



# 2022

## Georgia Ryan White Part B, Case Management Standard Operating Procedures

# Case Management Standards of Operating Procedures

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# Case Management Standards of Operations

## Introduction

Georgia Ryan White Part B Case Management Standard Operating Procedures (SOP) provide case management guidance based upon the changing needs of enrolled clients. Medical and Non-Medical Case Management in Georgia is available statewide through Ryan White HIV/AIDS Programs that receive federal funds from the Health Resources and Services Administration (HRSA). Funded case managers in the state also provide referrals to support services such as transportation, housing, food banks, etc. Clients who receive any Ryan White Part B Program funded services must be enrolled in case management.

The purpose of the Georgia Ryan White Part B Case Management SOP is to provide guidance to sub-recipients and case managers that will assist in fulfilling the programs minimum expectations for case management. These Standard Operating Procedures are not meant to replace or override existing, more detailed standards agencies may have in place. If any agency is unable to meet case management standards, there must be documentation explaining why they were unable to meet the standards. The Standards are intended to assist the agency and case managers in fulfilling the following goals of case management:

- To increase the quality of care and life for persons living with HIV/AIDS
- To provide coordinated services which reduce the cost of care from preventable emergency room(s), urgent care center(s) and hospital visits
- To provide client advocacy and crisis intervention services
- To annually retain clients in care
- To achieve and promote better health outcomes

## Background

The HIV services system provides several types of coordination, referral, and follow-up services that eliminate barriers and help people with HIV (PWH) get connected and stay in care. Medical Case Management (MCM) is the backbone of the HIV services delivery system and the primary way of ensuring that people living with HIV access, receive, and stay in primary medical care. MCM functions include, but are not limited to, assessment of primary and immediate needs of people living with HIV, coordination of referrals and follow-up with critical core medical and support services to ensure people living with HIV remain in medical care. The services provided are in alignment with the National HIV/AIDS Strategy and focus on entry into care, retention in care and viral load suppression.

HRSA strongly encourages Ryan White HIV/AIDS Program (RWHAP) recipients, subrecipients, planning bodies, and providers to leverage their expertise and RWHAP infrastructure to incorporate viral suppression messages in service delivery settings where PWH are engaged (e.g., outpatient ambulatory health services, medical and non-medical case management, health literacy, early intervention services, and treatment adherence discussion). To do this, providers should:

- 1) Involve consumers in the decision-making process of their HIV treatment and their sexual health
- 2) Develop a trusting relationship with their patients
- 3) Assess barriers to treatment adherence
- 4) Support PWH to achieve and maintain healthy outcomes

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The continuum of HIV/AIDS interventions is generally referred to as the HIV Care Continuum or the HIV Treatment Cascade. The HIV Care Continuum includes the diagnosis of HIV, linkage to primary care, lifelong retention in primary care, an appropriate prescription of antiretroviral therapy (ART), and ultimately HIV viral load suppression.

Sub-recipients are encouraged to assess the outcomes of their programs along the HIV Care Continuum. Sub-recipients should work with their community and public health partners to improve outcomes across the continuum. This is to ensure that PWH are linked to care, engaged in care, and encouraged to begin ART based on readiness of medical adherence. Remember, we must meet the client where they are at taking medications every day for life.

## Case Management Defined (Medical and Non-Medical)

Case management is a directed program of care and social service coordination. Typically, PWH are enrolled into case management to ensure a comprehensive continuum of care. PWH are also enrolled into case management to eliminate barriers to accessing care with the goal to improve health outcomes. Case managers should assist with coordination of support services and follow-up to medical treatment. There are many definitions that vary among agencies; however, the definition of case management used will be that from [HRSA PCN 16-02](#) for Ryan White Programs:

### Medical Case Management, including Treatment Adherence Services

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities under this service may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, email and telehealth and any other forms of communication.)

#### **Key activities for Medical Case Management services include**

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health, support services and continuity of care
- Continuous client monitoring to assess the efficacy of care plan
- Re-evaluation of the care plan at least every 3 to 6 months with adaptations as necessary for the client's medical care plan. This is not 6 monthly eligibility criteria.
- Ongoing assessment of the client and other key family members for client's personal support systems
- Treatment adherence counseling to ensure readiness for the adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services
- Coordination of Prenatal Care

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Medical case management services collaborate with Ryan White Medical providers and referred OB-GYN offices to maintain care for pregnant women living with HIV and improve communication between prenatal and HIV care providers. Case managers must conduct monthly phone consultations with the OB-GYN office to collect information on the patient's prenatal care. All case managers are required to document consultation notes into their prospective electronic medical record or client paper chart.

Additional information regarding the Prenatal Operating Procedure can be found in Appendix F page 48.

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

Visits to ensure treatment readiness and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

The **Medical Case Management** service category objective is to provide guidance and assistance to improve health care outcomes.

## **Non-Medical Case Management Services**

Non-Medical Case Management Services (NMCM) is the provision of a range of client centered support services focused on improving access and retention in medical services. NMCM provides coordination, guidance, and assistance navigating through healthcare and support services. Non-medical case managers educate and guide PWH in accessing medical, housing, linguistic, legal, financial, vocational, and other support services to eliminate barriers to care. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible. These include programs such as Medicaid, Children's Health Insurance Program (CHIP), private health insurance, Medicare Part D, State Pharmacy Assistance Programs, Patient Assistance Programs (PAP), Department of Labor, Housing Authority applications and referrals, Educational services, other state, or local healthcare and/ support services.

Non-medical case management services include all types of encounters including face-to-face, telehealth, electronic mail (e-mail), and any other form of communication. All encounters are documented in the client chart. Non-medical case management services are provided for PWH who have a lower acuity score ranging from one to three. Acuity Scoring is described in greater detail later in the Case Management Standard Operating Procedures. Non-Medical Case Management services provide support for PWH who are self-sufficient with non-urgent circumstances that provides structured guidance for PWH to develop client centered goals.

### **Key activities for Non-Medical Case Management Services include**

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan

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

## Assessment of service needs

Complete the Acuity Scale and develop key NMCM activities that are not intensive and are less frequent than medical case management activities. PWH enrolled in non-medical case management are self-sufficient and able to manage life situations within their own environment independently. Self-management allows case managers the opportunity to serve more clients and provide intensive support to those identified with a higher acuity score. Case Managers must ensure the following activities are completed for new and established clients.

- a comprehensive ISP within 30 days of beginning intake
- Timely and coordinated access to medically appropriate levels of health, support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the ISP efficacy
- Re-evaluation of the ISP at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- All clients should have documented evidence of coordination of services required to implement the ISP during service provision, referrals, and follow-up area.

The Non-Medical Case Management service category objective is to provide guidance and assistance to improve access to support services.

## Medical and Non-Medical Case Manager

### Roles of a Case Manager

The roles of the case manager are varied and require that case managers assist clients in addressing problems in all facets of their lives. Case managers often act in, but are not limited to the following roles:

- Advocate
- Counselor
- Problem solver
- Coordinator with Service Providers/Planners
- Prudent Purchaser

### Skill Set of a Case Manager

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In addition, to requiring that staff be knowledgeable in all areas listed above, case managers must possess a wide range of skills to perform job functions effectively and efficiently. The case manager must have considerable skills to locate, develop, and coordinate the provision of support services in the community. In addition, a case manager must coordinate and follow-up on medical treatment and adherence counseling. Case managers can benefit from training in the following areas regardless of their educational background:

- Motivational Interviewing
  - Oral, written, and communication skills
  - Establish rapport and maintain relationships
- Knowledge of eligibility requirements of applicable local, state, and federal programs
- Community Based Organizations (CBO's)
- Consultation strategies
- Basic working knowledge of HIV/AIDS
- Basic understanding of highly active antiretroviral therapy (HAART) including treatment adherence
- Record keeping and documentation
- Knowledge regarding the current standards of HIV/AIDS care and case management procedures

All staff should be provided opportunities for training to become familiar with the aspects of HIV/AIDS to better understand the needs of the clients served. Case managers should be provided an opportunity for training in all aspects of the disease including coordination and follow-up of medical treatments and the provision of treatment adherence counseling.

Publications and newsletters relating to HIV/AIDS can provide informative reading material for case managers. All case managers need to be trained in the use of state approved forms and methods of documentation.

## Caseload Size

Caseload size is one of the most important factors affecting job performance. Generally, a caseload of up to 1:75 is considered optimum. However, only a few case management agencies have caseloads at this level. Ryan White agencies are encouraged to have caseloads below 75. Unfortunately, caseloads are generally higher than 75. With a caseload size greater than 75 clients, the nature of the case manager's role may change in the following ways:

- Interactions with clients can become reactive rather than proactive
- More demanding clients may receive the greatest amount of attention from the case manager- please remember to maintain proper boundaries
- Case managers may not have enough time to develop a suitable rapport with the client
- Case managers should not do more for clients; rather work with the clients to foster their independence- clients are responsible to engage in their own care
- More time will be spent on documentation requirements, data collection and reporting
- Staff turnover may increase secondary to burnout

Caseload size alone is not necessarily indicative of the case manager's workload. The stage of the client's illness and/or the emergency circumstances which a client may or may not have (i.e., housing needs) often dictates how a case manager's time is spent. Case managers should be assigned caseloads in several



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ways including the number of PWH already assigned per case manager, distance from service provider, available funding criteria used to assign cases. Case management programs should establish a method of assigning caseloads based on the service organization population.

<b>Table 1. Case Management Personnel</b>	
<b>Standard</b>	<b>Measure</b>
<p>1.1 Newly hired HIV case managers will have the following minimum qualifications:</p> <ul style="list-style-type: none"> <li>• The appropriate skill set and relevant experience to provide effective case management, as well as be knowledgeable about HIV/AIDS and current resources available.</li> <li>• The ability to complete documentation required by the case management position.</li> <li>• Have a bachelor's degree in a Social Science or be a Registered Nurse with at least one year of Case Management experience. One year of full-time (or equivalent part-time) work experience in social services delivery (case management, outreach, prevention/education, etc.).</li> </ul>	Resume in personnel file.
1.2 Newly hired or promoted HIV Case Manager Supervisors will have at least the minimum qualifications described above for case managers plus two years of case management experience, or other experience relevant to the position (e.g., volunteer management experience).	Resume in personnel file.
1.3 Case management provider organizations will give a written job description to all case managers and all case manager supervisors.	Written job description on file
1.4 Case managers will comply with the Georgia HIV/AIDS Case Management Standards.	Review of case management records.
1.5 Case managers will receive at least two hours of supervision per month to include client care, case manager job performance, and skill development.	Documentation in personnel file of case manager job performance.
1.6 The optimum caseload per case manager is up to 75 active clients.	Observations during site visit and self-report by case manager.
1.7 Case managers will receive training on the Case Management Standards and standardized forms.	Documentation in training records/personnel file.



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Table 1. Case Management Personnel	
Standard	Measure
1.8 Case managers will participate in at least six (6) hours of education/training annually.	Documentation in training records/personnel file.
1.9 Each agency will have a case management supervision policy.	Written policy on file at provider agency.
1.10 Each agency must maintain the Case Managers credentials and/or evidence of training of health care staff providing case management services.	Documentation of credentials in records/personnel file.

## Agency Policy and Procedures

### Eligibility Policy

Agencies must establish client eligibility policies that comply with state and federal regulations. These include screenings of clients to determine eligibility for services within 15-30 days of intake. Agencies must have documentation of eligibility in client's records including:

- proof of HIV/AIDS positive medical diagnosis
- must be a Georgia resident
- have income at or below 400% of the Federal Poverty Level (FPL)
- must have no other payer source for the services provided

Eligibility for RW Part B Services occurs annually for all clients enrolled in the Georgia RW Part B Program.

### Confidentiality Policy

A confidentiality policy protects client's personal and medical information such as HIV status, behavioral risk factors, and use of services. The confidentiality policy must:

- include consent for release of medical information
- include how medical records are securely stored for privacy

### Client Right and Responsibilities Policy

Active participation in one's health care and sharing in health care decisions maximizes the quality of care and quality of life for people living with HIV/AIDS. Case Managers should encourage clients to actively participate in their own care. Case managers must explain options available to them regarding their rights and responsibilities to create a better health outcome. A signed copy of the rights and responsibility policy must be provided to the client and the agency is required to follow and maintain the original signed copy within the client chart record.

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## Grievance Policy

An agency's grievance policy must outline the process to report unfair treatment or lack of providing quality services. The grievance policy procedure must be posted and visible to everyone provided services. The policy should be specific detailing personnel to contact and the process to file a complaint.

## Health Insurance Portability and Accountability Act (HIPAA)

An agency must provide the client with the agency's Notice of Privacy Practices on the first date of service delivery as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). They should obtain a signed copy of the patient acknowledgement of Notice of Privacy Statement (HIPAA form) and provide the client with a copy of the signed statement.

<b>Table 2. Agency Policy and Procedures</b>	
<b>Standard</b>	<b>Measure</b>
2.1 Each agency must have an eligibility policy and procedure that comply with state and federal regulations (i.e., linguistically appropriate for the population being served).	Written policy on file at provider agency.
2.2 Each agency must have a client confidentiality policy (i.e., linguistically appropriate for the population being served). Every employee must sign a confidentiality agreement.	Written policy on file at provider agency. Copy of signed confidentiality agreement in personnel file.
2.3 Each agency must have grievance policies and procedures; and client's rights and responsibilities (i.e., linguistically appropriate for the population being served).  Each agency must implement, maintain, and display documentation regarding client's grievance procedures and client's rights and responsibilities.	Written policy on file at provider agency.  Grievance procedures and client's rights and responsibilities displayed in public areas of the agency.
2.4 Inform the client of the client confidentiality policy, grievance policies and procedures, and client's rights and responsibilities at intake and annually.  The case manager and client will sign documentation of the above. The case manager will provide the client with copies of the signed documents.	Documentation in the client's record indicating that the client has been informed of the confidentiality policy, grievance policies and procedures and client's rights and responsibilities.  Signed documentation in client's record.
2.5 Obtain written authorization to release information for each specific request. Each request must be signed by the client or legal guardian. (e.g., linguistically appropriate for the population being served)	Release of information forms signed by client in case management record.

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Table 2. Agency Policy and Procedures	
Standard	Measure
<b>Note:</b> If releasing AIDS Confidential Information (ACI), the client must sign an authorization for release of information, which specifically allows release of ACI. (See <a href="#">Georgia Code Section 24-9-47</a> for medical release of ACI.)	
2.6 Provide the client with the agency's Notice of Privacy Practices on the first date of service delivery as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Obtain a signed copy of the patient acknowledgement of Notice of Privacy Statement (HIPAA form). Provide the client with a copy of the signed statement.	Signed acknowledgement of Notice of Privacy Statement (HIPAA form) in the client's record.

## Section 2: Intake Overview

The purpose of the intake process is to ensure PWH understand the purpose of case management and to screen if the client is currently receiving Ryan White Case Management service at another agency. It is extremely important to provide mandated information and obtain required consents, releases, and disclosure. An intake is also a time to gather and provide basic information to and from PWH with care and compassion. It is a pivotal moment to establish trust, confidence, and rapport between both parties. If there is an indication that the client may be facing an imminent loss of medication or other forms of medical crisis at intake, the process should be expedited, and appropriate intervention take place prior to formal enrollment.

Five steps must be completed for every client who is new or re-enrolling into case management: Client Intake, Income/Expense Spreadsheet, Acuity Scale, Individualized Service Plan (ISP), and case note documentation. The above-mentioned forms will be discussed in further detail throughout this document.

### 1) Intake

The first step in the enrollment process is to complete the Client Intake form. Upon completing this form, the case manager will review the document to ensure that the requested information is complete and accurate. The intake form should be signed by both the person receiving services and the case manager. All supporting documents provided should be reviewed for accuracy. Case Management intake must be completed within 15-30 days of beginning the initial services based on the client's level of acuity. **Additional information regarding a Client Intake Form can be found in Appendix A, page 28.**

### 2) Income/Expense Spreadsheet

The second document to be completed is the Income/ Expense Spreadsheet. This document will tabulate as numbers are entered into the cells. The purpose of this form is to obtain information regarding a client's financial expenses/resources. The Income/Expense Spreadsheet must be completed within 15-30

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days of beginning the initial intake assessment based on the client's level of acuity. **The spreadsheet is in Appendix B, page 30.**

## 3) Acuity Scale

The third step is to complete the Acuity Scale assessment. It is not necessary for a client to sign this document, only the case manager. The scale is a tool for case managers that can be used in conjunction with the initial intake to develop an ISP. The Acuity Scale translates the assessment into a level of support designed to provide appropriate aid to the client's assessed level of functioning. This document must be completed within 15-30 days of assessment based on the level of acuity. **Additional information regarding the Case Management Acuity Scale is in Appendix C, page 32.**

## 4) Individualized Service Plan (ISP)

The fourth step is to develop the initial comprehensive ISP, which constitutes another essential function of case management. The ISP is the "bridge" from the assessment phase to the actual delivery of services. The primary goal of the ISP is to ensure client's access, retention, and adherence to primary medical care by removing barriers to care. A comprehensive assessment is developed using information gathered while completing the Intake and Acuity Scale to determine the level of client's needs and personal support systems. The information is then used to develop a mutually agreed upon comprehensive ISP with specific goals and action steps to address barriers to care.

The ISP's should be developed using SMART objectives. Smart objectives are as follows; **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, and **T**ime Specific. A comprehensive ISP must be signed by both the client and case manager within 15-30 days of beginning the initial services based on the client's level of acuity. **Additional information regarding the ISP can be found in Appendix D, page 38.**

## 5) Case Note Documentation

The final step is to complete a case note that contains specific details to explain information gathered during the intake process as well as other relevant information. Case note documentation, regardless of complexity, must be comprehensive enough to support the design and implementation of the ISP and the nature of case management services provided. A client's history is usually reflective of trends and may offer valuable insight about what to expect in the future. It is important that the case managers documentation reflects the following: subjective (what you hear) and objective (what you see) observations (e.g. changes in health status or feelings of anxiety or depression). Document any actions done in response to the observations and the client's response to the actions.

To provide a more complete picture of the client's situation, the case manager may document the client's, family member or significant other's actual response (verbal or non-verbal) to any aspect of care provided. A verbal response may be documented using quotations (e.g. "response" marks). Non-verbal responses should be described in as much detail as possible. This case note documentation must be completed within 15-30 days of beginning the initial intake. **Additional information regarding the case note documentation can be found on page 24.**

## Section 3: Initial Intake

An Initial Intake is the formal process of collecting information to determine the client's eligibility for services and his/her immediate service needs. The case manager becomes familiar with the eligibility

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requirements of numerous assistance programs to provide appropriate referrals to address client barriers to care. The Ryan White HIV/AIDS Program requires that funds be utilized as the payer of last resort. The following eligibility documents must be provided during intake:

1. HIV Status
2. Low-Income
3. Residency

As referenced by [PCN 21-02](#) guidelines

During intake, clients should be informed of the case management services available that can assist with improving health outcomes and gain self-sufficiency. The information collected during the intake process provides the basis to obtain informed consent for case management services and conducting the comprehensive needs assessment. The following are the objectives of an intake process:

1. Establish rapport and trust between the client and case manager
2. Determine the client's immediate needs assessment and link them to the appropriate resources
3. Inform the client of the scope of services offered by the Ryan White program which includes.
  - a. Benefits and limitations,
  - b. Rights and responsibilities as a participant in the program
  - c. Case managers should allow the interactions with the client to evolve in such a way that the client feels free to express needs openly and for those needs to be acknowledged by the case manager.

An intake must be completed for new or re-enrolling case management clients. The client should serve as the primary source of information. A case manager should actively engage the client in the assessment process avoiding yes/no questions, utilize open ended questions and enhance communication between the two parties.

Clients may be asked to identify their own strengths/weaknesses and to assist in identifying support services that will be needed for independent living. The healthcare team may be contacted for more information regarding the client's medical condition and support services. Additional sources of information might include hospital or social service agency records, family, friends, and therapists. These sources of information must be utilized only with the knowledge and consent of the client. Six major areas of a client's life for consideration when conducting an intake include the following:

1. [Clinical/Medical](#) – This includes discussion of the client's health status, diagnosis, possible treatments, the client's right to refuse care or insist upon a different approach and access to primary care.
2. [Psychosocial](#) – This includes discussion of the client's level of coping or functioning and past coping strategies that were tried. A review of available resources for client support, an assessment of the client's strengths/weaknesses, support groups and barriers to care should also be addressed.
3. [Social](#) – This includes discussion of the client's family structure, significant others, and cultural background. The case manager should meet with the client's family members and significant others only when deemed appropriate for continuum of care and treatment and at the agreement of the client wishes. The client's history of family, friends, spouses, domestic partners, and others are essential to the client's well-being. This network can provide a range and depth of services which can only be enhanced.

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4. Economic – This includes the current financial resources and insurance coverage, and financial assistance that has not been explored (i.e., food, housing, transportation, etc.). Budget counseling and debt management should be provided as an option. All resources including but not limited to employment and disability coverage vigorously be explored continuously documented in chart records. The client and family should be educated about insurance and terminology. (See Appendix 2. Income/Expenses Form.)
5. Cultural – This includes assessing culturally specific needs of the client and ensuring that case management services are provided in the preferred language of the client. Please note that it is not encouraged to rely on children or family to interpret for the client.
6. Linguistic - Language assistance must be provided by the agency when an interpreter is required to communicate effectively with staff to translate key information including, but not limited to, the consent for services, consent for release of medical/psychosocial information, grievance policy and any other similar documents that a provider might typically use during service provision to clients.

Typically, the initial intake interaction with the client regarding case management services will occur via face-to-face encounter. However, the intake can be conducted in other locations such as: office, hospital, clinic, home, or shelters. The intake is necessary to determine whether the client is experiencing a crisis and/or requires an immediate referral. The case manager and client will discuss services offered, the expectation from both client and case manager, and requirements to access case management services. It is during this interaction that the case manager and client establish the basis for developing rapport and trust, which are essential elements of case management. This information must be discussed during the intake to avoid future miscommunication and inappropriate expectations.

If it is determined that the client is eligible for HIV/AIDS services, the case manager or another staff member proceed with the following:

- Obtain consent for services based on agency's policies
- Explain medical and support services available and other case management procedures
- Explain the agency's regular, after-hours, weekend, and holiday policies (if applicable)
- Explain the agency's grievance policy, policies/procedures and client rights and responsibilities
- Advise client of his/her rights to confidentiality as specified by state statutes and obtain authorization to release confidential information as needed
- Initiate a client file/record to be maintained throughout the duration of the client's involvement with the case management agency

**Note:** The client must sign an authorization for release of information, which specifically allows release of AIDS Confidential Information (ACI). (See [Georgia Code Section 24-9-47](#) for medical release of ACI.)

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Table 3. Intake	
Standard	Measure
3.1 Determine Ryan White Part B Program eligibility for services.	Documentation of eligibility in client's records including proof of HIV/AIDS positive medical diagnosis, proof of Georgia residency, income at or below 400% of the Federal Poverty Level (FPL) and must have no other payer source for the services provided.
3.2 Obtain client's authorization to obtain and/or release information if there is an immediate need to release or request information.	Signed Release (or No-Release) of Information in client's record.
3.3 Complete the Initial Intake, Income/Expense Spreadsheet, Acuity Scale, initial ISP, and case note within 15-30 days of beginning the initial Intake assessment.	Completed Intake, Income/Expense Spreadsheet, Acuity Scale, initial ISP, and case note in client's record.

## Section 4: Acuity Scale

All new and re-enrolling clients must have an Acuity Scale completed. The scale is a tool for the case managers to use in conjunction with the initial intake to develop an Individualized Service Plan (ISP). The intent is to provide a framework for documenting important assessment elements and standardizing the key questions that should be asked as part of an assessment. This scale also translates the assessment into a level of programmatic support designed to provide the client assistance appropriate to their assessed need and function.

The case manager can, at his/her discretion, increase the acuity level based upon his/her assessment and client needs, i.e., there are circumstances which indicate the client may benefit from additional services or support.

**\*Please note:** The acuity level can only be decreased after completing a new Acuity Scale, which indicates a lower level of acuity than the previously dated Acuity Scale.

### Acuity Levels

Level 1 and 2 clients are lower levels of acuity, which require less intensive case management services. Most case management services provided for level 1 and 2 clients are non-medical vs. medical. The objective is to provide coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services.

Level 3 clients are at a higher acuity level which require more case management services.

Level 4 clients are at the highest acuity level which require intensive case management services. Most case management services provided for level 3 and 4 clients will be medical vs. non-medical, as the objective is to improve health care outcomes. Appropriate case management activities are assigned in



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accordance with the Activities by Acuity Level document according to the indicated acuity scale levels. Below are the Acuity Levels, point values and a brief description of a client who has been assigned that level of acuity.

## Level 1 Self-Management 16-17 points

Self-management is appropriate for clients who are adherent to medical care and treatment, are independent, and can advocate for themselves. Clients may need occasional assistance from the case manager to update eligibility forms. These clients have demonstrated capability of managing self and disease, are independent, medically stable, virally suppressed and have no problem getting access to HIV care. Additionally, their housing and income source(s) should be stable. If clients have a mental health diagnosis, they should be in the care of a mental health provider and adherent to their treatment plan. If clients have a history of substance abuse, they should have more than 12 months of sobriety and should preferably be accessing continued support services to maintain their sobriety. Most case management services provided will be non-medical vs. medical. Re-evaluation of the acuity scale and ISP must occur at least every 6 months with adaptations, as necessary.

## Level 2 Supportive 18-22 points

Supportive case management is appropriate for clients with needs that can be addressed in the short term. Clients should be adherent to their medical care and treatment, independent, and able to advocate for themselves. Additionally, these clients require minimal assistance and their housing and income source(s) should be stable. Clients may require service provision assistance no more than 2-3 times a year. If the clients have a mental health diagnosis, they should be in the care of a mental health provider and adherent to their treatment plan. If clients have a history of substance abuse, they should have no less than 6-12 months of sobriety and should preferably be accessing continued support services to maintain their sobriety. This includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Most case management services provided will be non-medical vs. medical. Re-evaluation of the acuity scale and ISP must occur at least every 6 months with adaptations, as necessary.

## Level 3 Intermediate 23-37 points

Intermediate case management is appropriate for clients who are considered medically case managed. Coordination and follow-up of medical treatment is a component of medical case management. These clients require assistance to access and/or remain in care and are at risk of medication and appointment non-compliance. They may have opportunistic infections and other co-morbidities that are not being treated or addressed and have no support system in place to address related issues. The case manager should 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. Key activities include but are not limited to completing initial intake within 15-30 days of beginning the intake, development of an individualized service plan (ISP) within 15-30 days of beginning the intake, and re-evaluation of the acuity scale and ISP with a revision at least every 6 months. Most case management services provided will be medical vs. non-medical. Documentation should be reflective of goals, activities, and outcomes in the case notes. Consultation with a multi-disciplinary team, case management supervisor and/or others as needed should be documented.

## Level 4 Intensive 38-56 points

# Case Management Standards of Operations

Intensive case management is appropriate for clients who are considered medically case managed. These clients require assistance to access and/or remain in care. The clients are at risk of becoming lost to care and are considered medically unstable without MCM assistance to ensure access and participation in the continuum of care. The case manager should 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. Key activities include but are not limited to completing initial intake within *15 days* of beginning the intake, development of an individualized service plan (ISP) within 15-30 days of beginning the intake, and re-evaluation of the acuity scale and ISP with a revision at least every 3 months. Most case management services provided are for medical services rather than non-medical. Documentation should be reflective of goals, activities, and outcomes in the case notes. All services provided must be documented any service provided without documentation will not be acknowledged.

Upon completing and scoring the Acuity Scale, the Activities by Acuity Level document in Appendix 5 provides timelines and activities that must be followed depending on the acuity level score.

Information obtained while completing the Acuity Scale can be used to develop the ISP.

After the initial documents have been completed for a new or re-enrolling client, the next step is to determine when the Acuity Scale and ISP will need to be revised.

For level 4 clients, this will be at least every 3 months.

Level 1-3 clients will require revision at least every 6 months. However, the ISP and Acuity scale can be updated more frequently if needed.

Table 4. Acuity Scale	
Standard	Measure
4.1 All new or re-enrolling case management client charts will have a completed Acuity Scale within 15-30 days of initial assessment.	Acuity Scale must be assessed, and a score assigned and in the client chart.
4.2 All case managed client charts containing a completed Acuity Scale will have a level of acuity assigned.	Every Acuity Scale must contain the Total Score and Assigned Acuity Level reflective on each completed Acuity Scale Assessment and in the client chart.
4.3 All Acuity Scale assessments will be updated in accordance with the Activities by Acuity Level document. (see Appendix 5)	At a minimum, the Acuity Scale should be revised as follows: Level 4 – Every 3 months. Level 1-3 – Every 6 months.

## Section 5: Individualized Service Plan (ISP)

The development of the ISP consists of the translation of information acquired during intake and completion of the acuity scale into short and long-term objectives for the maintenance and independence of the client. The service plan includes:

# Case Management Standards of Operations

- identification of all services client currently needs
- identification of agencies with capacity to provide needed services to client
- specification of how client will acquire needed services
- the process identified to assure client has successfully obtains needed services
- develop a plan for how the various services the client receives will be coordinated while specifically defining the role of the case manager.
  - Client participation in the development of the service plan is fully required as is possible.
  - Client feedback should be obtained on each element of the service plan before it is implemented and signed by case managers and PWH.

Every new or re-enrolling case management client must have an ISP completed and signed by both the case manager and PWH. Additionally, there must be an ISP completed for every new and re-certifying Ryan White Part B Program ADAP/HICP client at least every 6 months. If an ADAP/HICP client already has a case manager, the same ISP can be utilized for the ADAP/HICP client charts and documented to include ADAP/HICP service screenings and current enrollment status of all applicable clients. Any client who only receives ADAP/HICP must be informed of the additional services offered by the Ryan White Part B Program. If the client decides to decline these additional services except for ADAP/HICP, the client must sign a Declination of Services except ADAP/HICP form. The declination form must be updated accordingly to the RW Eligibility guidelines and remain within the chart record. See Appendix G page 54.

The primary goal of the ISP is to ensure clients access, retention, coordination of care and follow-up, and medical/treatment adherence to primary medical care by removing barriers to care. A medical, psychosocial, and financial portrait of the client is created using information gathered during the intake and acuity scale process. The information is then utilized to develop a mutually agreed upon comprehensive ISP with specific goals and action steps to address barriers to care.

The ISP is the “bridge” from the assessment phase to the actual delivery of services and constitutes another essential function of case management. It is developed based on the information obtained from the client assessment and pinpoints the individualized needs of the client and links the appropriate services with the needs. The ISP is a map of actions that documents the interventions, actions, responsibilities, and timeframes needed to meet the identified goals. Interventions and actions may be immediate, short term or future focused. Future focused interventions anticipate a persons’ changing life circumstances and recognize the role of prevention. The realistic needs of the client should be reflected in the development of the plan. The ISP must include coordination and follow-up of medical treatments, referrals for outside medical treatments, and treatment adherence.

The client is involved with the planning of the ISP, but it is the responsibility of the case manager to write the plan. The client’s primary physician, mental health provider, caregiver, and other appropriate individuals should be contacted for additional information if deemed appropriate. It is important that the case manager have a comprehensive knowledge of the community resources to address the needs of the client during the development of the ISP. ISP’s should be developed using **SMART objectives**; Specific, Measurable, Attainable, Realistic, and Time Specific. Information documented on the ISP can be brief statements that explain the client’s situation. The document contains a set of goals and activities that help client’s access and maintain access to services, particularly primary medical care, gain or maintain medication adherence, and move towards self-sufficiency. Short term goals address immediate needs, especially those required to stabilize the client or to deal with a crisis. These are goals that the client can

# Case Management Standards of Operations

realize soon, such as in a day, within the week or even a few months. Long term goals are achieved over a longer period. These goals are usually those that are meaningful, thus giving the client a sense of greater importance. It is important to prioritize goals and help clients decide what is most important right now. The ISP documents the resources readily available to help the client make immediate improvements in his/her situation.

After completing the assessment, case managers should be able to answer basic questions about the new client and his/her care needs. Information collected should be used as a baseline from which to update the client's health status and change service needs over time. Both the case manager and client must sign and date the ISP; however, agencies using electronic medical records (EMR) may use an electronic signature for case managers. Additionally, the client must be offered a copy of his/her ISP and to retain a copy in the client chart.

Implementation requires the case manager and the client to work together to achieve the goals and objectives of the ISP. Providing social support and encouragement to the client is as much a part of implementation as the actual brokerage and coordination of services. To make the ISP work, the case manager and client need to determine how much autonomy the client can exercise on his/her own behalf and how much assistance he/she needs to acquire the services. Implementation of the ISP includes careful documentation in the case notes of each encounter with the client, dates of contact, information on who initiated contact, and any action that resulted from the contact be included in the case notes.

## When to revise the ISP

The ISP should be completed for all case managed clients. Level 4 clients should have an ISP revised at least every 3 months and Level 1-3 revised at least every 6 months. The acuity scale should be updated during this time as well. Upon revising the ISP, a case note must be completed. Case Managers must ensure that the following activities are completed for all new and established **Medical Case Managed** clients:

- Assessment of service needs
- Complete the Acuity Scale and develop a comprehensive ISP within 30 days of beginning the intake
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the ISP
- Re-evaluation of the ISP at least every 3-6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services
- All clients should have documented evidence of coordination of services required to implement the ISP during service provision, referrals, and follow-up

# Case Management Standards of Operations

Table 5. ISP Assessment	
Standard	Measure
5.1 Conduct client eligibility evaluation every 6 months. The process to determine client eligibility must be completed in a time frame so that services are not delayed.	<p>Eligibility assessment must include at a minimum:</p> <ul style="list-style-type: none"> <li>• Proof of income</li> <li>• Proof of residency</li> <li>• Proof of active participation in primary care or documentation of the client's plan to access primary care.</li> </ul>
5.2 All newly enrolled or reactivated case managed clients must have an acuity scale and comprehensive ISP completed within 15 days for a Level 4 and 30 days for a Level 1-3 of beginning the initial intake	<p>At minimum, the initial assessment should cover the following areas:</p> <ul style="list-style-type: none"> <li>• Medical History/Physical Health Status</li> <li>• Medical Treatment and Adherence</li> <li>• Health Insurance</li> </ul>
5.3 All newly enrolled or re-certifying ADAP/HICP client must have an ISP completed within 30 days of beginning the application.	<ul style="list-style-type: none"> <li>• Family/Domestic Situation</li> <li>• Housing Status</li> <li>• Source of Income</li> <li>• Nutrition/Food</li> <li>• Mental Health</li> <li>• Substance Abuse</li> <li>• Personal and Community Support Systems</li> <li>• Disclosure</li> <li>• Risk Reduction</li> <li>• Legal Issues</li> <li>• Transportation</li> <li>• Cultural Beliefs and Practices/Languages</li> <li>• Dental</li> <li>• Emergency Financial Assistance</li> <li>• Additional Service Needs</li> </ul> <p>Ensure that documentation (case notes, initial assessment, or re-assessment) is in the client's record.</p>

## Coordination of Care and Re-Evaluating ISP

Coordination involves communication, information sharing, and collaborating regularly with case management and other agencies serving the client. The case manager and other agencies work together on a case-by-case basis to ensure that clients receive appropriate services without duplication. During coordination of services the case manager will focus on the clients' strength and accomplishments rather than focusing on short comings or relapses. Coordination activities may include directly arranging access, reducing barriers to obtaining services, establishing linkages, and other activities recorded in the case note.

# Case Management Standards of Operations

Table 6. Coordination of Services	
Standard	Measure
6.1 Implement client's ISP.	Documentation in client's record of progress toward resolution and outcome of each item in client's ISP.
6.2 Identify and communicate with other case managers with whom the client may be working with. Collaboratively determine with all parties and the client the person most appropriate to serve as the primary case manager.	Documentation in client's record of other case managers with whom the client may be working with and documentation of who is the most appropriate person to serve as the primary case manager.
6.3 With consent of the client, identify and communicate with other service providers with whom the client may be working. This can occur during team meetings to coordinate continuity of care.	Documentation of communication in client's record.  Agenda or meeting notes.
6.4 Coordination and follow-up of primary medical care and treatment adherence. Clients should have one visit with their primary care provider (i.e., MD/DO, PA, and APRN) at least every six (6) months. For clients who have not had a visit with their primary care provider, the case manager should follow-up with the client within 30 days to determine barriers to care and adherence.	Attendance at medical visits.  Documentation of referrals to primary care and follow-up within 30 days.

## Re-evaluating the ISP

The case manager must complete an assessment of the client's needs in accordance with the Activities by Acuity document. It is critical that the ISP be updated in collaboration with the client, considering his/her priorities and perception of needs. The ISP should be revised at least every 6 months, including any new goals identified and completed. This includes a re-evaluation of health issues related to HIV and non-HIV, resources available to a client, as well as compliance with treatment adherence. The case manager will ensure that PWH who do not access or utilize primary medical care from the RW facility itself can still receive other supportive services if desired. Access to other HIV supportive services is *not* conditional upon access to or use of primary medical care.

Table 7. Re-Evaluating the ISP	
Standard	Measure
7.1 ISPs for medical and non-medical case management clients should ensure that all areas of assessment have been completed and	At minimum, the assessment should cover the following areas: <ul style="list-style-type: none"> <li>• Medical History/Physical Health Status</li> </ul>

# Case Management Standards of Operations

	updated in accordance with the Activities by Acuity Level document.	<ul style="list-style-type: none"> <li>• Medical Treatment and Adherence</li> <li>• Health Insurance</li> <li>• Family/Domestic Situation</li> </ul>
7.2	ISPs for ADAP and HICP clients should ensure that all areas of assessment have been addressed and updated at least every 6 months.	<ul style="list-style-type: none"> <li>• Housing Status</li> <li>• Source of Income</li> <li>• Nutrition/Food</li> <li>• Mental Health</li> <li>• Substance Abuse</li> <li>• Personal and Community Support Systems</li> <li>• Disclosure</li> <li>• Risk Reduction</li> <li>• Legal Issues</li> <li>• Transportation</li> <li>• Cultural Beliefs and Practices/Languages</li> <li>• Dental</li> <li>• Emergency Financial Assistance</li> <li>• Additional Service Needs</li> </ul> <p>Ensure that documentation (case notes, initial assessment, or re-assessment) is in the client's record.</p>
7.3	All medical and non-medical case management clients must have an Acuity Scale and ISP revised in accordance with the Activities by Acuity Level document.	The following information must be provided for each area assessed on the ISP: Identified Needs, Goals, Interventions/Timelines, and Outcomes. Documentation (case notes, initial assessment, or re-assessment) in client's record.

## Termination of Case Management Services/Discharge Planning

Termination of Case Management Services/Discharge Planning is an important component of medical and non-medical case management. There are legitimate reasons for terminating medical case management services with a client, but keep in mind that termination must never be assumed. A good faith effort must be attempted and clearly documented in the client's chart prior to discharge from case management.

<b>Table 8. Discharge</b>	
<b>Standard</b>	<b>Measure</b>
<p>8.1 Discharge a client from case management services if any of the following conditions apply:</p> <ul style="list-style-type: none"> <li>• Client is deceased</li> <li>• Client requests discharge and is no longer receiving RW Part B Program services (except ADAP/HICP only clients with completed declination form)</li> </ul>	<p>Reason for discharge must be documented.</p> <p>Upon re-enrolling in case management services, the prior documentation detailing the reason for discharge must remain in the chart for explanation of lapses in case management services.</p>



# Case Management Standards of Operations

<ul style="list-style-type: none"><li>• If a client's actions put the agency, <del>case manager</del> staff, or other clients at risk (i.e., terrorist threats, threatening or violent behavior, obscenities, harassment, or stalking behavior).</li><li>• If client moves/re-locates out of service area</li><li>• If after repeated and documented attempts, a case manager is unable to reach a client for six (6) months.</li><li>• <i>If the client no longer meets Ryan White eligibility requirements.</i></li></ul>	
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## Section 6: Documentation

Documentation is a key means of communication amongst team members. It contributes to a better understanding of PWH and their family/caregiver's unique needs and allows for interdisciplinary service delivery to address those needs while reflecting the accountability and involvement of the case manager. Documentation is an important process that facilitates and explains what services were provided and what actions were taken. Documentation will facilitate communication between service providers and ensure coordinated, rather than fragmented service provision. It is important to be able to provide relevant client information at any given time. This is necessary for the legal protection of both the agency and the case manager. *Remember "if it's not documented, it never happened".*

Documentation runs concurrently throughout the entire case management process and should be objective, specific, descriptive, substantive, concise, accurate, up-to-date, meaningful, and consistent. The following information should be documented:

- history and needs of client
- any services that were rendered
- outcomes achieved or not during periodic review
- any additional information (e.g. case conferences, email exchanges, consultation with others, and any additional exchanges regarding the client).

Case note documentation should be complete so anyone reading the case notes can understand who the client is, what brought them to the office, what goals were established, what is the plan, what interventions were used, and what referral/follow-up will happen, if any (who, what, where, when, why and how). It is also useful to record contact and other details of agencies used, such as phone numbers and contact names of an interpreter service, or the hours of availability of a service provider for future reference. Language in case notes needs to be strengths based. Anyone reading the case note can clearly identify how a timeline of events has or will occur systematically. Documentation must ensure that the following activities are being completed for all new and established case management clients:

### New

- Standardized Case Management Intake
- Acuity Scale

# Case Management Standards of Operations

- Acuity Scale completed and leveled in accordance with the Activities by Acuity Level document
- ISP
- Case note

## Established Clients

- Acuity Scale updated every 3-6 months and leveled in accordance with the Activities by Acuity Level document
- The ISP updated every 3-6 months and leveled in accordance with the Activities by Acuity Level document
- Case notes documented in client's chart, in accordance with the Activities by Acuity Level document

To standardize documentation and be in alignment with federal guidelines, all case note documentation must be reflective of how healthcare outcomes are being improved as well as how providing guidance and assistance is improving access to services for clients. In 2017, the Georgia Ryan White Part B Program adopted two standardized formats for documenting case notes for charting: 1) APIE (Assessment, Plan, Intervention, and Evaluation); and 2) SOAP notes (Subjective, Objective, Assessment, and Plan). Medical and Non-Medical Case Management services are provided by both case managers and nurse case managers. The nurse case manager often functions in a dual capacity as both nurse and case manager, which means he/she is also expected to follow Georgia Case Management Standard Operating Procedures during service provision.

The case manager will have the option of using an APIE or SOAP note format. Nurse case managers can continue to use the SOAP note format for documentation in client charts. APIE is a format that condenses client statements by combining subjective and objective information into the Assessment section. APIE format combines the actions with the expected outcomes of client care into the Plan component.

The four phases of **APIE** are:

- **Assessment:** information about the client's presenting issues, gathering of the facts, some historical perspective, and assessment of the client's needs
- **Plan:** a plan is developed to address the identified need of the client
- **Implementation:** specific tasks or action steps that need to be taken to fulfill the plan
- **Evaluation:** provides a means for accountability in ensuring that the plan is being worked on and progress is updated. It should include timelines and specific measurable outcomes

A **SOAP** note is another documentation format used to document in a client's chart.

The four parts of SOAP note documentation are:

- **Subjective:** describes the client's perception of their condition in narrative form
- **Objective:** documents your perception of the client's physical state or status
- **Assessment:** details the assessment or presenting reason for the visit
- **Plan:** describes the plan for managing the client's concern/condition

Regardless of the documentation format utilized APIE or SOAP, the content must detail the following: Reason for the interaction with the client, client's needs, if any; unique circumstances or changes since the last assessment/encounter; current medical status; if any changes and actions taken to address the

# Case Management Standards of Operations

needs and/or interventions performed on behalf of the client. The strength of case management services provided depends on good documentation in the client's records. Charts should include:

- Important enrollment forms and information such as intake forms, consent for enrollment forms, release of information forms, etc.
- Client information used to develop the initial assessment and the individualized service plan (ISP), monitoring activities, and revisions to the ISP
- Medical information and service provider information, and confirmation of diagnosis
- Benefits/entitlement counseling and referral services provided. Documentation should include assistance in obtaining access to both public and private programs, such as but not limited to, Medicaid, Medicare Part D, Patient Assistance Programs (PAP), co-pay cards, AIDS Drug Assistance Programs (ADAP), other state and local healthcare documents and supportive services
- The nature, content, units of case management services provided and whether the goals specified in the care plan have been achieved and/ next steps to achieve goal
- Whether the client has declined services at any time while being an active client in case management
- Timelines for providing services and re-evaluations
- Clear documentation of the need and coordination with case managers of other programs
- Entries should be documented in chronological order. Do not skip lines or leave spaces
- Be specific, use time frames, and quotations if indicated. Avoid generalizations with documentation
- Avoid labeling or judging a client, family, or visitor in the documentation
- Use a problem-oriented approach: identify the problem, state what was done to solve it, and document any follow-up instructions including timelines as well as the outcome
- Document all interactions with the client, outside organizations and other consulting disciplines

## General Documentation Principles

Follow general documentation principles including:

- Document in ink only or typed notes for electronic medical record (EMR)
- Record the PWH name and identifiers (e.g., date of birth or clinic ID number) on every page
- Record date on all entries
- Document the duration of the encounter (i.e., 15 minutes, 30 minutes, 1 hour etc.)
- Ensure the type of encounter is identified (face-to-face, telephone contact, consult, etc.)
- Personnel must sign all entries with full name and professional title.
- Ensure that entries are legible
- All entries should be made in a timely manner (i.e., the same day).
- Late entries should be clearly indicated as such (i.e., document as Late entry for (date of encounter
- If an error is made, then make one strike through the error, initial and date the error, ***do not use white out under any circumstances***
- Thoroughly complete all forms, applications, and other documents with the most accurate information available
- **Do not** alter forms, applications, or other documents
- **Do not** forge signatures (i.e., do not sign for the provider (MD/DO, APRN, PA), client, etc.)

# Case Management Standards of Operations

- Things staff must avoid:
  - Casual abbreviations
  - Taking shortcuts at the cost of clarity (re-read out loud)
  - Generalizations or over-interpretations
  - Grammatical errors
  - Negative, biased, and prejudicial language.
- Use of medical diagnoses that have not been verified by a medical provider (i.e., rather than “the client is depressed”, say, “client states that PWH is having feelings of sadness or depressed mood” or “describes seeing hallucinations or feeling sad daily”

Note: Submission of incomplete, inaccurate, or altered applications may result in delays in client services. Submission of incomplete ADAP applications will result in the delay of medications to the client.

<b>Table 9. Documentation</b>	
<b>Standard</b>	<b>Measure</b>
9.1 Each agency must have a documentation policy.	Written policy on file at provider agency.
9.2 Case Managers must participate in documentation training	Training records in personnel file
9.3 Case managers must ensure that appropriate signatures are on all applicable documents	Documents maintained in client’s charts
9.4 Case Managers must document all interactions or collaborations which occurred on client’s behalf.	Documents maintained in client’s charts
9.5 Each client’s case management record must be complete and include all relevant forms and documentation	Client chart contains all relevant forms, proof of eligibility, ISP, case notes, and other pertinent documents

# Case Management Standards of Operations

## Appendix A

# Case Management Standards of Operations

## CLIENT INTAKE

☐ New Client ☐ Annual Recert ☐ Re-Enroll

Date:

Social Security #:

Client #:

### PERSONAL INFORMATION

PRIMARY LANGUAGE \_\_\_\_\_

NAME: \_\_\_\_\_

NEED INTERPRETER ☐ YES ☐ NO

STREET ADDRESS \_\_\_\_\_

CITY/STATE \_\_\_\_\_

ZIP \_\_\_\_\_

ALTERNATE ADDRESS \_\_\_\_\_

CITY/STATE \_\_\_\_\_

ZIP \_\_\_\_\_

COUNTY \_\_\_\_\_ SEXUAL IDENTITY: \_\_\_\_\_

Preferred Method of Contact ☐ PHONE ☐ MAIL ☐ EMAIL

Consent to Send Mail ☐ YES ☐ NO Consent to Send Email ☐ YES ☐ NO Email \_\_\_\_\_

Anonymous return address requested ☐ YES ☐ NO

(\_\_\_\_\_) May we leave a message? ☐ YES ☐ NO Message/Day Phone (\_\_\_\_\_) \_\_\_\_\_

HOME PHONE

Discreet message only: ☐ YES ☐ NO May we contact you at work? ☐ YES ☐ NO PHONE (\_\_\_\_\_) \_\_\_\_\_

ETHNICITY: ☐ HISPANIC/LATINO ☐ NON-HISPANIC/NON-LATINO

RACE: ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER

☐ AMERICAN INDIAN OR ALASKAN NATIVE

☐ OTHER

### KEY CONTACTS

EMERGENCY CONTACT \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

PHONE NUMBER

(\_\_\_\_\_) \_\_\_\_\_

AWARE OF STATUS? ☐ YES ☐ NO

HIV/AIDS PROVIDER \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

PRIMARY CARE PROVIDER \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

DENTAL PROVIDER \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

BEHAVIORAL HEALTH PROVIDER \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

REFERRAL AGENCIES \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

### EDUCATION/DISABILITY

Do you have a disability? ☐ YES ☐ NO

If yes, please explain.

Highest level of education completed? \_\_\_\_\_

Case Managers Initials: \_\_\_\_\_

Date: \_\_\_\_\_

**Place Client Label Here**

# Case Management Standards of Operations

## Appendix B



# Case Management Standards of Operations

## 2022 Income Expense Sreadsheet

Is client's income enough to cover monthly expenses? Yes \_\_\_ No \_\_\_

INCOME		EXPENSES	
SOURCE	AMOUNT	ITEMIZATION	AMOUNT
Salary		RENT/Mortgage	
Spouse's Salary		Property Tax	
Short-Term Disability		Insurance (renters/house)	
Long-Term Disability		Phone (cell/home)	
SSI		Utilities (Electric)	
SSDI		Utilities (Gas)	
TANF		Utilities (Water)	
Pension		Cable/Internet	
Child Support		Garbage Collection	
Alimony		Car Payment	
General Assistance		Car insurance	
Food Stamps		Car maintenance	
Rental Income		Gasoline	
Unemployment		Transportation (Taxi/public transportation/ other)	
Retirement Benefits		CARE Assist Cost Share	
Family Support		Food (grocery, lunch, eating out)	
Savings/Investments		Day Care	
Children SSI		Child Support	
Annuity		Alimony	
Military Income		Medical Insurance	
Other Support		Medical Expense/Co-Pay	
		Medical Equipment	
		Prescription Meds/ Co-Pays	
		Over The Counter Meds	
		Life insurance	
		Personal Hygiene and Toiletries	
		Household and Laundry	
		Recreation/ Leisure (movies, books, activities)	
		Substance Use (Tobacco products, Alcohol, Drugs)	
		Pet expenses (vet, food, maintenance)	
		Monthly Dues (Tithes, probation, memberships)	
		Credit Card	
		Other:	
<b>TOTAL</b>	\$0.00	<b>TOTAL</b>	\$0.00

Place Client Label Here

CM Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Case Management Standards of Operations

## Appendix C

# Case Management Standards of Operations

Case Management Acuity Scale		New Client		Reactivated	Recert
Life Areas	Level 1	Level 2	Level 3	Level 4	
<b>Medical / Physical Health</b> 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score _____	<input type="checkbox"/> Lab work periodically <input type="checkbox"/> Asymptomatic and in medical care 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score _____	<input type="checkbox"/> Needs primary care referral <input type="checkbox"/> HIV care referral needed <input type="checkbox"/> Short-term acute condition in treatment <input checked="" type="checkbox"/> Chronic non-HIV related condition under control with medication /treatment <input type="checkbox"/> HIV symptomatic with one or more conditions that impair overall health	<input type="checkbox"/> Needs treatment or medication for non-HIV related conditions <input type="checkbox"/> Pregnancy <input type="checkbox"/> Debilitating HIV disease symptoms / infections <input type="checkbox"/> Multiple medical diagnoses <input type="checkbox"/> Home bound; home health care services needed	<input type="checkbox"/> Medical Emergency <input type="checkbox"/> End-stage of HIV disease <input type="checkbox"/> Intensive and or complicated home care required <input type="checkbox"/> Hospice services or placement	
<b>Medical Treatment and Adherence</b> 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score _____	<input type="checkbox"/> Adherent to medications > six months w/o assistance <input type="checkbox"/> Maintain primary care appts. <input type="checkbox"/> Not currently prescribed medication <input type="checkbox"/> Expresses no issues w/side effects or their schedule	<input type="checkbox"/> Adherent to medication as prescribed < six months or > 3 months w/ minimal assist <input type="checkbox"/> Keeps majority of medical appts	<input type="checkbox"/> Adherent only w/ assistance <input type="checkbox"/> Doesn't understand prescribed medications <input type="checkbox"/> Consistently misses doses of medication <input type="checkbox"/> Misses at least half of scheduled medical appts <input type="checkbox"/> Takes long/extended "drug holidays" against medical advice	<input type="checkbox"/> Resists adherence to medication & treatment plans w/assistance <input type="checkbox"/> Refuses/declines to take medication against medical advice <input type="checkbox"/> Uses ER only for primary care <input type="checkbox"/> Inability to take meds as scheduled; requires professional assistance to take medication and keep appointments <input type="checkbox"/> Cannot describe or name current medication <input type="checkbox"/> New to care	
<b>Dental</b> 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score _____	<input type="checkbox"/> Current w/care <input type="checkbox"/> Has seen a dentist w/I the past six months <input type="checkbox"/> No complaints of pain <input type="checkbox"/> Practices oral hygiene daily	<input type="checkbox"/> Has not seen dentist w/I six months <input type="checkbox"/> Has dentures requesting dental follow-up care <input type="checkbox"/> Does not practice daily oral hygiene	<input type="checkbox"/> Has not seen a dentist > 1 yr. <input type="checkbox"/> Reports episodic issues with the mouth and pain <input type="checkbox"/> Reports problems with teeth, gums, and mouth <input type="checkbox"/> Reports difficulty eating	<input type="checkbox"/> Has never seen a dentist <input type="checkbox"/> Current or severe pain reported <input type="checkbox"/> Reports severe or major problems with teeth, gums, mouth <input type="checkbox"/> Few or no teeth <input type="checkbox"/> Reports significant difficulty eating	

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# Case Management Standards of Operations

Life Events	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 1	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 2	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 3	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 4
Behavioral Health  1 <sup>st</sup> Date 1 <sup>st</sup> Score  2 <sup>nd</sup> Date 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> No history of behavioral health issues, psychological /tropic disorder, or medications <input type="checkbox"/> <input type="checkbox"/> No counseling referral needed	<input type="checkbox"/> <input type="checkbox"/> History of disorder/treatments with client/family background <input type="checkbox"/> <input type="checkbox"/> High stress level of client/family dynamic; emotional support referral to avert crisis <input type="checkbox"/> <input type="checkbox"/> Depressed but functions along w/others <input type="checkbox"/> <input type="checkbox"/> Difficulty in getting treatment	<input type="checkbox"/> <input type="checkbox"/> In acute episode and/or crisis <input type="checkbox"/> <input type="checkbox"/> Severe stress, behavioral assessment needed <input type="checkbox"/> <input type="checkbox"/> Depressed non-functioning <input type="checkbox"/> <input type="checkbox"/> Requires significant emotional support <input type="checkbox"/> <input type="checkbox"/> Cannot get along with others <input type="checkbox"/> <input type="checkbox"/> Recently Hospitalization <input type="checkbox"/> <input type="checkbox"/> Currently Not adherent	<input type="checkbox"/> <input type="checkbox"/> Is a danger to self/others <input type="checkbox"/> <input type="checkbox"/> Needs immediate psychiatric assessment <input type="checkbox"/> <input type="checkbox"/> Active chaos due to violence / abuse <input type="checkbox"/> <input type="checkbox"/> Requires therapy, not accessing it <input type="checkbox"/> <input type="checkbox"/> Pregnant and not taking medication
Substance Abuse/Addictions  1 <sup>st</sup> Date 1 <sup>st</sup> Score  2 <sup>nd</sup> Date 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> No addictions w/alcohol, drugs, sex, and/or gambling <input type="checkbox"/> <input type="checkbox"/> Past Problems w/addictions; > 1 yr. in recovery <input type="checkbox"/> <input type="checkbox"/> No need for treatment referral	<input type="checkbox"/> <input type="checkbox"/> Past problem(s) with addiction; < yr. in recovery	<input type="checkbox"/> <input type="checkbox"/> Current w/addiction; willing to get treatment. Impacts client functionality and the ability to be medically adherent <input type="checkbox"/> <input type="checkbox"/> Major addiction impairment of significant other	<input type="checkbox"/> <input type="checkbox"/> Active Addiction; not willing to get treatment or resume treatment <input type="checkbox"/> <input type="checkbox"/> Fails to realize the impact of addiction on life/indifference regarding consequences of substance abuse <input type="checkbox"/> <input type="checkbox"/> Pregnant and actively using
Support System  1 <sup>st</sup> Date 1 <sup>st</sup> Score  2 <sup>nd</sup> Date 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> Has strong support of family/friends/peers <input type="checkbox"/> <input type="checkbox"/> No support system needed	<input type="checkbox"/> <input type="checkbox"/> Strong systems in place; requests additional support <input type="checkbox"/> <input type="checkbox"/> Few family/friends in area <input type="checkbox"/> <input type="checkbox"/> Family/friends/peers often not available during crisis <input type="checkbox"/> <input type="checkbox"/> Gaps in support system	<input type="checkbox"/> <input type="checkbox"/> No stable system in place <input type="checkbox"/> <input type="checkbox"/> Only available support is through professional services	<input type="checkbox"/> <input type="checkbox"/> Crisis is imminent <input type="checkbox"/> <input type="checkbox"/> Acute situation; client unable to cope w/o professional support with particular situation / time frame
Violence and Trauma  1 <sup>st</sup> Date 1 <sup>st</sup> Score  2 <sup>nd</sup> Date 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> No history of violence or domestic abuse	<input type="checkbox"/> <input type="checkbox"/> History of past violence/abuse with relationships	<input type="checkbox"/> <input type="checkbox"/> Current issues of violence/abuse occurring <input type="checkbox"/> <input type="checkbox"/> Agency(s) currently involved; signs of abuse (emotional, sexual, and physical)	<input type="checkbox"/> <input type="checkbox"/> Current Chronic violence/abuse occurring <input type="checkbox"/> <input type="checkbox"/> Medical/Legal intervention currently occurring <input type="checkbox"/> <input type="checkbox"/> Unsafe home environment

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# Case Management Standards of Operations

Life Events	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 1	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 2	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 3	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 4
<b>Legal</b> _____ 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> No recent or current legal issues <input type="checkbox"/> <input type="checkbox"/> Legal documents completed	<input type="checkbox"/> <input type="checkbox"/> Possible current or legal issues <input type="checkbox"/> <input type="checkbox"/> Wants assistance completing legal documents	<input type="checkbox"/> <input type="checkbox"/> Currently involved with civil or criminal matter <input type="checkbox"/> <input type="checkbox"/> Unaware of standard legal documents necessary to current situation <input type="checkbox"/> <input type="checkbox"/> Incarcerated	<input type="checkbox"/> <input type="checkbox"/> Crisis involving legal issues present (altercation w/landlord, employer, coworkers, civil or criminal)
<b>Culture and Language</b> _____ 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> Can navigate service system & understands <input type="checkbox"/> <input type="checkbox"/> No language barrier accessing system (includes sign language)	<input type="checkbox"/> <input type="checkbox"/> Needs interpreter for Medical and CNJ services <input type="checkbox"/> <input type="checkbox"/> Family/others needs education and interpreter to provide support to client <input type="checkbox"/> <input type="checkbox"/> Few cultural barriers accessing services	<input type="checkbox"/> <input type="checkbox"/> Interpreter needed to access additional services <input type="checkbox"/> <input type="checkbox"/> Family lacks understanding and is barrier to care <input type="checkbox"/> <input type="checkbox"/> Some cultural barriers to accessing services	<input type="checkbox"/> <input type="checkbox"/> Family's lack of understanding is a barrier for client accessing services <input type="checkbox"/> <input type="checkbox"/> Current crisis intervention needed
<b>Food</b> _____ 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> Eats at least 2 meals/daily <input type="checkbox"/> <input type="checkbox"/> No problems w/weight <input type="checkbox"/> <input type="checkbox"/> No problems eating <input type="checkbox"/> <input type="checkbox"/> No other food related morbidities (diabetes, hypertension or hyperlipidemia requiring diet changes)	<input type="checkbox"/> <input type="checkbox"/> Changes in eating habits last 3 months <input type="checkbox"/> <input type="checkbox"/> Unplanned weight loss < 3 months <input type="checkbox"/> <input type="checkbox"/> Overweight <input type="checkbox"/> <input type="checkbox"/> Chronic medical condition requiring diet changes; following diet plan	<input type="checkbox"/> <input type="checkbox"/> Moderate problems w/eating (dental issues, thrush, etc.) <input type="checkbox"/> <input type="checkbox"/> Shows signs of "wasting syndrome" or other physical malades <input type="checkbox"/> <input type="checkbox"/> Obese <input type="checkbox"/> <input type="checkbox"/> Difficulty following chronic medical condition diet plan <input type="checkbox"/> <input type="checkbox"/> Needs assistance getting food	<input type="checkbox"/> <input type="checkbox"/> Severe problems w/eating <input type="checkbox"/> <input type="checkbox"/> Significant weight loss < 3 months <input type="checkbox"/> <input type="checkbox"/> Persistent nausea, vomiting and/or diarrhea <input type="checkbox"/> <input type="checkbox"/> Obesity impairs activities <input type="checkbox"/> <input type="checkbox"/> Needs referral to registered dietician for nutritional therapy w/chronic condition for diet <input type="checkbox"/> <input type="checkbox"/> Difficulty obtaining food
<b>Transportation</b> _____ 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> Has consistent transportation options <input type="checkbox"/> <input type="checkbox"/> Can afford private or public transportation	<input type="checkbox"/> <input type="checkbox"/> Has very little private transportation options <input type="checkbox"/> <input type="checkbox"/> Needs occasional assistance w/transportation to/from appointments	<input type="checkbox"/> <input type="checkbox"/> No access to private transportation <input type="checkbox"/> <input type="checkbox"/> Resides in area with little to no public transport access <input type="checkbox"/> <input type="checkbox"/> No knowledge of transportation services and/or needs help accessing	<input type="checkbox"/> <input type="checkbox"/> No transportation services available causing a crisis <input type="checkbox"/> <input type="checkbox"/> No transportation services <u>is</u> causation for medical appointment adherence

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# Case Management Standards of Operations

Life Events	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 1	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 2	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 3	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 4
<b>Income</b> _____ 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> Stable steady source of income <input type="checkbox"/> <input type="checkbox"/> Has savings and/or resource Can pay monthly bills	<input type="checkbox"/> <input type="checkbox"/> Income source in jeopardy <input type="checkbox"/> <input type="checkbox"/> Has short-term benefits <input type="checkbox"/> <input type="checkbox"/> Needs information about benefits, financial assistance <input type="checkbox"/> <input type="checkbox"/> Occasional need of financial assistance	<input type="checkbox"/> <input type="checkbox"/> No income <input type="checkbox"/> <input type="checkbox"/> Benefits denied <input type="checkbox"/> <input type="checkbox"/> Unfamiliar with application process; needs assistance <input type="checkbox"/> <input type="checkbox"/> Needs financial planning counseling	<input type="checkbox"/> <input type="checkbox"/> Emergency financial assistance needed <input type="checkbox"/> <input type="checkbox"/> Referral to representative payee for immediate assistance
<b>Emergency Financial Assistance</b> _____ 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> Needs no financial assistance <input type="checkbox"/> <input type="checkbox"/> Able to access w/o assistance <input type="checkbox"/> <input type="checkbox"/> Lives w/I financial means	<input type="checkbox"/> <input type="checkbox"/> Needs financial assistance 1-2 times / yearly <input type="checkbox"/> <input type="checkbox"/> Needs information on application process for assistance	<input type="checkbox"/> <input type="checkbox"/> Needs financial assistance 3-6 times/ yr. <input type="checkbox"/> <input type="checkbox"/> Difficulty maintaining sufficient income for meeting basic needs <input type="checkbox"/> <input type="checkbox"/> Assistance needed on budgeting and financial planning	<input type="checkbox"/> <input type="checkbox"/> Needs financial assistance > 6 times/yr. <input type="checkbox"/> <input type="checkbox"/> In financial crisis, immediate assistance requested
<b>Housing</b> _____ 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> Affordable, stably housed, meets client needs <input type="checkbox"/> <input type="checkbox"/> Resides in supportive housing program	<input type="checkbox"/> <input type="checkbox"/> Safe & secure non-subsidized housing <input type="checkbox"/> <input type="checkbox"/> Lives in stable subsidized housing <input type="checkbox"/> <input type="checkbox"/> Housing in jeopardy; assistance w/rent, utilities to remain housed <input type="checkbox"/> <input type="checkbox"/> Lives in long-term transitional rented housing	<input type="checkbox"/> <input type="checkbox"/> Temporarily residing with family/friends <input type="checkbox"/> <input type="checkbox"/> Eviction is Imminent <input type="checkbox"/> <input type="checkbox"/> Lives in transitional shelter	<input type="checkbox"/> <input type="checkbox"/> Needs assisted living facility <input type="checkbox"/> <input type="checkbox"/> Home uninhabitable; health and/or safety hazards <input type="checkbox"/> <input type="checkbox"/> Recently evicted from rental subsidy program <input type="checkbox"/> <input type="checkbox"/> Homeless (lives in emergency shelter, car, street or camping etc.) <input type="checkbox"/> <input type="checkbox"/> Pregnant
<b>Risk Reduction</b> _____ 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> Abstains from risk behaviors through safe practices <input type="checkbox"/> <input type="checkbox"/> Good understanding of risks <input type="checkbox"/> <input type="checkbox"/> Understands preventing spread of HIV/reinfection	<input type="checkbox"/> <input type="checkbox"/> Has occasional risky behavior <input type="checkbox"/> <input type="checkbox"/> Fair understanding of risks	<input type="checkbox"/> <input type="checkbox"/> Has moderately risky behavior <input type="checkbox"/> <input type="checkbox"/> Has poor understanding of risks <input type="checkbox"/> <input type="checkbox"/> Mild to moderate risky behavior related to A&D, BH issues or relationship barriers to safer behaviors	<input type="checkbox"/> <input type="checkbox"/> Significant risky behavior <input type="checkbox"/> <input type="checkbox"/> Has little understanding or risks Has Significant risk behavior related to A&D, BH issues or relationship barriers to safer behaviors

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# Case Management Standards of Operations

Life Events	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 1	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 2	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 3	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> Level 4
Health Insurance _____ 1 <sup>st</sup> Date _____ 1 <sup>st</sup> Score _____ 2 <sup>nd</sup> Date _____ 2 <sup>nd</sup> Score	<input type="checkbox"/> <input type="checkbox"/> Has health insurance and/or other medical coverage <input type="checkbox"/> <input type="checkbox"/> Has ability to pay own coverage/care <input type="checkbox"/> <input type="checkbox"/> Can pay monthly bills	<input type="checkbox"/> <input type="checkbox"/> Income source in jeopardy <input type="checkbox"/> <input type="checkbox"/> Has short-term benefits <input type="checkbox"/> <input type="checkbox"/> Needs information about benefits, financial assistance <input type="checkbox"/> <input type="checkbox"/> Occasional need of financial assistance	<input type="checkbox"/> <input type="checkbox"/> No income <input type="checkbox"/> <input type="checkbox"/> Benefits denied <input type="checkbox"/> <input type="checkbox"/> Unfamiliar with application process, needs assistance <input type="checkbox"/> <input type="checkbox"/> Needs financial planning counseling	<input type="checkbox"/> <input type="checkbox"/> Emergency financial assistance needed <input type="checkbox"/> <input type="checkbox"/> Referral to health insurance representative to assist client with obtaining health insurance coverage

1<sup>st</sup> Total Score  Assigned Acuity Level  Date  Level 1 Self-Management 16-17 points

Level 2 Supportive 18-22 points

2<sup>nd</sup> Total Score  Assigned Acuity Level  Date  Level 3 Intermediate 23-37 points

Level 4 Intensive 38-64 points

1<sup>st</sup> Case Managers Name \_\_\_\_\_ CM Initials  Date \_\_\_\_\_

2<sup>nd</sup> Case Managers Name \_\_\_\_\_ CM Initials  Date \_\_\_\_\_



# Case Management Standards of Operations

## Appendix D

# Case Management Standards of Operations

## Case Management Individual Service Plan

Area of Assessment	Identified Needs List clients' current situation.	Goal(s) Outcomes/Desired. List client goals.	Intervention/Time Frame What steps will be implemented to assist client in achieving their goal? Who is assigned to follow-up and when?	Outcome and reevaluation date. What time frame ISP goals/objectives should be reviewed?
<b>Medical History/ Physical Health</b>  Client Initial _____	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>
<b>Dental</b>  Client Initial _____	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>
<b>Medical Treatment/ Adherence</b>  Client Initial _____	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>
<b>Health Insurance</b>  Client Initial _____	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>

Docu

Client Name  Client ID #  Date:

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# Case Management Standards of Operations

## Case Management Individual Service Plan

Area of Assessment	Identified Needs. List clients' current situation.	Goal(s) Outcomes/Desired. List client goals.	Intervention/Time Frame What steps will be implemented to assist client in achieving their goal? Who is assigned to follow-up and when?	Outcome and reevaluation date. What time frame ISP goals/objectives should be reviewed?
<b>Mental Health</b>	[Click here to enter text]	[Click here to enter text]	[Click here to enter text]	[Click here to enter text]
Client Initial _____				
<b>Substance Abuse/Addiction</b>	[Click here to enter text]	[Click here to enter text]	[Click here to enter text]	[Click here to enter text]
Client Initial _____				
<b>Income</b>	[Click here to enter text]	[Click here to enter text]	[Click here to enter text]	[Click here to enter text]
Client Initial _____				
<b>Housing</b>	[Click here to enter text]	[Click here to enter text]	[Click here to enter text]	[Click here to enter text]
Client Initial _____				

Client Name [ ] Client ID # [ ] Date: [ ]

# Case Management Standards of Operations

## Case Management Individual Service Plan

Area of Assessment	Identified Needs. List clients' current situation.	Goal(s) Outcomes/Desired. List client goals.	Intervention/Time Frame What steps will be implemented to assist client in achieving their goal? Who is assigned to follow-up and when?	Outcome and reevaluation date. What time frame ISP goals/objectives should be reviewed?
<b>Mental Health</b>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
Client Initial _____				
<b>Substance Abuse/Addiction</b>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
Client Initial _____				
<b>Income</b>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
Client Initial _____				
<b>Housing</b>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
Client Initial _____				

Client Name  Client ID #  Date:

# Case Management Standards of Operations

## Case Management Individual Service Plan

Area of Assessment	Identified Needs List clients' current situation.	Goal(s) Outcomes/Desired. List client goals.	Intervention/Time Frame What steps will be implemented to assist client in achieving their goal? Who is assigned to follow-up and when?	Outcome and reevaluation date. What time frame ISP goals/objectives should be reviewed?
Risk Reduction	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>
Client Initial				
Disclosure	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>
Client Initial				
Transportation	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>
Client Initial				
Legal	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>
Client Initial				

Client Name  Client ID #  Date:

# Case Management Standards of Operations

## Case Management Individual Service Plan

Area of Assessment	Identified Needs List clients' current situation.	Goal(s) Outcomes/Desired. List client goals.	Intervention/Time Frame What steps will be implemented to assist client in achieving their goal? Who is assigned to follow-up and when?	Outcome and reevaluation date. What time frame ISP goals/objectives should be reviewed?
Cultural Beliefs  Client Initial _____	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>	<a href="#">[Click here to enter text]</a>

Client ID #

Acuity Level

Client Name

Client Signature \_\_\_\_\_

Client Initials \_\_\_\_\_

Date

Case Managers Name \_\_\_\_\_

CM Initials \_\_\_\_\_

Date

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# Case Management Standards of Operations

## Appendix E

# Case Management Standards of Operations

## Activities by Acuity Levels

Level 4 (Intensive) 38-64 points	Level 3 (Intermediate) 23-37 points
<p style="text-align: center;"><u>Intake</u></p> <ul style="list-style-type: none"> <li>• Case Management Intake and assessment should be completed within 15 days of beginning intake.</li> <li>• Complete the Acuity Scale assessment.</li> <li>• Develop the initial ISP based on identified needs or current situation including goals, barriers, task, and outcomes within 30 days of beginning Intake.</li> <li>• An ISP should be completed upon Intake regardless of Acuity Level score.</li> <li>• Additional goals, activities, and outcomes should be documented in the case notes.</li> <li>• Newly diagnosed clients should automatically be assigned a Level 3 or 4.</li> </ul>	<p style="text-align: center;"><u>Intake</u></p> <ul style="list-style-type: none"> <li>• Case Management Intake and assessment should be completed within 30 days of beginning intake.</li> <li>• Complete the Acuity Scale assessment.</li> <li>• Develop the initial based on identified needs or current situation including goals, barriers, task, and outcomes within 30 days of beginning Intake.</li> <li>• An ISP should be completed upon Intake regardless of Acuity Level score.</li> <li>• Additional goals, activities, and outcomes should be documented in the case notes.</li> <li>• Newly diagnosed clients should automatically be assigned a Level 3 or 4.</li> </ul>
<p style="text-align: center;"><u>Established Client</u></p> <ul style="list-style-type: none"> <li>• Revise the Acuity Scale and ISP a minimum of every 3 months from the last date both documents were completed.</li> <li>• Additional goals, activities, and outcomes should be documented in the case notes. A case note should be completed for every encounter with the client or consult regarding the client.</li> <li>• Assist with referrals and follow-up as appropriate.</li> <li>• Timely and coordinated access to medically appropriate levels of health and support services and continuity of care.</li> <li>• Continuous client monitoring to assess the efficacy of the ISP.</li> <li>• Ongoing assessment of clients and other family members' needs and personal support systems.</li> <li>• Treatment adherence counseling to ensure readiness and adherence to HIV treatments.</li> <li>• Provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible.</li> <li>• Consult with multi-disciplinary team, case management supervisor and others as needed.</li> <li>• The majority of case management services provided are medical vs. non-medical, the objective is to <u>improve health care outcomes</u>.</li> <li>• Minimum contact (phone, face-to-face, or consult) every 30 days.</li> </ul>	<p style="text-align: center;"><u>Established Client</u></p> <ul style="list-style-type: none"> <li>• Revise the Acuity Scale and ISP a minimum of every 6 months from the last date both documents were completed.</li> <li>• Additional goals, activities, and outcomes should be documented in the case notes. A case note should be completed for every encounter with the client or consult regarding the client.</li> <li>• Assist with referrals and follow-up as appropriate.</li> <li>• Timely and coordinated access to medically appropriate levels of health and support services and continuity of care.</li> <li>• Continuous client monitoring to assess the efficacy of the ISP.</li> <li>• Ongoing assessment of clients and other family members' needs and personal support systems.</li> <li>• Treatment adherence counseling to ensure readiness and adherence to HIV treatments.</li> <li>• Provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible.</li> <li>• Consult with multi-disciplinary team, case management supervisor and others as needed.</li> <li>• The majority of case management services provided are medical vs. non-medical, the objective is to improve health care outcomes. minimum contact (phone, face-to-face, or consult) every 2-3 months.</li> </ul>



# Case Management Standards of Operations

Level 2 (Supportive)	18-22 points	Level 1 (Self-Management)	16-17 points
<p style="text-align: center;"><u>Intake</u></p> <ul style="list-style-type: none"> <li>Case Management Intake and assessment should be completed within 30 days of beginning intake.</li> <li>Complete the Acuity Scale assessment.</li> <li>Develop the ISP based on identified needs or current situation including goals, barriers, task, and outcomes within 30 days of beginning Intake.</li> <li>An ISP should be completed upon Intake regardless of Acuity Level score.</li> <li>Additional goals, activities, and outcomes should be documented in the case notes.</li> <li>Newly diagnosed clients should automatically be assigned a Level 3 or 4.</li> </ul>		<p style="text-align: center;"><u>Intake</u></p> <ul style="list-style-type: none"> <li>Case Management Intake and assessment should be completed within 30 days of beginning intake.</li> <li>Complete the Acuity Scale assessment.</li> <li>Develop the ISP based on identified or current situation including goals, barriers, task, and outcomes within 30 days of beginning Intake.</li> <li>An ISP should be completed upon Intake regardless of Acuity Level score.</li> <li>Additional goals, activities, and outcomes should be documented in the case notes.</li> <li>Newly diagnosed clients should automatically be assigned a Level 3 or 4.</li> </ul>	
<p style="text-align: center;"><u>Established Client</u></p> <ul style="list-style-type: none"> <li>Revise the Acuity Scale and ISP a minimum of every 6 months from the last date both documents were completed.</li> <li>Continuous client monitoring to assess the efficacy of the care plan</li> <li>Ongoing assessment of the client's and other key family members' needs and personal support systems</li> <li>A case note should be completed for every encounter with the client or consult regarding the client (phone, face-to-face, or consult).</li> <li>Assist with referrals and follow-up as appropriate.</li> <li>The majority of case management services provided are non-medical vs. medical, the objective is to provide guidance and assistance in improving access to needed services</li> <li>Minimum contact (phone or face-to-face) at least every 6 months with adaptations as necessary</li> </ul>		<p style="text-align: center;"><u>Established Client</u></p> <ul style="list-style-type: none"> <li>Revise the Acuity Scale and ISP a minimum of every 6 months from the last date both documents were completed.</li> <li>Continuous client monitoring to assess the efficacy of the care plan</li> <li>Ongoing assessment of the client's and other key family members' needs and personal support systems</li> <li>A case note should be completed for every encounter with the client or consult regarding the client (phone, face-to-face, or consult).</li> <li>Assist with referrals and follow-up as appropriate.</li> <li>The majority of case management services provided are non-medical vs. medical, the objective is to provide guidance and assistance in improving access to needed services.</li> <li>Minimum contact (phone or face-to-face) at least every 6 months with adaptations as necessary</li> </ul>	

# Case Management Standards of Operations

## Appendix F

# Case Management Standards of Operations

Georgia Department of Public Health Office of HIV/AIDS  Standard Operating Procedure ( HIV Perinatal Program)	<b>SOP Name: Ryan White Part A, B, C, D Coordination of Prenatal Care</b>	
	Revised Date: 6/21/2018	
	Implementation Date 2018	
Effective Original Date: 2017	Total Pages: 3	Revised Date: 2018
Approval Date: 2017	Date Reviewed: 2018	Approved By: Program Leadership

## Standard Operating Procedure

**1. Purpose:** To strengthen collaboration between all Ryan White Part A, B, C, and D Case Managers, Ryan White Medical Providers, and the referred OB-GYN office(s) (including designated staff) to improve continuity of care for HIV positive pregnant women and increase seamless communication between prenatal and HIV Care providers.

**2. Scope:** The identified population is limited to Perinatal HIV/OB-GYN women receiving services.

**3. Prerequisites:** Electronic Medical Record and/or paper charts, telephone, call conference phone line, notepad, etc.

**4. Responsibilities:** All Ryan White Part A, B, C, and D case managers' responsibilities will be to conduct monthly phone consultations with OB-GYN office to collect information on the patient's prenatal care. All case managers are expected to document consultation notes into their prospective electronic medical record or client paper chart. Case managers are responsible for collecting/updating the following information during the call:

*\*\*\* The following information should be collected from the OB-GYN office for all pregnant clients referred from Ryan White Clinics. \*\*\**

### A. Scheduled prenatal appointment

- Attended prenatal appointment
- Missed prenatal appointment and provide a list of reason(s) for missed appointment
- Rescheduled prenatal appointment

### B. Estimated date of delivery

### C. Discussion on referral for Infectious Disease Pediatrician for infant after delivery

# Case Management Standards of Operations

Georgia Department of Public Health Office of HIV/AIDS  Standard Operating Procedure ( HIV Perinatal Program)	SOP Name: Ryan White Part A, B, C, D Coordination of Prenatal Care	
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## D. Plan of delivery and reason why?

- Vaginal
- C-section

## E. Treatment recommendations ( Medication(s) and dosages)

- ARVs
- AZT for mother at delivery
- Newborn prophylaxis

## F. Nutritional Recommendations

- Discussion of plan relating to formula feeding.
- Discussion of avoidance of pre-mastication of food for baby.

\* Each month all case managers are to submit the HIV Form 582 Perinatal Care Monthly Report to the State Office HIV Perinatal Coordinator.\*

## 5. Procedure:

**Who:** Each month all Ryan White Part A, B, C, and D case managers will call OB-GYN office to discuss prenatal care services regarding their pregnant clients.

\*All case managers will designate a specific day and time each month with the OB-GYN office to conduct the phone consultation.\*

**What:** Phone consultation and Quality Improvement.

**When:** Monthly

**Where:** Via phone consultation

**Why:** To improve communication amongst all case managers, medical providers, OB-GYN, Pharmacy, Hospital, Nutritionist, Social Workers, etc.

# Case Management Standards of Operations

Georgia Department of Public Health Office of HIV/AIDS  Standard Operating Procedure ( HIV Perinatal Program)	<b>SOP Name: Ryan White Part A, B, C, D Coordination of Prenatal Care</b>	
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**6. Follow up for baby:** Highly encourage the Ryan White clinic to follow up with mother and the pediatrician concerning appropriate follow up, testing, and prophylaxis of baby to prevent seroconversion of HIV.

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## 7. Acronyms:

Case manager-CM

Obstetrics and Gynecology- OB-GYN

Follow up- F/U

Electronic medical record-EMR

Cesarean Section- C- section

Zidovudine- AZT

Human Immunodeficiency Virus- HIV

Antiretroviral- ARV

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## 7. Definitions:

**Newly enrolled client:** Client with initial referral to the OB-GYN for prenatal care and appointment has not yet been attended.

**Currently enrolled client:** Client has attended one or more prenatal care scheduled appointments.

# Case Management Standards of Operations

## Appendix G

# Case Management Standards of Operations

## Georgia Case Management Definitions

### Medical Case Management

#### **Medical Adherence Assessment**

- new to treatment or experienced
- change in regimen
- determine willingness to adhere
- by RN in clinical setting

#### **Individual Medication Adherence**

##### **Counseling**

- new to treatment or experienced
- change in regimen
- ongoing regimen
- by RN in clinical setting

#### **Initial Enrollment**

- intake, assessment, and initiation of Individual Service Plan
- coordination and follow-up of medical treatment
- discussion of treatment adherence

#### **Individual Service Plan (ISP)**

- face-to-face
- review progress, identify additional needs, establish next steps, and set new goals
- discuss medical treatment, adherence
- initial or comprehensive updated
- determine acuity level

#### **Interim contacts**

- face-to-face or non face-to-face
- must include coordination and follow-up of medical treatment and adherence
- follow-up on ISP goals and current needs

#### **Discharge linkage**

- coordinate care for clients leaving hospital
- link to clinic, access services and medication
- education on enrollment
- by RN or medical case manager in treatment setting

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### Non-Medical Case Management

#### **Initial Enrollment – Nonmedical**

- intensive enrollment visit for intake and assessment
- explanation of program, navigating health care system, discussion of needs, and collection of eligibility information (income, etc.)
- may include assistance in obtaining medical, social, community, legal, financial, emergency assistance to self-managed client (housing, transportation, food, etc.) and other needed services.

#### **Interim Contacts**

- face-to-face or non face-to-face
- follow-up on ISP goals and current needs
- including obtaining updates on needs and income.
- may include assistance in obtaining medical, social, community, legal, financial, emergency assistance to self-managed client (housing, transportation, food, etc.) and other needed services.

#### **Supportive/Self Management**

- face-to-face or non face-to-face
- reevaluate and update
- does **not** involve coordination or follow-up of medical treatment

#### **Benefits/Financial Counseling**

- enrolling in ADAP, PAP, HICP and other entitlements
- determining eligibility for Medicaid, Medicare, other payer
- regardless of credential of staff performing activity

#### **Peer Encounter**

- face-to-face or non face-to-face
- by a peer advocate/educator
- includes follow-up with clients lost to care, other client follow-up, and navigation
- does not include benefit/financial counseling
- does not include client education

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**Source:** Georgia Ryan White Parts A, B, D CAREWare Sub-services and Definitions, 2018

# Case Management Standards of Operations

## **Appendix H**



# Case Management Standards of Operations

## Georgia Department of Public Health Ryan White Part B Program Request to Receive ADAP/HICP Only

Client Name: \_\_\_\_\_

Client ID #: \_\_\_\_\_

The Ryan White Part B/ADAP Program provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. All funded agencies provide primary care services, support services including ADAP and HICP, which provide medications and health insurance coverage. Please refer to [HRSA PCN #16-02](#) for a complete list of service definitions. An example of the services offered are listed below:

### **Core Medical Services**

Outpatient/Ambulatory Medical Care (OMAC)  
Oral Health  
AIDS Drug Assistance Program (ADAP)  
Health Insurance Premium (HICP) and Cost Sharing Assistance  
Mental Health  
Medical Nutrition Therapy  
Medical Case Management  
Substance Abuse Outpatient Care

### **Support Service**

Non-Medical Case Management  
Emergency Financial Assistance  
Food Bank/Home Delivered Meals  
Health Education/Risk Reduction  
Housing  
Linguistic Services  
Medical Transportation Services  
Psychosocial Support Services

My signature below confirms that I was informed of all the services offered by the Ryan White Part B Program. I decline all additional services and request to only receive assistance with ADAP/HICP. I understand the process to obtain additional services if needed. If my circumstances change, I understand how to access Case Management Services to schedule an assessment.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Case Managers Signature: \_\_\_\_\_

Date: \_\_\_\_\_