Security withholding and the cost of health care coverage paid by the client. Updated Federal Poverty Guidelines may be accessed by visiting: <http://aspe.hhs.gov/poverty/index.shtml>
 - (1) **Income Source** – Include all sources of income for the client and all household members. This is income only for household members with whom the client has a legally responsible relationship (for example, spouse or child but not uncle, cousin or roommate). Documentation of income is required.
 - (2) **For Wage Earners** - Income should be documented by copies of pay stubs for the past 30 days. If you cannot get a paystub, a notarized letter from the employer showing gross pay for the past 30 days is acceptable.
 - (3) **Self-employed Individuals** – Income determination should be based on business records for the preceding three month period.
 - (4) **Rental Income** - Income received from rental property can be documented by a copy of the lease or most recent income tax return.
 - (5) **All Other Income** - Copies of SSD/SSI award letters, unemployment checks, Social Security checks, pension checks, etc. from the past 30 days can be used as proof of other types of income.
 - (6) **No Income, Supported by Others** - If the client has no income and is supported by a friend or family member, obtain a letter from that friend or family member stating how they support the client.
- iii) Income status must be documented in the Financial Information Screen in AIRS. The Household Size and Annual Household Income fields are **required**. Federal poverty level cannot be calculated without these two pieces of information. The remaining fields may be used to help you record more detailed income information. Providers may use the "Verify" button on the Financial Information screen to indicate to the AIDS Institute that proper recertification procedures were followed and the information contained in AIRS is accurate. This means that for the in-depth recertification requirement, all client documentation was gathered and reviewed and the information in AIRS

remains unchanged. If the “Verify” button was used as part of the client “self-attestation” recertification, using this button means that the client was asked and they are attesting to the fact that the information in AIRS is unchanged.

f) Insurance Status

- i) Contractors must screen clients for eligibility to receive health care coverage through other programs (e.g., Medicaid, Medicare, VA benefits, private health insurance, employer sponsored insurance, HIV Uninsured Care Program, New York State of Health Marketplace). Contractors must have policies and procedures in place addressing these screening requirements. Contract managers will review these policies and procedures as well as documentation of screening activities and client eligibility during contract monitoring.
- ii) Insurance Status must be recorded in AIRS and recertified every six months. Contractors may use the “Verify” button on the Insurance Status screen to indicate to the AIDS Institute that proper recertification procedures were followed and the information contained in AIRS is accurate. This means that for the in-depth recertification requirement, all client documentation was gathered and reviewed and the information in AIRS remains unchanged. If the “Verify” button was used as part of the client “self-attestation” recertification, using this button means that the client was asked and they are attesting to the fact that the information in AIRS is unchanged.

11) Allowable Costs

- a) CONTRACTOR shall maintain documentation of policies that forbid use of contract funds for cash payments to service recipients.
- b) For vehicle purchases, CONTRACTOR shall seek HRI assistance in obtaining written approval and maintain documentation of such approval in file. Three quotes are required.
- c) CONTRACTOR shall prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities.

12) Unallowable Costs: Funds cannot be used to support the following services:

- (1) HIV prevention/risk reduction for HIV-negative or at-risk individuals.
- (2) Syringe exchange programs.
- (3) HIV counseling and testing.
- (4) Employment, vocational rehabilitation, or employment-readiness services.
- (5) Art, drama, music, dance, or photography therapy.
- (6) Social, recreational, or entertainment activities. **Federal funds cannot be used to support social, recreational or entertainment activities.** Ryan White funds cannot be used to support amusement, diversion, social activities, or any costs related to such activities, such as tickets to shows, movies or sports events, meals, lodging, transportation, and gratuities. Movie tickets or other tickets cannot be used as incentives. Funds should NOT be used for off-premise social/recreational activities or to pay for a client's gym membership. Ryan White funds cannot support parties, picnics, structured socialization, athletics, etc.
- (7) Non-client-specific or non-service-specific advocacy activities.
- (8) Services for incarcerated persons, except transitional case management, per HRSA policy Notice 7-04.
- (9) Costs associated with operating clinical trials.
- (10) Funeral, burial, cremation or related expenses.
- (11) Funds awarded under the Ryan White HIV/AIDS Program may NOT be used for direct 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. This restriction does not apply to vehicles operated by organizations for program purposes.

- (12) Funds awarded under the Ryan White HIV/AIDS Program may NOT be used to pay local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
- (13) Criminal defense or class action suits unrelated to access to services eligible for funding under Ryan White.
- (14) In no case may Ryan White HIV/AIDS Program funds be used to make direct payments of cash to recipients of services. Where direct provision of the service is not possible or effective, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. Grantees are advised to administer voucher programs in a manner which assures that vouchers cannot be used for anything other than the allowable service, and that systems are in place to account for disbursed vouchers.
- (15) Inpatient services.
- (16) Clothing.
- (17) Installation of permanent systems for filtration of all water entering a private residence.
- (18) Professional licensure or to meet program licensure requirements.
- (19) Broad-scope awareness activities about HIV services which target the general public.
- (20) **Fund raising.** Federal funds cannot be used for organized fund raising, including financial campaigns, solicitation of gifts and bequests, expenses related to raising capital or contributions, or the costs of meetings or other events related to fund raising or other organizational activities, such as the costs of displays, demonstrations, and exhibits, the cost of meeting rooms, and other special facilities used in conjunction with shows or other special events, and costs of promotional items and memorabilia, including gifts and souvenirs. These costs are unallowable regardless of the purpose for which the funds, gifts or contributions will be used.
- (21) Transportation for any purpose other than acquiring medical services or acquiring support services that are linked to medical outcomes associated with HIV clinical status. Transportation for personal errands, such as grocery shopping, other shopping, banking, social/recreational events, restaurants, or family gatherings is not allowed.
- (22) Pediatric developmental assessment and early intervention services, defined as the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children.
- (23) Permanency planning defined as the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
- (24) Voter registration activities.
- (25) Costs associated with incorporation.
- (26) Herbal supplements/herbal medicines.
- (27) Massage and related services.
- (28) Reiki, Qi Gong, Tai chi and related activities.
- (29) Relaxation audio/video tapes.
- (30) Yoga, yoga instruction, yoga audio/video tapes, yoga/exercise mats.
- (31) Acupuncture services.
- (32) Buddy/companion services.
- (33) International travel.
- (34) Purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility.
- (35) Lobbying activities.
- (36) Funds may not be used for household appliances, pet foods or other non-essential products.

(37)Funds cannot be used to support materials designed to promote intravenous drug use or sexual activity.

(38)Purchase of vehicle without approval.

(39)Pre-exposure prophylaxis.

13) For Direct Service Contracts Only - CONTRACTORS are expected to provide documented, fundable services to eligible clients and to clearly define the scope and nature of such services in the contract work plan. Contract work plans and duties descriptions of staff supported by these funds will be reviewed to ensure that they include only those activities that are fundable under this contract.

APPENDIX 2

Attachment “B-1” – Ryan White Guidance for Part B Direct Service Subcontractors

This guidance sets forth requirements related to AIDS Institute Ryan White Part B contracts as stipulated in the Ryan White HIV/AIDS Treatment Extension Act and as mandated by HRSA policy and New York State policy. The following information provides guidance for contractors in developing budgets and work plans. Ryan White Part B contracts **must** adhere to these requirements. This guidance includes information on allowable services, client eligibility, time and effort reporting, administration, and payer of last resort requirements. Please note that these policies may not be applicable to Ryan White Part A contracts administered by PHS.

Ryan White Service Categories

The Ryan White law limits the persons eligible for Ryan White services and limits the services that are allowable with Ryan White funds. Activities supported and the use of funds appropriated under the law must be in accordance with legislative intent, federal cost principles, and program-specific policies issued by the federal Health Resources and Services Administration (HRSA). HRSA policy related to Ryan White Parts A and B states that no service will be supported with Ryan White funds unless it falls within the legislatively defined range of services. In addition, the law stipulates that Ryan White is the “payer of last resort” (see payer of last resort section on page 6). In conducting program planning, developing contracts, and overseeing programs, you must comply with legislative intent and HRSA policy regarding allowable services and payer of last resort requirements.

Ryan White funded medical and support services must be provided in settings that are accessible to low income individuals with HIV disease.

By receiving Part B funds, the contractor agrees to participate, as appropriate, in Ryan White HIV/AIDS Treatment Extension Act initiatives. The contractor agrees that such participation is essential in meeting the needs of clients with HIV as well as achieving the overall goals and objectives of the Ryan White HIV/AIDS Treatment Extension Act.

Ryan White Part B funds may be used to support the following services:

CORE SERVICES

- 1. Mental health services for HIV-positive persons.** Psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, including individual and group counseling, based on a detailed treatment plan, provided by mental health professionals licensed by the NYS Department of Education and the Board of Regents to practice within the boundaries and scope of their respective profession. This includes Psychiatrists, Psychologists, Psychiatric Nurse Practitioners, Masters prepared Psychiatric Registered Nurses, and Licensed Clinical Social Workers. All mental health services must be provided in accordance with the AIDS Institute Mental Health Standards of Care.
- 2. Medical case management services (including treatment adherence)** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are key components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client’s and other key family members’ needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the care plan at least every 6 months, as necessary during the enrollment of the client. It includes client-specific advocacy and/or review of utilization of

services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. Medical case management services must be provided by trained professionals who provide a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. Medical case management may be provided in a variety of medical settings, including community health centers, County Departments of Health, hospitals, or other Article 28 facilities. All medical case management services must be provided in accordance with AIDS Institute medical case management standards.

SUPPORT SERVICES, defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS. Support services must be shown to improve clinical outcomes. Support services must facilitate access to care. Allowable support services are:

3. **Case management (non-medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed support services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. In accordance with HRSA HAB policy notice 07-04, this includes transitional case management for incarcerated persons as they prepare to exit the correctional system as part of effective discharge planning, or who are in the correctional system for a brief period, which would not include any type of discharge planning. All non-medical case management services must be provided in accordance with AIDS Institute non-medical case management standards.
4. **Emergency financial** - Ryan White HIV/AIDS Program funds may be used to provide Emergency Financial Assistance (EFA) as an allowable support service.
 - a. The decision-makers deliberately and clearly must set priorities and delineate and monitor what part of the overall allocation for emergency assistance is obligated for transportation, food, essential utilities, and/or prescription assistance. Careful monitoring of expenditures within a category of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to indicate when reallocations may be necessary.
 - b. In addition, Grantees and planning councils/consortia must develop standard limitations on the provision of Ryan White HIV/AIDS Program funded emergency assistance to eligible individuals/households and mandate their consistent application by all contractors. It is expected that all other sources of funding in the community for emergency assistance will be effectively utilized and that any allocation of Ryan White HIV/AIDS Program funds to these purposes will be the payer-of-last-resort, and for limited amounts, limited use and limited periods of time
5. **Food bank/home-delivered meals** - Food and Meal Services assist with improving the nutrition status of the client while they develop the necessary skills to make appropriate food choices that will improve and/or maintain their health status. Nutrient dense, well balanced, and safe meals and food tailored to the specific dietary needs of PLWH/A can assist in maximizing the benefits of medical interventions and care. The food and meal services include home-delivered meals, congregate meals, pantry bags, and food gift cards/vouchers. Meals and pantry bags must provide culturally acceptable foods based on knowledge of the food habits and preferences of the target populations.
6. **Health education/risk reduction** -HIV education and risk reduction services include short term individual and/or group level activities to address medical and/or health related education intended to increase a client's knowledge of and participation in their health care, address secondary HIV prevention, improve health, and decrease the risk of transmission of HIV. Education and risk reduction services should be structured to enhance the knowledge base, health literacy, and self efficacy of HIV-infected persons in accessing and maintaining HIV medical services and staying healthy. Recreational and socialization activities are not included in this category.
7. **Housing services** are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

8. **Linguistic services** include interpretation/translation services (both written and oral), provided to HIV-infected individuals (including non-English speaking individuals, and those who are deaf or hard of hearing) for the purpose of ensuring the client's access to medical care and to Ryan White fundable support services that have a direct impact on primary medical care. Funded providers must ensure linguistic services are provided by a qualified professional interpreter.
9. **Medical Transportation services** include conveyance services provided, directly or through voucher, to an eligible client so that he or she may access HIV-related health and support services intended to maintain the client in HIV/AIDS medical care. If this contract is funded under Catalog of Federal Domestic Assistance Number 93.917 or 93.915, the contractor certifies that it will provide transportation services for eligible clients to medical and support services that are linked to medical outcomes associated with HIV clinical status. Transportation should be provided through: A contract(s) with a provider(s) of such services; Voucher or token systems, Mileage reimbursement that enables individuals to travel to needed medical or other support services may be supported with Ryan White HIV/AIDS Program funds, but should not in any case exceed the established rates for Federal Programs. Federal Joint Travel Regulations provide further guidance on this subject; Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed); or, Purchase or lease of organizational vehicles for client transportation programs. Note: Grantees must receive prior approval for the purchase of a vehicle.
10. **Outreach services** are programs that have as their principal purpose identification of people who know their status so that they may become aware of, and may be enrolled in care and treatment services, **NOT** HIV counseling and testing or HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.
11. **Psychosocial support services** are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups that improve medical outcomes, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.
12. **Referral for health care/supportive services** is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.
13. **Treatment adherence counseling** - Short term individual and/or group level activities used to provide HIV/AIDS treatment information, adherence counseling, monitoring, and other strategies to support clients in readiness to begin ARV treatment or maintain maximal adherence to prescribed HIV/AIDS treatment. Treatment adherence counseling activities are provided by non-medical personnel outside of the medical case management and clinical setting. The ultimate goal of treatment education is for a consumer to self-manage their own HIV/AIDS-related care. Self-management is the ability of the consumer to manage their health and health care autonomously, while working in partnership with their physician.

Ryan White funds may also be used to support training of providers delivering allowable services that is intended to improve medical outcomes and consumer education/training that is intended to improve medical outcomes.

Payer of Last Resort

- Ryan White is payer of last resort. The Ryan White HIV/AIDS Treatment Extension Act requires that "...the State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made with respect to that item or service under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or by an entity that provides health services on a prepaid basis. "DSS program policy guidance No. 2 further states that at the individual client level, grantees and/or their subcontractors are expected to make reasonable efforts to secure other funding instead of Ryan White whenever possible. Ryan White funding may only be used for services that are not reimbursable by Medicaid, ADAP Plus or

other third-party payers.

- The Contractor shall (i) maintain policies and staff training on the requirement that Ryan White be the payer of last resort and how that requirement is met; (ii) screen each client for insurance coverage and eligibility for third party programs, assist clients in applying for such coverage and document this in client files; and (iii) carry out internal review of files and billing system to ensure Ryan White resources are used only when a third party payer is not available.
- The Contractor shall (i) have billing, collection, co-pay and sliding fee policies that do not act as a barrier to providing services regardless of the clients ability to pay and (ii) maintain file of individuals refused services with reasons for refusal specified and any complaints from clients with documentation of complaint review and decision reached.
- The Contractor shall ensure that policies and procedures classify veterans receiving VA health benefits as uninsured, thus exempting these veterans from the payer of last resort requirement.

Medicaid Certification & Program Income

- Contractors that provide Medicaid-eligible services pursuant to this agreement shall (i) participate in New York State's Medicaid program; (ii) maintain documentation of their Medicaid certification; (iii) maintain file of contracts with Medicaid insurance companies; and (iv) document efforts to obtain Medicaid certification or request waiver where certification is not feasible.
- The Contractor shall bill, track and report to HRI all program income (including drug rebates) pursuant to this agreement that are billed and obtained. Report of program income will be documented by charges, collections and adjustment reports or by the application of a revenue allocation formula.
- The Contractor shall (i) establish policies and procedures for handling Ryan White revenue including program income; (ii) prepare a detailed chart of accounts and general ledger that provide for the tracking of Ryan White revenue; and (iii) make the policies and process available for granted review upon request.

Client Charges

The Ryan White HIV/AIDS Program legislation requires grantees and subgrantees to develop and implement policies and procedures that specify charges to clients for Ryan White funded services. These policies and procedures must also establish sliding fee scales and discount schedules for clients with incomes greater than 100% of poverty. The legislation also requires that individuals be charged no more than a maximum amount (cap) in a calendar year according to specified criteria.

Each subcontractor may adopt the following policy for use in their policies and procedures in order to satisfy this legislative requirement.

All clients receiving Ryan White Part B services must meet the following income eligibility requirements. Financial eligibility is based on 435% of the Federal Poverty Level (FPL). Clients above 435% of FPL are not eligible for services. FPL varies based on household size and is updated semi-annually. Financial eligibility is calculated on the gross income available to the household:

- If an individual's income is less than or equal to 100% of the Federal Poverty Level (FPL), the individual may not be charged for services.
- For individuals with income from 101% to 200% of the FPL, a nominal fee of \$5 will be charged per service visit. Cumulative charges in a calendar year can be no more than 5% of the individual's annual gross income. Once the 5% cap is reached, the individual may no longer be charged for services.
- For individuals with incomes from 201% to 300% of the FPL, a nominal fee of \$7 will be charged per service visit. Cumulative charges in a calendar year can be no more than 7% of the individual's annual gross income. Once the 7% cap is reached, the individual may no longer be charged for services.

- For individuals with income over 300% of the FPL, a nominal fee of \$10 will be charged per service visit. Cumulative charges in a calendar year can be no more than 10% of the individual's annual gross income. Once the 10% cap is reached, the individual may no longer be charged for services.

The following discounted fee schedule shall be applied to all individuals receiving a Ryan White Part B service as follows:

- For individuals with income from 101% to 200% of the FPL, a discount of \$5 will be applied to each charge per service visit.
- For individuals with income from 201% to 300% of the FPL, a discount of \$7 will be applied to each charge per service visit.
- For individuals with income over 300% of the FPL, a discount of \$10 will be applied to each charge per service visit.

Services must be provided to eligible clients without regard to either the ability of the individual to pay for such services or the current or past health conditions of the individuals to be served.

Time and Effort Reporting

Contractors must have systems in place to document time and effort of direct program staff supported by all federal funds. New federal contractors must submit their written policies related to time and effort to HRI for approval. Most often, such systems take the form of a time sheet entry. These time and effort reporting procedures must clearly identify the percentage of time each staff person devotes to contract activities in accordance with the approved budget. The percent of effort devoted to the project may vary from month to month. The employee's time sheet must indicate the percent of effort the employee devotes to each particular project for a given time period. The effort recorded on the time sheet must reflect the employee's funding sources, and the percent of effort recorded for Ryan White funds must match the percentage being claimed on the Ryan White voucher for the same time period. In addition, 100 percent of the employee's time must be documented. In cases where the percentage of effort of contract staff changes during the contract period, contractors must submit a budget modification request to the AIDS Institute.

On audit, contractors will be expected to produce this documentation. Failure to produce this documentation could result in audit disallowances. HRI also has the right to request back-up documentation on any vouchers if they choose to do so. Only indirect staff is not subject to time and effort reporting requirements. Such staff must be included in the indirect costs line, rather than in the salaries section.

Quality

Ryan White Part B contractors are expected to participate in quality management activities as contractually required, at a minimum compliance with relevant service category standards of care and collection and reporting of data for use in measuring performance. Quality management activities should incorporate the principles of continuous quality improvement, including agency leadership and commitment, staff development and training, participation of staff from all levels and various disciplines, and systematic selection and ongoing review of performance criteria, including consumer satisfaction.

HRSA National Monitoring Standards

The National Monitoring Standards (Standards) are designed to help Ryan White HIV/AIDS Program Part A and B (including AIDS Drug Assistance Program) grantees meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness. Requirements set forth in other sources are consolidated into a single package of materials that provide direction and advice to grantees for monitoring both their own work and the performance of service providers. The Standards consolidate existing HRSA/HAB requirements for program and fiscal management and oversight based on federal law, regulations, policies, and guidance documents.

The Standards were developed by the Division of Service Systems (DSS) within the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB) in response to several Office of Inspector General (OIG)

and Government Accountability Office (GAO) reports. These reports identified the need for a specific standard regarding the frequency and nature of grantee monitoring of subgrantees and a clear HRSA/HAB Project Officer role in monitoring grantee oversight of subgrantees.

Grantees and Subgrantees are required to comply with the Standards as a condition of receiving Ryan White Part A and Part B funds. The Standards can be accessed by visiting:

<http://www.hab.hrsa.gov/manageyourgrant/granteebasics.html>

Administration

The Ryan White legislation imposes a cap on contractor administration. The legislative intent is to fund services and keep administrative costs to a minimum. Contractors shall ensure that expenses on administrative costs do not exceed 10% of the total grant. The appropriate assignment of Ryan White administrative expenses is to include usual and recognized overhead activities including rent, utilities and facilities costs, costs of management oversight of specific programs funded under this title including program coordination, clerical, financial and management staff not directly related to patient care; program evaluation; liability insurance; audits; and computer hardware/software not directly related to patient care. **The following items of expense are considered administrative and should be included in the column for administrative costs when completing the budget forms.**

(A) Salaries

Management and oversight: This includes staff that has agency management responsibility but no direct involvement in the program or the provision of services.

Finance and Contract administration: This includes proposal, work plan and budget development, receipt and disbursement of contract funds, and preparation of programmatic and financial reports as required by the AIDS Institute.

A position **or** percentage of a position may be considered administrative. Examples of titles that are 100% administrative: Controller, Accounting Manager, Director of Operations, Bookkeeper, Accountant, Payroll Specialist, Finance Coordinator, Maintenance Worker, or Security Officer.

Examples of titles that may in part involve administrative duties: Deputy Executive Director; Program Manager, Program Coordinator, or Clinic Manager. With regard to supervision, the percentage of time devoted to supervising programmatic activities and/or providing overall direction to program activities should be considered programmatic.

In the example below, the Chief Operating Officer and Chief Administrative Officer have wholly administrative positions. As such the entire amount requested from the AIDS Institute for these salaries is transferred into the administrative cost line. A calculation on the Salary budget form page will divide all administrative salaries by the total salaries. This percentage may be applied to items in the miscellaneous category that may be shared by program and administrative staff.

IT Staff: All Information/Technology positions are considered administrative. AIRS Data entry staff are considered 100% administrative. However, up to 25% of the data entry position costs charged to the contract may be considered programmatic if the position is involved with data quality/quality improvement activities within the agency. The job description provided must describe the position's involvement with these activities in order to justify the charges.

Position Title/Incumbent Name(s) <small>List only those positions funded on this contract. If salary for position will change during the contract period, use additional lines to show salary levels for each period of time. If additional space is needed, copy this page.</small>	Hours Worked Per Week <small>Hours worked per week, regardless of funding source.</small>	Annual Salary <small>Salary for 12 months, regardless of funding source.</small>	# of months or pay periods funded on this contract	% of effort worked on this contract	Amount Requested from AIDS Institute ⁽¹⁾		Administrative Costs <small>Includes administrative staff salaries supported by this contract ⁽³⁾</small>	
					<small>Col 3 x Col 4 x Col 5</small>	<small>12 mos. or 26 pp</small>		
Director of Case Mgt & Treatment Adherence	35	\$60,000	12	75.00%		\$45,000		
Chief Operating Officer	35	\$85,000	12	4.00%		\$3,400	\$3,400	
Chief Administrative Officer	35	\$75,000	12	4.00%		\$3,000	\$3,000	
Case Manager I	35	\$30,000	12	100.00%		\$30,000		
Case Manager II	35	\$38,000	12	100.00%		\$38,000		
Data Entry	35	\$28,000	12	20.00%		\$5,600	\$4,200	
IT Specialist	35	\$40,000	12	4.00%		\$1,600	\$1,600	
						\$126,600		
SUBTOTAL					% Admin Staff		\$12,200	9.64% ⁽²⁾

Notes:

- 1: If the full % of effort worked on this contract cannot be supported, this formula may need to be adjusted and a notation should be made that the balance is supported in-
- 2: This rate has been calculated using the proportion of administrative salaries to the total salaries requested on the contract. It may be applied to Other than Personal Services expenses where appropriate.
- 3: Administrative salaries include those for accounting, human resources, secretarial and management positions not directly related to patient care.

(B) Fringe

The fringe rate should be applied to the amount of staff salaries devoted to administration (\$12,200 in the above example) in order to calculate the amount of administrative fringe benefits. The summary budget form will calculate this amount once the administrative salaries have been identified on the salary page and the fringe rate has been entered on the fringe page.

(C) Supplies

All funds budgeted for office supplies are considered administrative. Supplies such as educational or clinical materials would be considered programmatic. The administrative supply amount should be entered directly on the supply budget form.

(D) Travel

Travel pertaining to the financial operations or overall management of the organization is considered administrative. Client travel or travel of program staff to training would be considered programmatic. The administrative travel amount should be entered directly on the travel budget form.

(E) Equipment

Equipment purchased for administrative staff or for the financial operations or overall management of the organization is considered administrative. Equipment purchased for program staff or to support or enhance service delivery would be considered programmatic. The administrative equipment amount should be entered directly on the equipment budget form.

(F) Miscellaneous

Includes 100% of rent, utilities, telecommunications (except for those telecommunication expenses that relate to a unique number specifically for this program), audit expenses, general liability and board insurance. In addition, the percentage of staff time devoted to administration (as calculated on the salary page) should be applied to items of expense shared by program and administrative staff (such as photocopiers, printers, and maintenance agreements). The amount of administrative telecommunications, space and miscellaneous other costs should be entered directly on the miscellaneous budget form. Cell phone costs for direct program staff will be considered programmatic expenses and should not be charged as administrative costs.

(G) Subcontracts/Consultant

Includes contractors who perform non-service delivery functions (bookkeepers, payroll services, accountants, security, maintenance, etc.) The administrative contractual amount should be entered directly on the subcontracts/consultants budget form.

(H) Indirect

100% of funds budgeted in the indirect line are administrative. Only contractors with an HHS approved indirect cost rate agreement may request indirect costs (capped at 10%). The contractor must submit a current copy of the indirect cost rate agreement to HRI. The total amount of indirect costs requested should be transferred to the administrative cost line on the indirect costs budget form.

The summary budget form will calculate a rate based on the entries made on each budget form. This rate must be 10% or less for Ryan White contractors. We recognize that some administrative resources are needed by contractors to support direct service programs; however, it is important to note that Ryan White funds are meant to support direct services rather than administration. Upon review of the budget, contract managers will work with you if necessary to reduce administrative costs.

APPENDIX 3

Authorization for Release of Health Information and Confidential HIV Related Information form

The AIDS Institute makes available the “Authorization for Release of Medical Information and Confidential HIV Related Information” (DOH-2557) form and the “Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information” (DOH-5032).

“Authorization for Release of Medical Information and Confidential HIV Related Information” (DOH-2557, 2/11)
The form was streamlined and may be used for disclosures to single parties as well as multiple parties. It may be used to allow multiple parties to exchange information among and between themselves or to disclose information to each listed party separately.

“Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information” (DOH-5032, 4/11)
This form was created to facilitate sharing of substance use, mental health and HIV/AIDS information. The form is somewhat like the DOH-2557 form, but fulfills a need within facilities in which different teams handle substance use, mental health and HIV/AIDS-related issues. In addition, this form fulfills a need between facilities and providers that care for the same patient. Like the DOH-2557 form, the DOH-5032 form is intended to encourage multiple providers to discuss a single individual’s care among and between themselves to facilitate coordinated and comprehensive treatment.

When appropriate, the DOH-5032 form should be used in place of (but not in addition to) the DOH-2557 form.

Both of the above forms can be accessed and printed from the NYSDOH web site at:
<http://www.health.ny.gov/diseases/aids/forms/informedconsent.htm>

APPENDIX 4

Behavioral Health Education and Engagement – AIRS Intake and Data Collection Forms

Behavioral Health Education and Engagement – Screening Form

Behavioral Health Education and Engagement – Provider Listing

See next page for forms



Ryan White Part B HIV/AIDS Behavioral Health Education Initiative INTAKE & PERSONAL INFORMATION

IDENTIFICATION

* INTAKE DATE: ____/____/____
MONTH DAY YEAR

Please Check Box If Incomplete Agency Intake

* CLIENT ID:

Please Check Box If This Client Is Anonymous

SS #: ____ - ____ - ____

Case #:

* LAST NAME:

* GENDER: 10 Female 12 Transgender - Id As Female
 11 Male 13 Transgender - Id As Male

* FIRST NAME:

* PRIMARY LANGUAGE:

Middle Name:

- 01 English
- 02 Spanish
- 03 French
- 04 Haitian Creole
- 05 Cape Verdean Creole
- 06 Italian
- 07 Russian
- 08 German
- 09 Chinese
- 10 Japanese
- 11 Other East Asian
- 12 Hindi
- 13 Other Indian / Pakistani
- 14 Vietnamese
- 15 Korean
- 16 Other Southeast Asian
- 17 Native American
- 18 Greek
- 19 Urdu
- 20 Sign Language
- 21 Braille
- 22 Portuguese
- 23 Arabic
- 24 Hebrew
- 25 Other African Language
- 26 Other Slavic Language
- 27 Khmer
- 28 Laotian
- 29 Bangla
- 30 Chinese - Cantonese
- 31 Chinese - Mandarin
- 32 Hmong
- 33 Bahasa Indonesia
- 34 Bahasa Melayu
- 35 Punjabi
- 36 Tagalog
- 37 Thai

AKA:

* DATE OF BIRTH (DOB): ____/____/____
MONTH DAY YEAR

Current Age: ____

Secondary Language:

- 01 English
- 02 Spanish
- 03 French
- 04 Haitian Creole
- 05 Cape Verdean Creole
- 06 Italian
- 07 Russian
- 08 German
- 09 Chinese
- 10 Japanese
- 11 Other East Asian
- 12 Hindi
- 13 Other Indian / Pakistani
- 14 Vietnamese
- 15 Korean
- 16 Other Southeast Asian
- 17 Native American
- 18 Greek
- 19 Urdu
- 20 Sign Language
- 21 Braille
- 22 Portuguese
- 23 Arabic
- 24 Hebrew
- 25 Other African Language
- 26 Other Slavic Language
- 27 Khmer
- 28 Laotian
- 29 Bangla
- 30 Chinese - Cantonese
- 31 Chinese - Mandarin
- 32 Hmong
- 33 Bahasa Indonesia
- 34 Bahasa Melayu
- 35 Punjabi
- 36 Tagalog
- 37 Thai

* SEXUAL ORIENTATION:

- DO YOU THINK OF YOURSELF AS:
- GAY
 - LESBIAN
 - STRAIGHT OR HETEROSEXUAL
 - BISEXUAL
 - SOMETHING ELSE
 - DON'T KNOW
 - CHOSE NOT TO RESPOND

ADDRESS & CONTACT

Street: _____

This Person Can Be Contacted (Please Check All That Apply):

- Discretion
- Home Visit
- By Mail
- By Phone

* ZIP CODE: ____ - ____

Daytime Telephone: (____) ____ - ____

City:

* STATE:

Evening: (____) ____ - ____

* COUNTY:

LIVING SITUATION

- Head of Household? Yes No N/A
- Dependent Children Living With Client? Yes No N/A
- Is Client Inadequately Housed? Yes No N/A

HOUSEHOLD DATA:

Household Size: _____

* HOUSING:

- 01 Homeless On Street
- 02 Homeless In Shelter
- 03 Transitional Housing
- 04 Residential - Psychiatric Facility
- 05 Residential - Group Home
- 06 Residential - Drug Treatment
- 07 Skilled Nursing Facility Or Hospice
- 08 Hospital
- 09 Correctional Facility (Jail / Prison)
- 10 Permanent Housing - Rental
- 11 Permanent Housing - Owns Home
- 12 With Relations / Friends
- 13 Domestic Violence Situation

Total Annual Household Income: \$ _____

Chronic Homelessness (as defined by HUD)



Ryan White Part B HIV/AIDS Behavioral Health Education Initiative INTAKE & PERSONAL INFORMATION

* CLIENT: _____
 * LAST NAME _____ * FIRST NAME _____ Middle _____

MORE DETAILS

* ETHNICITY: NON-HISPANIC HISPANIC
 Details: 31 Puerto Rican 33 South American 35 Central American
 32 Dominican 34 Mexican / Mexican-American / Chicano(a) 36 Cuban

(Please Note: Detail Is Required For Hispanic Clients Reported In The RSR)

* RACE: WHITE Details: 41 Eastern Europe / Russia 43 Other Europe
 BLACK / AFRICAN AMERICAN Details: 42 Southern Europe / Mediterranean 44 Arab / Middle East / North Africa
 ASIAN Details: 21 African National 24 South African 26 Haitian
 22 East African 25 West African 27 Jamaican
 23 North African 28 Other Caribbean
 11 Asian Indian 16 Vietnamese 82 Hmong 92 Taiwanese
 12 Chinese 17 Bangladeshi 83 Indonesian 93 Sri Lankan
 13 Filipino 18 Pakistani 84 Lao 94 Afghani
 14 Japanese 19 Thai 85 Malaysian 95 Other Asian
 15 Korean 81 Cambodian 91 Tibetan 96 Burmese
 97 Nepalese

(Please Note: Detail Is Required For Asian Clients Reported In The RSR)

AMERICAN INDIAN OR ALASKA NATIVE
 NATIVE HAWAIIAN / PACIFIC ISLANDER Details: Native Hawaiian Guamanian Or Chamorro Samoan Other Pacific Islander

(Please Note: Detail Is Required For Native Hawaiian / Pacific Islander Clients Reported In The RSR)

* INSURANCE STATUS: KNOWN UNKNOWN / UNREPORTED NO INSURANCE

* INSURANCE INFORMATION – IF INSURANCE IS KNOWN, PLEASE COMPLETE FORM ON NEXT PAGE (Page 3)

Citizenship Status: U.S. Other Unknown If Other: _____

<p>Marital Status: <input type="radio"/> 01 Single (Never Married) <input type="radio"/> 02 Married <input type="radio"/> 03 Legally Separated <input type="radio"/> 04 Informally Separated <input type="radio"/> 05 Divorced <input type="radio"/> 06 Widowed <input type="radio"/> 07 Domestic Partner</p>	<p>Religion: <input type="radio"/> 01 Agnostic <input type="radio"/> 15 Presbyterian <input type="radio"/> 27 Naturalism <input type="radio"/> 02 Atheist <input type="radio"/> 16 Seventh Day Adventist <input type="radio"/> 28 Pantheist <input type="radio"/> 03 Baptist <input type="radio"/> 17 Unitarian <input type="radio"/> 30 Quaker <input type="radio"/> 05 Episcopalian <input type="radio"/> 18 Anglican <input type="radio"/> 32 Taoist <input type="radio"/> 06 Protestant <input type="radio"/> 19 Orthodox Jewish <input type="radio"/> 33 None <input type="radio"/> 07 Buddhist <input type="radio"/> 20 Greek Orthodox <input type="radio"/> 35 Reform Jewish <input type="radio"/> 08 Christian <input type="radio"/> 21 Roman Catholic <input type="radio"/> 36 Hassidic Jewish <input type="radio"/> 10 Jewish <input type="radio"/> 22 Hindu <input type="radio"/> 37 Scientology <input type="radio"/> 12 Lutheran <input type="radio"/> 23 Jehovah Witness <input type="radio"/> 38 Christian Science <input type="radio"/> 13 Methodist <input type="radio"/> 24 Mormon <input type="radio"/> 39 Santeria <input type="radio"/> 14 Pentecostal <input type="radio"/> 26 Muslin <input type="radio"/> 99 Other</p>
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<p>* REFERRED BY - SOURCE: <input type="radio"/> 101 Physician <input type="radio"/> 102 Community Health Center <input type="radio"/> 103 Designated AIDS Center Hospital <input type="radio"/> 104 Other Hospital <input type="radio"/> 105 TB Clinic <input type="radio"/> 106 STD Clinic <input type="radio"/> 107 Family Planning / PCAP <input type="radio"/> 108 Home Health Agency <input type="radio"/> 109 Emergency Medical Services <input type="radio"/> 111 ICF (Intermediate Care Facility) <input type="radio"/> 112 Residential Health Care Facility <input type="radio"/> 113 Skilled Nursing Facility <input type="radio"/> 114 HIV Counseling & Testing</p>	<p><input type="radio"/> 116 CHWP / NFP / Home Visiting <input type="radio"/> 117 School <input type="radio"/> 501 Community Service Provider (CSP) <input type="radio"/> 502 Community Based Organization (CBO) <input type="radio"/> 503 Adolescent Service Program <input type="radio"/> 504 Shelter / Hotel <input type="radio"/> 505 Supportive Housing Provider <input type="radio"/> 506 Local Department of Social Services <input type="radio"/> 507 Foster Care Agency <input type="radio"/> 508 CFP / COBRA Case Management Agency <input type="radio"/> 509 Women's Service Organization <input type="radio"/> 520 Migrant Education Program</p>	<p><input type="radio"/> 651 HIV + Partner <input type="radio"/> 652 HIV - Partner <input type="radio"/> 653 HIV Status Unknown Partner <input type="radio"/> 654 Friend Or Family <input type="radio"/> 655 Media <input type="radio"/> 656 Hotline <input type="radio"/> 657 Street Outreach / Education <input type="radio"/> 658 Self <input type="radio"/> 659 Hemophilia Association <input type="radio"/> 660 Partner Services <input type="radio"/> 701 Drug Rehab Program <input type="radio"/> 702 Detox Program <input type="radio"/> 703 Substance Use Program <input type="radio"/> 704 Alcohol Use Program</p>	<p><input type="radio"/> 801 Community Mental Health Program <input type="radio"/> 802 Psychiatric Services Provider <input type="radio"/> 803 Psychological Counseling Provider <input type="radio"/> 901 Legal Services Provider <input type="radio"/> 902 Correctional Association Hotline <input type="radio"/> 903 Division of Parole <input type="radio"/> 904 Rape Unit <input type="radio"/> 905 Department of Corrections <input type="radio"/> 906 Criminal Justice Initiative <input type="radio"/> 907 Other Inmate <input type="radio"/> 999 Other</p>
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* TYPE OF REFERRAL SOURCE: IN HOUSE EXTERNAL Organization: _____

Contact: _____



Ryan White Part B HIV/AIDS Behavioral Health Education Initiative INTAKE & PERSONAL INFORMATION

* CLIENT:		
* LAST NAME	* FIRST NAME	<i>Middle</i>
INSURANCE INFORMATION		
* TYPE OF INSURANCE:		* TYPE OF INSURANCE COVERAGE:
<input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY <input type="checkbox"/> TERTIARY <input type="checkbox"/> FUNDED / OTHER		<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> N/A
* INSURANCE PROVIDER:		* PLAN NAME
<input type="checkbox"/> MEDICAID SNP (SelectHealth)		
<input type="checkbox"/> MEDICAID SNP (AMIDA CARE)		
<input type="checkbox"/> MEDICAID SNP (MetroPlus)		
<input type="checkbox"/> MEDICAID FHPLUS	<input type="checkbox"/> Aetna Health <input type="checkbox"/> Affinity Health Plan <input type="checkbox"/> American Progressive (Todays Options NY) <input type="checkbox"/> AMERIGROUP New York <input type="checkbox"/> Atlantis Health Plan <input type="checkbox"/> Blue Cross Blue Shield Of Western NY <input type="checkbox"/> Blue Cross Blue Shield Of Northern Eastern NY <input type="checkbox"/> CDPHP – Capital District Physician’s Health Plan <input type="checkbox"/> EmblemHealth <input type="checkbox"/> Empire Blue Cross / Empire Blue Cross Blue Shield <input type="checkbox"/> Empire Health Choice HMO <input type="checkbox"/> Excellus Blue Cross Blue Shield <input type="checkbox"/> Excellus Health Plan <input type="checkbox"/> Fidelis (New York State Catholic Health Plan) <input type="checkbox"/> GHI HMO Select <input type="checkbox"/> Health Net Of New York	<input type="checkbox"/> Health Republic Insurance (NY CO-OP) <input type="checkbox"/> Health First <input type="checkbox"/> HealthNow New York <input type="checkbox"/> HIP (Health Insurance Plan of Greater NY) <input type="checkbox"/> Hudson Health Plan <input type="checkbox"/> Independent Health Association <input type="checkbox"/> Managed Health <input type="checkbox"/> MetroPlus Health Plan <input type="checkbox"/> MVP Health Plan <input type="checkbox"/> Neighborhood Health Providers <input type="checkbox"/> North Shore LIJ <input type="checkbox"/> Oscar Insurance Corporation <input type="checkbox"/> SCHC Total Care <input type="checkbox"/> The New York Presbyterian Community Health Plan <input type="checkbox"/> United Healthcare Of New York (Oxford) <input type="checkbox"/> Univera <input type="checkbox"/> WellCare Of New York
<input type="checkbox"/> CHPLUS	<input type="checkbox"/> Aetna Health <input type="checkbox"/> Affinity Health Plan <input type="checkbox"/> American Progressive (Todays Options NY) <input type="checkbox"/> AMERIGROUP New York <input type="checkbox"/> Atlantis Health Plan <input type="checkbox"/> Blue Cross Blue Shield Of Western NY <input type="checkbox"/> Blue Cross Blue Shield Of Northern Eastern NY <input type="checkbox"/> CDPHP – Capital District Physician’s Health Plan <input type="checkbox"/> EmblemHealth <input type="checkbox"/> Empire Blue Cross / Empire Blue Cross Blue Shield <input type="checkbox"/> Empire Health Choice HMO <input type="checkbox"/> Excellus Blue Cross Blue Shield <input type="checkbox"/> Excellus Health Plan <input type="checkbox"/> Fidelis (New York State Catholic Health Plan) <input type="checkbox"/> GHI HMO Select <input type="checkbox"/> Health Net Of New York	<input type="checkbox"/> Health Republic Insurance (NY CO-OP) <input type="checkbox"/> Health First <input type="checkbox"/> HealthNow New York <input type="checkbox"/> HIP (Health Insurance Plan of Greater NY) <input type="checkbox"/> Hudson Health Plan <input type="checkbox"/> Independent Health Association <input type="checkbox"/> Managed Health <input type="checkbox"/> MetroPlus Health Plan <input type="checkbox"/> MVP Health Plan <input type="checkbox"/> Neighborhood Health Providers <input type="checkbox"/> North Shore LIJ <input type="checkbox"/> Oscar Insurance Corporation <input type="checkbox"/> SCHC Total Care <input type="checkbox"/> The New York Presbyterian Community Health Plan <input type="checkbox"/> United Healthcare Of New York (Oxford) <input type="checkbox"/> Univera <input type="checkbox"/> WellCare Of New York
<input type="checkbox"/> MEDICARE / MEDICAID		
<input type="checkbox"/> HEALTH HOMES – TCM		
<input type="checkbox"/> HEALTH HOMES – TCM ENGAGEMENT		
<input type="checkbox"/> HEALTH HOMES		
<input type="checkbox"/> HEALTH HOMES – ENGAGEMENT		
<input type="checkbox"/> NEW YORK STATE OF HEALTH MARKETPLACE	<input type="checkbox"/> Aetna Health <input type="checkbox"/> Affinity Health Plan <input type="checkbox"/> American Progressive (Todays Options NY) <input type="checkbox"/> AMERIGROUP New York <input type="checkbox"/> Atlantis Health Plan <input type="checkbox"/> Blue Cross Blue Shield Of Western NY <input type="checkbox"/> Blue Cross Blue Shield Of Northern Eastern NY <input type="checkbox"/> CDPHP – Capital District Physician’s Health Plan <input type="checkbox"/> EmblemHealth <input type="checkbox"/> Empire Blue Cross / Empire Blue Cross Blue Shield <input type="checkbox"/> Empire Health Choice HMO <input type="checkbox"/> Excellus Blue Cross Blue Shield <input type="checkbox"/> Excellus Health Plan <input type="checkbox"/> Fidelis (New York State Catholic Health Plan) <input type="checkbox"/> GHI HMO Select <input type="checkbox"/> Health Net Of New York	<input type="checkbox"/> Health Republic Insurance (NY CO-OP) <input type="checkbox"/> Health First <input type="checkbox"/> HealthNow New York <input type="checkbox"/> HIP (Health Insurance Plan of Greater NY) <input type="checkbox"/> Hudson Health Plan <input type="checkbox"/> Independent Health Association <input type="checkbox"/> Managed Health <input type="checkbox"/> MetroPlus Health Plan <input type="checkbox"/> MVP Health Plan <input type="checkbox"/> Neighborhood Health Providers <input type="checkbox"/> North Shore LIJ <input type="checkbox"/> Oscar Insurance Corporation <input type="checkbox"/> SCHC Total Care <input type="checkbox"/> The New York Presbyterian Community Health Plan <input type="checkbox"/> United Healthcare Of New York (Oxford) <input type="checkbox"/> Univera <input type="checkbox"/> WellCare Of New York
<input type="checkbox"/> MEDICAID FEE-FOR-SERVICE		



Ryan White Part B HIV/AIDS Behavioral Health Education Initiative INTAKE & PERSONAL INFORMATION

* CLIENT: _____
 * LAST NAME _____ * FIRST NAME _____ Middle _____

The Following Information Is Required To Complete The Intake
 * After The Intake Is Completed And Saved, You Will Need To Use The Proper "Historical Information" Form to Maintain The Following Information.

HIV STATUS * EFFECTIVE DATE: _____ / _____ / _____
 MONTH DAY YEAR

- | | | |
|--|--|--|
| <p>* HIV ADULT STATUS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 01 HIV- POSITIVE, NOT AIDS <input type="checkbox"/> 02 HIV-POSITIVE, AIDS STATUS UNKNOWN <input type="checkbox"/> 03 HIV-NEGATIVE, AT RISK, NOT AFFECTED <input type="checkbox"/> 04 UNKNOWN / UNREPORTED <input type="checkbox"/> 08 HIV-NEGATIVE, AFFECTED <input type="checkbox"/> 10 HIV-POSITIVE, CDC-DEFINED AIDS | <p>* HIV PEDIATRIC STATUS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 05 HIV-INFECTED (PEDIATRIC) <input type="checkbox"/> 06 HIV-VERTICAL (PERINATAL) EXPOSURE <input type="checkbox"/> 07 HIV-NEGATIVE SEROREVERTER <input type="checkbox"/> 09 HIV-AFFECTED (PEDIATRIC) <input type="checkbox"/> 11 HIV-NEGATIVE, AT RISK, NOT AFFECTED <input type="checkbox"/> 12 UNKNOWN / UNREPORTED | <p>* SYMPTOMS (PEDIATRIC ONLY):</p> <ul style="list-style-type: none"> <input type="checkbox"/> 01 NONE <input type="checkbox"/> 02 MILD <input type="checkbox"/> 03 MODERATE <input type="checkbox"/> 04 SEVERE |
|--|--|--|

HIV / AIDS RISK HISTORY

FACTORS * EFFECTIVE DATE: _____ / _____ / _____ Recall Period: CDC Local Initial Exposure
 MONTH DAY YEAR

* FOR ALL OF THE QUESTIONS IN THIS SECTION: NO RISK IDENTIFIED REFUSED NOT ASKED

SEXUAL RISK FACTORS: SEX (VAGINAL OR ANAL) WITH ...

- | | | | |
|-------------------------------|---------------------------------|--------------------------------------|--|
| <input type="checkbox"/> MALE | <input type="checkbox"/> FEMALE | <input type="checkbox"/> TRANSGENDER | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IN EXCHANGE: SEX FOR DRUGS / MONEY |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | WHILE INTOXICATED AND / OR HIGH ON DRUGS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | WITH PERSON WHO IS AN IDU |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | WITH PERSON WHO IS HIV POSITIVE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | WITH PERSON OF UNKNOWN HIV STATUS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | WITH PERSON WHO EXCHANGES SEX FOR DRUGS / MONEY |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | WITH ANONYMOUS PARTNER |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | WITH HEMOPHILIAC OR TRANSFUSION / TRANSPLANT RECIPIENT |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | WITH PERSON WHO IS A KNOWN MSM (FEMALE CLIENT ONLY) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | NO ADDITIONAL RISK INFORMATION SPECIFIED |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | REFUSED TO REPORT ADDITIONAL RISK FACTORS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | NOT ASKED ADDITIONAL RISK FACTORS |

NON-SEXUAL

- INJECTION DRUG USE (IDU)
- SHARED DRUG INJECTION EQUIPMENT
- HEMOPHILIA / COAGULATION DISORDER
- BLOOD PRODUCT OR TRANSPLANT RECIPIENT
- MOTHER AT RISK / PERINATAL
- OTHER

RISK IN THE LAST 12 MONTHS

* FOR ALL OF THE QUESTIONS IN THIS SECTION: REFUSED NOT ASKED

- | | | | |
|---|--|--|--|
| <p>* RECENT STD (NOT HIV):</p> <ul style="list-style-type: none"> <input type="checkbox"/> YES (SELF-REPORTED) <input type="checkbox"/> YES (LAB CONFIRMED) <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW <input type="checkbox"/> REFUSED <input type="checkbox"/> NOT ASKED | <p>* INCARCERATED:</p> <ul style="list-style-type: none"> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> NOT ASKED | <p>* SEX WORKER:</p> <ul style="list-style-type: none"> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSED <input type="checkbox"/> NOT ASKED | <p>* HOUSING STATUS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> PERMANENT <input type="checkbox"/> NON-PERMANENT <input type="checkbox"/> INSTITUTION <input type="checkbox"/> OTHER <input type="checkbox"/> DON'T KNOW <input type="checkbox"/> REFUSED <input type="checkbox"/> NOT ASKED |
|---|--|--|--|

CHARACTERISTICS

- | | | | |
|---|---|--|--|
| <p>* PREGNANT</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused <input type="radio"/> Not Asked | <p>* PREVIOUS HIV TEST</p> <ul style="list-style-type: none"> <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> DON'T KNOW <input type="radio"/> REFUSED <input type="radio"/> NOT ASKED <p>MM/YYYY ___ / ___ - ___ - ___</p> | <p>* SELF-REPORTED TEST RESULT</p> <ul style="list-style-type: none"> <input type="radio"/> Preliminary Positive <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Indeterminate <input type="radio"/> Don't Know <input type="radio"/> Refused <input type="radio"/> Not Asked | <p>* IN HIV MEDICAL CARE</p> <ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused <input type="radio"/> Not Asked |
|---|---|--|--|

IN PRENATAL CARE

- Yes
- No
- Don't Know
- Refused
- Not Asked

* If you answer "Yes" to "Previous HIV Test," you must enter the MM/YYYY and answer the "Self-reported Test Results" Question

* If you answer "Positive" In "Self-reported Test Results," you must answer the "In HIV Medical Care" Question



**Ryan White Part B HIV/AIDS
BEHAVIORAL HEALTH EDUCATION SERVICE ENCOUNTER SHORT FORM** Page 1 of 1

Community Based HIV/AIDS Behavioral Health Education and Engagement Services

CLIENT: _____ ID: _____		
* LAST NAME	* FIRST NAME	MIDDLE
PROGRAM: BCSS Behavioral Health Educ	CONTRACT #:	DATE OF SERVICE: ____/____/____ MONTH DAY YEAR
SERVICE CATEGORY: <u>Behavioral Health Education (00052)</u>		
<p>ENCOUNTER: <input type="checkbox"/> <u>BEHAVIORAL HEALTH EDUCATION (304)</u></p> <p>SERVICES:</p> <p>436 <input type="checkbox"/> Intake</p> <p>1231 <input type="checkbox"/> Behavioral Health Education – Individual</p> <p>1230 <input type="checkbox"/> Behavioral Health Education – Group</p> <p>1105 <input type="checkbox"/> Coordination with Primary Care Provider</p> <p>1234 <input type="checkbox"/> Coordination with Behavioral Health Provider</p> <p>1235 <input type="checkbox"/> Coordination with Care Manager</p> <p>705 <input type="checkbox"/> Referral*</p> <p>708 <input type="checkbox"/> Referral Verification and Follow Up**</p> <p>704 <input type="checkbox"/> Re-engagement Efforts <u>Score:</u></p> <p>1236 <input type="checkbox"/> Perceived BH Stigma Screen _____</p> <p>1232 <input type="checkbox"/> Behavioral Health Readiness Screen – MH _____</p> <p>1233 <input type="checkbox"/> Behavioral Health Readiness Screen – SA _____</p> <p>1237 <input type="checkbox"/> Stage of Change Screen _____</p> <p>72 <input type="checkbox"/> Case Closure/Discharge</p> <p><small>*used ONLY for the initial referral for first appointment with each behavioral health provider</small></p> <p><small>**used for verification of appointments and when making subsequent appointments (i.e. 2nd and 3rd). Upon a third successful BH appointment, the referral status in the referral tracker should indicate "Client attended 3rd Beh Health Appt"</small></p> <p><small>BH = Behavioral Health SA = Substance Abuse MH= Mental Health</small></p>	<p>ENCOUNTER: <input type="checkbox"/> <u>BEHAVIORAL HEALTH PEER EDUCATION (305)</u></p> <p>SERVICES:</p> <p>1143 <input type="checkbox"/> Engagement</p> <p>615 <input type="checkbox"/> Peer Education one on one</p> <p>238 <input type="checkbox"/> Escort</p> <p>705 <input type="checkbox"/> Referral*</p> <p>708 <input type="checkbox"/> Referral Verification and Follow Up**</p> <p>704 <input type="checkbox"/> Re-engagement efforts</p> <p><small>*used ONLY for the initial referral for first appointment with each behavioral health provider</small></p> <p><small>**used for verification of appointments and when making subsequent appointments (i.e. 2nd and 3rd). Upon a third successful BH appointment, the referral status in the referral tracker should indicate "Client attended 3rd Beh Health Appt"</small></p> <p><small>BH = Behavioral Health SA = Substance Abuse MH= Mental Health</small></p>	
STAFF:	SERVICE SITE:	
ENCOUNTER WITH:	100 Client	200 Client Representative or Collateral
		300 Others on Behalf of Client
PROGRESS NOTES (Document interventions and follow-up to identified problems.)		

NOTES:

1. The services listed on the **Community Based HIV/AIDS Behavioral Health Education and Engagement Service Encounter Short Form** are the only ones that should be recorded in AIRS for the Bureau of Community Support Services (BCSS) Ryan White Part B HIV/AIDS Behavioral Health Education Initiative.
2. Please see the AIDS Institute Ryan White Part B HIV/AIDS Behavioral Health Education Initiative Guidelines for more information.



Ryan White Part B HIV/AIDS

BEHAVIORAL HEALTH EDUCATION SERVICE REFERRAL TRACKING SHEET

Community Based HIV/AIDS Behavioral Health Education and Engagement Services

For second appointment

Date referral made: _____ / _____ / _____

Referred to : See above

Date need identified: _____ / _____ / _____

Appointment date: _____ / _____ / _____

Follow up method: Active referral

USE WITH "REFERRAL VERIFICATION AND FOLLOW UP" SERVICE ONLY

Referral Verification-Date verified _____ / _____ / _____

- +01 Client Received
- 01 Client Refused Service
- 02 Client On Waiting List
- 03 Service Not Available
- 04 Appointment Pending
- 06 Client No Show For Appt
- 07 Lost To Follow-Up
- 08 Pending - Client In Hospital
- 09 Pending - Client Too Ill

- 10 Pending - Letter / Info Sent
- 11 Pending - Needs Home Visit
- 12 Pending - Scheduling Conflict
- 15 Pending - Unable To Contact
- 16 Pending - Requires Assess/ Reassess
- 18 Pending - Needs Spanish Sp Staff
- 20 Referral Inappropriate

For third appointment

Date referral made: _____ / _____ / _____

Referred to : See above

Date need identified: _____ / _____ / _____

Appointment date: _____ / _____ / _____

Follow up method: Active referral

USE WITH "REFERRAL VERIFICATION AND FOLLOW UP" SERVICE ONLY

Referral Verification-Date verified _____ / _____ / _____

- +01 Client Received
- 01 Client Refused Service
- 02 Client On Waiting List
- 03 Service Not Available
- 04 Appointment Pending
- 06 Client No Show For Appt
- 07 Lost To Follow-Up
- 08 Pending - Client In Hospital
- 09 Pending - Client Too Ill

- 10 Pending - Letter / Info Sent
- 11 Pending - Needs Home Visit
- 12 Pending - Scheduling Conflict
- 15 Pending - Unable To Contact
- 16 Pending - Requires Assess/ Reassess
- 18 Pending - Needs Spanish Sp Staff
- 20 Referral Inappropriate

+02 Client attended 3rd Beh Health appt

Referral # 3

700 ALCOHOL / SUBSTANCE USE SERVICES

OR
 710 HARM REDUCTION/ SYRINGE EXCHANGE

- 010 DRUG TX - AMBULATORY /NON-METHADONE
- 021 DRUG TX - LONG TERM RESIDENTIAL
- 031 DETOX - OUTPATIENT
- 036 METHADONE TOABSTINENCE
- 038 BUPRENORPHINE WITH AMBULATORY TX
- 050 AA / NA MEETINGS / SELF-HELP
- 010 ESAP
- 070 HARM REDUCTION
- 075 SYRINGE EXCHANGE
- 020 DRUG TX - SHORTTERM RESIDENTIAL
- 030 DETOX - INPATIENT
- 035 METHADONE MAINTENANCE
- 037 BUPRENORPHINE ONLY
- 040 SUBSTANCE USE COUNSELING
- 060 ALCOHOL TX
- 080 RECOVERY READINESS

For first Referral only (not second and third appointments):

Date referral made: _____ / _____ / _____

Referred to : _____

Date need identified: _____ / _____ / _____

Appointment date: _____ / _____ / _____

Follow up method: Active referral

USE WITH "REFERRAL" SERVICE ONLY

Referral Verification-Date verified _____ / _____ / _____

- +01 Client Received
- 01 Client Refused Service
- 02 Client On Waiting List
- 03 Service Not Available
- 04 Appointment Pending
- 06 Client No Show For Appt
- 07 Lost To Follow-Up
- 08 Pending - Client In Hospital
- 09 Pending - Client Too Ill

- 10 Pending - Letter / Info Sent
- 11 Pending - Needs Home Visit
- 12 Pending - Scheduling Conflict
- 15 Pending - Unable To Contact
- 16 Pending - Requires Assess/ Reassess
- 18 Pending - Needs Spanish Sp Staff
- 20 Referral Inappropriate

For second appointment

Date referral made: _____ / _____ / _____

Referred to : See above

Date need identified: _____ / _____ / _____

Appointment date: _____ / _____ / _____

Follow up method: Active referral

USE WITH "REFERRAL VERIFICATION AND FOLLOW UP" SERVICE ONLY

Referral Verification-Date verified _____ / _____ / _____

- +01 Client Received
- 01 Client Refused Service
- 02 Client On Waiting List
- 03 Service Not Available
- 04 Appointment Pending
- 06 Client No Show For Appt
- 07 Lost To Follow-Up
- 08 Pending - Client In Hospital
- 09 Pending - Client Too Ill

- 10 Pending - Letter / Info Sent
- 11 Pending - Needs Home Visit
- 12 Pending - Scheduling Conflict
- 15 Pending - Unable To Contact
- 16 Pending - Requires Assess/ Reassess
- 18 Pending - Needs Spanish Sp Staff
- 20 Referral Inappropriate

For third appointment

Date referral made: _____ / _____ / _____

Referred to : See above

Date need identified: _____ / _____ / _____

Appointment date: _____ / _____ / _____

Follow up method: Active referral

USE WITH "REFERRAL VERIFICATION AND FOLLOW UP" SERVICE ONLY

Referral Verification-Date verified _____ / _____ / _____

- +01 Client Received
- 01 Client Refused Service
- 02 Client On Waiting List
- 03 Service Not Available
- 04 Appointment Pending
- 06 Client No Show For Appt
- 07 Lost To Follow-Up
- 08 Pending - Client In Hospital
- 09 Pending - Client Too Ill

- 10 Pending - Letter / Info Sent
- 11 Pending - Needs Home Visit
- 12 Pending - Scheduling Conflict
- 15 Pending - Unable To Contact
- 16 Pending - Requires Assess/ Reassess
- 18 Pending - Needs Spanish Sp Staff
- 20 Referral Inappropriate

+02 Client attended 3rd Beh Health appt

AIDS Institute/ Bureau of Community Support Services

Behavioral Health Education and Engagement –Screening Form

Completed by : _____ Intake date: _____

CLIENT INFORMATION

Name: _____ Client ID # _____
 Case manager name: _____ Agency: _____ Ph: _____

HIV Status

HIV+? Yes No for how long? _____ Documentation of HIV status in chart? Yes No
 Client currently taking medication for HIV? Yes No What form of documentation? _____
 If "yes" for how long? _____ and how would client rate their adherence on a scale from 1-10? _____
 (1 meaning missed doses everyday, 5 meaning missed doses every week, and 10 doses are never missed)

	At intake/enrollment (pre) date _____	At disenrollment (post) date _____
CD4		
Viral Load		

BEHAVIORAL HEALTH BRIEF HISTORY

Substance Use (drugs used currently or in the past)

None

Type	Frequency	Amount	Date of last use
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____
Cocaine	_____	_____	_____
Crack	_____	_____	_____
Heroin	_____	_____	_____
Hallucinogens	_____	_____	_____
Crystal Meth	_____	_____	_____
Tobacco	_____	_____	_____
Other	_____	_____	_____

Past substance abuse treatment history? Yes No

Date	Type	Location	Completed (y or n)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Type: Detox, Inpatient, Outpatient, Methadone Maintenance)

Experience with harm reduction or self help (AA/NA):

Reasons for not engaging in substance abuse treatment: _____

Mental Health Treatment

None

Date	Type	Location	Completed (y or n)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Type: Ind counseling, Groups, Family counseling, Outpatient (MD), Inpatient care)

Diagnosed with a psychiatric condition? Yes No

If yes, what: _____

Who diagnosed it: _____

Previous history of taking medication for a psychiatric/emotional condition:

Medication	Last used	Dosage	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Feelings about taking medication: _____

History of Trauma: Yes No _____

Past Suicide attempts: Yes No

Current suicidal ideation: Yes No

If "yes", current plan: Yes No

(if "yes" to last two questions – discuss with supervisor)

AIDS Institute/ Bureau of Community Support Services

Behavioral Health Education and Engagement –Screening Form

BEHAVIORAL HEALTH EDUCATION SCREENING TOOL		
<p>Substance Use – CAGE-AID (CAGE – adapted to Include Drugs)</p> <p>1. Have you ever felt the need to Cut down on your use of alcohol or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Has anyone Annoyed you by criticizing your use of alcohol or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever felt Guilty because of something you’ve done while drinking or using drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you ever taken a drink or used drugs to steady your nerves or get over a hangover (Eye-opener)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(a “yes” for each question = 1 point) A total of ≥ 2 may be suggestive of a problem with drugs or alcohol and warrant education and a referral Total Yes: _____</p>		
<p>Depression</p> <p>1. In the past year, were you ever on medication or antidepressants for depression or nerve problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. In the past year, was there ever a time when you felt sad, blue, or depressed for more than 2 weeks in a row? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. In the past year, was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work, or activities that usually give you pleasure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(a “yes” for each question = 1 point) A total of ≥ 1 may be suggestive of a problem with depression and warrant education and a referral Total Yes: _____</p>		
<p>Anxiety</p> <p>1. In the past year, did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. In the past year, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. In the past year, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn’t catch your breath? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(a “yes” for each question = 1 point) A total of ≥ 1 may be suggestive of a problem with anxiety and warrant education and a referral Total Yes: _____</p>		
<p>Perceived Behavioral Health Stigma Screen*</p> <p>Scale: 1 ← 2 3 4 5 6 7 8 9 10 → Strongly Agree</p> <p>Rate each statement from 1-10 (strongly disagree to strongly agree)</p> <ol style="list-style-type: none"> 1. Anyone who gets help for emotional issues is “mentally ill” 2. Anyone who gets help for substance use/abuse is an “addict” 3. Society looks down on those who are <i>considered</i> “mentally ill” 4. Society looks down on those who are <i>considered</i> “addicts” 5. People who are considered “mentally ill” are violent and dangerous 6. People who are “addicts” are violent and dangerous 7. Those who are in treatment are weak 8. Medications/mental health and substance abuse programs don’t work 9. Substance abuse programs don’t work 10. Once you start treatment, you will never stop and never get better <p>Add the scores for 1-10 up and total.</p> <p>*Enter score in AIRS under the Perceived BH Stigma Screen “service” under the BHE category at enrollment and disenrollment</p>	<p>Enrollment Date: _____</p> <p>Stigma SCORE: _____</p> <p>Score: <input style="width: 50px; height: 20px;" type="text"/></p>	<p>Disenrollment Date: _____</p> <p>Stigma SCORE: _____</p> <p>Score: <input style="width: 50px; height: 20px;" type="text"/></p>
<p>Behavioral Health Readiness Screen*</p> <p>1. On a 10 point scale, how much do you want to start and continue in</p>		
<p>Enrollment Date: _____</p> <p>Disenrollment Date: _____</p>		

Ryan White Part B Behavioral Health Education Initiative Providers

AIDS CENTER OF QUEENS COUNTY
161-21 Jamaica Avenue, 6th Floor
Jamaica, NY 11432
Phone: (718) 896-2500
www.acqc.org

ERIE COUNTY MEDICAL CENTER
462 Grider St
Buffalo, NY 14215
Phone: (716) 898-4119
www.ecmc.edu

AIDS COMMUNITY RESOURCES, INC.
627 West Genesee St
Syracuse, NY 13204
Phone: (315) 475-2430
www.aidscommunityresources.com

HUDSON VALLEY COMMUNITY SERVICES
40 Saw Mill River Rd
Hawthorne, NY 10532
Phone: (914) 785-8265
www.hudsonvalleycs.org

AIDS COUNCIL OF NORTHEASTERN NEW YORK, INC.
927 Broadway
Albany, NY 12207
Phone: (518) 427-4686
www.aidscouncil.org

**LONG ISLAND COUNCIL ON ALCOHOLISM AND DRUG
DEPENDENCE**
114 Old Country Road, Suite 114
Mineola, NY 11501
Phone: (516) 747-2606
www.licadd.com

AIDS SERVICE CENTER OF LOWER MANHATTAN, INC.
41 East 11th St., 5th Fl
New York, NY 10003
Phone: (212) 645-0875
www.ascnyc.org

NORTH SHORE UNIVERSITY HOSPITAL
The Center for AIDS Research and Treatment
400 Community Drive
Manhasset, NY 11030
Phone: (516) 562-4280
www.northshorelij.com

BRONX AIDS SERVICES, INC. D/B/A BOOM! HEALTH
540 East Fordham Rd
Bronx, NY 10458
Phone: (718) 295-5605
www.basnyc.org

RESEARCH FOUNDATION OF SUNY STONYBROOK
30 Main Street Suite 102
Riverhead, NY 11203-2012
Phone: (631) 369-8696
www.stonybrook.edu

CATHOLIC CHARITIES COMMUNITY SERVICES
1099 Jay St, Bldg J
Rochester, NY 14611
Phone: (585) 339-9800
www.cccsrochester.org

SOUTHERN TIER AIDS PROGRAM, INC.
Office of Sponsored Programs
22 Riverside Dr
Binghamton, NY 11794-3362
Phone: (607) 798-1706
www.stapinc.org

EHS, INC.
206 South Elmwood Ave
Buffalo, NY 14201
Phone: (716) 847-0212
www.evergreenhs.org

THE AFTER HOURS PROJECT, INC.
1204 Broadway
Brooklyn, NY 13905
Phone: (718) 249-0755
www.afterhoursproject.org

HIV/AIDS Behavioral Health Education Training & Technical Assistance Center

CICATELLI ASSOCIATES, INC.
505 Eighth Avenue, 16th Floor
New York, NY 10018
Phone: (212) 594-7741
www.cicatelli.org/AIMH/