



## New Orleans EMA Ryan White Part A

# Eligibility for Services Policies & Forms

FY2016

Office of Health Policy and AIDS Funding  
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## Updated from the Eligibility section of the New Orleans EMA Ryan White Part A Policy Manual

### CLIENT ELIGIBILITY POLICY

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#### **Purpose:**

The Ryan White Treatment Modernization Act helps meet the unmet health needs of persons living with HIV disease (PLWH) by funding primary health care and supportive services that enhance access and improve retention in care. Part A funds support a comprehensive continuum of quality, community-based care for low-income individuals and families with HIV disease. All persons receiving Ryan White Part A services must be screened for residency, HIV status and financial eligibility through an agency funded by Ryan White Part A. Agencies are responsible for intake/eligibility screening to ensure that Ryan White funds are used as **funds of last resort**, as specified by the Ryan White Treatment Modernization Act.

#### **Policy:**

##### Residency

Eligibility requires the client to reside in one of the following eight parishes: Orleans, Jefferson, Plaquemine, St. Bernard, St. Charles, St. James, St. John the Baptist, or St. Tammany. If a client does not reside in one of the eight listed parishes, he/she is **NOT ELIGIBLE** for services funded by the New Orleans EMA. Evidence of residency must be provided. Acceptable documentation for residency include a LA State ID or LA Driver's License, residential program on a letterhead, official state documents (i.e. award letters) or other government issued documents, to name a few. Additional acceptable documents are listed in the Ryan White Client Eligibility Documentation Form. Self attestation may be used as a last resort for clients who do not have any of the documents listed.

##### Financial Eligibility

Client must meet financial eligibility and income may not exceed 500% federal poverty level. Client must provide information on each source of income and present evidence to verify the numbers reported. Acceptable documentation for income are recent check stubs, award letter for SSI or SSDI for current calendar year, most recent benefits summary statement for AFDC or Food Stamps. Self attestation may be utilized after efforts to obtain all other supporting documents have been exhausted. If the client is married, all income information must also be presented for the spouse.

All income for the client and spouse is calculated together and multiplied by 12 to obtain an annual income for the client. Identify the number of persons living in the client's household. You may refer to the Federal Poverty Guidelines website at <https://aspe.hhs.gov/poverty-guidelines> to determine the appropriate poverty level or review the Ryan White Eligible Documentation Checklist. Note this changes annually around the month of January.

## HIV Status

Eligibility requires that clients be HIV/AIDS infected. Non-infected (affected) individuals may be appropriate candidates for Ryan White services in limited situations, but these services must always have at least indirect benefit to a person with HIV infection. Funds awarded under Part A of the Ryan White Treatment Extension Act may be used for services to individuals not infected with HIV only in circumstances described below.

a. The primary purpose of the service is to enable the affected individual to participate in the care of someone living with HIV or AIDS. Examples include individual mental health counseling, caregiver training for in-home medical or support services, support groups, counseling, and practical support that assist with the stresses of caring for someone with HIV.

b. The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care. Examples include payment of premiums for a family health insurance policy to ensure continuity of insurance coverage for a low-income HIV+ family member, or while an infected parent secures medical care or support services.

c. The service promotes family stability in coping with the unique challenges posed by HIV/AIDS. Examples include permanency planning for infected and affected children of HIV+ parents, and mental health services, which focus on equipping, affected family members and caregivers to manage the stress and loss associated with HIV, and short-term post-death bereavement counseling. Services to non-infected clients that meet this criterion may not continue subsequent to the death of the HIV-infected family member beyond the period of short-term bereavement counseling and/or permanency planning for uninfected children.

The following forms must be in client file for eligibility documentation along with supporting documents:

- Ryan White Client Eligibility Documentation Checklist
- Client Eligibility Recertification Verification Form (CERV)
- Self-Attestation for Eligibility (if applicable)

Effective: 3/1/2005

Revised: 3/24/2016

# Ryan White Client Eligibility Documentation Checklist

CITY OF NEW ORLEANS – OFFICE OF HEALTH POLICY AND AIDS FUNDING



Review dates must be entered into LACAN:

- Annual Eligibility Review
- 6 Month Eligibility Review

URN: \_\_\_\_\_

Date (of review): \_\_\_\_\_

**RESIDENCY eligibility documentation used** (check all that apply):

Individuals living in the following parishes are eligible: Orleans, Jefferson, St. Bernard, Plaquemines, St. Charles, St. James, St. Tammany and St. John the Baptist

- Louisiana ID/Driver's License
- Utility bill
- Lease or mortgage
- Benefits letter with current address
- Voter registration card
- Residential program on letterhead
- Self-Attestation Form
- Other (please specify): \_\_\_\_\_

**FINANCIAL eligibility documentation used** (check all that apply):

Please refer to the most current poverty level guidelines.

- Pay stub
- W-2
- Tax return
- Benefits letter with address
- Department of Labor letter
- Prison release letter (within 30 days of release)
- Self-Attestation Form
- Other (please specify): \_\_\_\_\_

## 2016 HHS Poverty Guidelines

Persons in Family or Household	100%	133%	200%	300%	400%	500%
	Up to 100%	100% to 133%	101% to 200%	201% to 300%	301% to 400%	401% to 500%
1	\$ 11,880	\$ 15,800	\$ 23,760	\$ 35,640	\$ 47,520	\$ 59,400
2	\$ 16,020	\$ 21,307	\$ 32,040	\$ 48,060	\$ 64,080	\$ 80,100
3	\$ 20,160	\$ 26,813	\$ 40,320	\$ 60,480	\$ 80,640	\$ 100,800
4	\$ 24,300	\$ 32,319	\$ 48,600	\$ 72,900	\$ 97,200	\$ 121,500
5	\$ 28,440	\$ 37,825	\$ 56,880	\$ 85,320	\$ 113,760	\$ 142,200
6	\$ 32,580	\$ 43,331	\$ 65,160	\$ 97,740	\$ 130,320	\$ 162,900
7	\$ 36,730	\$ 48,851	\$ 73,460	\$ 110,190	\$ 146,920	\$ 183,650
8	\$ 40,890	\$ 54,384	\$ 81,780	\$ 122,670	\$ 163,560	\$ 204,450
For each additional person, add	\$ 4,160	\$ 5,533	\$ 8,320	\$ 12,480	\$ 16,640	\$ 20,800

<b>Ryan White Part A Food Bank</b>
<b>Louisiana STD/HIV Programs: LAHAP (ADAP &amp; Health Insurance Program)</b>
<b>Part A Health Insurance Assistance Program (HIA)</b>
<b>Home Delivered Meals</b>
<b>All other New Orleans EMA Part A services</b>

<https://www.federalregister.gov/articles/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines>

**HIV DIAGNOSIS eligibility documentation used** (check all that apply):

- Lab results (VL or ELISA)
- Proof of diagnosis standard letter signed by a doctor (with agency name and address)
- HIV Negative (URN of HIV positive individual associated with this client: \_\_\_\_\_)
- Other (please specify): \_\_\_\_\_

## CLIENT ELIGIBILITY REVIEW VERIFICATION FORM (CERV)

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### **Purpose:**

The Client Annual Review Form (CERV) has been created for conducting Client Annual Reviews.

### **Policy:**

It is the responsibility of each provider to avoid duplication of clients or services. This form must be completed for each client. The information entered on the review form must be entered in CAREWARE and will be used to verify. A copy of the CERV form follows. Client eligibility must be verified every 6 months.

### **Procedure:**

*\*\* See section on Unique Record Number to develop a URN for each client\*\**

- CERV must be completed during the following times:
  - Annually
  - During the 6 month eligibility review based on the client's anniversary date.
- CERV must be completed by agencies where clients receive services if one is not available from a referring agency.
- All Client's file must contain a copy of the CERV.
- CERV must be shared to referred agencies as needed.
- To avoid duplication,
  - ask client if he/she used another name or if there have been any changes in the last 12 months in the following: name, race, gender, SSN, birthdate
  - search in LACAN/CAREWare prior to adding the client.

### **Attachment:**

- CERV Form

Effective: 3/01/2007

Revised: 3/31/2016





Initial date: \_\_\_\_\_  Update: \_\_\_\_\_ UIN

INSURANCE	Client Eligible?		If eligible, does client have?	If no, client applied?
<b>FEDERAL HEALTH INSURANCE EXCHANGE "Marketplace"</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No (Stop! Next row.)	<input type="checkbox"/> Yes (Plan Chosen) <input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze Plan name: _____ Policy #: _____ <input type="checkbox"/> No (→ next column)	<input type="checkbox"/> Yes <input type="checkbox"/> No Application Date: / /
<b>DENTAL INSURANCE</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No (Stop!)	<input type="checkbox"/> Yes <input type="checkbox"/> No (→ next column)	<input type="checkbox"/> Yes <input type="checkbox"/> No Application Date: / /

SERVICES	Client Eligible?		If eligible, does client have?	If no, client applied?
<b>VETERANS AFFAIRS</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No (Stop! → next row.)	<input type="checkbox"/> Yes, Check all covered <input type="checkbox"/> Primary Care <input type="checkbox"/> Dental <input type="checkbox"/> Hospital <input type="checkbox"/> Mental Health <input type="checkbox"/> Medication <input type="checkbox"/> No (→ next column)	<input type="checkbox"/> Yes <input type="checkbox"/> No Application Date: / / If no, justification:
Louisiana Health Access Program: <b>LOUISIANA DRUG ASSISTANCE PROGRAM "L-DAP"</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No (Stop! → next row.)	<input type="checkbox"/> Yes, Effective Date: / / <input type="checkbox"/> No (→ next column)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Application Date: / /

INSURANCE ASST. PROGRAMS	Client Eligible?		If eligible, does client have?	If no, client applied?
Louisiana Health Access Program: <b>HEALTH INSURANCE "HIP"</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No (Stop! → next row.)	<input type="checkbox"/> Yes, Effective Date: / / <input type="checkbox"/> No (→ next column)	<input type="checkbox"/> Yes <input type="checkbox"/> No Application Date: / / Update: / / <input type="checkbox"/> Approved <input type="checkbox"/> Not approved
<b>LOW INCOME SUBSIDY "Extra Help"</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No (Stop! → Next row.)	<input type="checkbox"/> Yes <input type="checkbox"/> No (→ next column)	<input type="checkbox"/> Yes <input type="checkbox"/> No Application Date: / /

Comments: \_\_\_\_\_

**ANNUAL REVIEW/ADDITIONAL CLIENT INFORMATION**

Source of Monthly Income (Household)	Client (\$)	Legal Spouse	Blood Relative	TOTAL
AFDC				
Affidavit of No Income				
Child support/foster care				
Food Stamps				
Military Disability				
Other:				
SSDI				
SSI				
Temporary Assistance for Needy Family (TANF)				
Unemployment				
Veterans Benefits				
Wages or Salary				
Worker's Compensation				
<b>TOTAL AMOUNT</b>				

Current Employment (check one):  Full Time  Medically unable to work  Part Time  Unemployed  NA, child

If not working, how long since your last employment?  < 6 months  6 months to a year  1-2 years  > 2 years

Initial date: \_\_\_\_\_  Update: \_\_\_\_\_ UIN

**ANNUAL REVIEW- Annual**

<b>Primary Insurance</b> (Check one) Date: / /	<b>Other Insurance</b> (Check all that apply.)	<b>Primary HIV Medical Care</b> Date: / /
<input type="checkbox"/> Medicaid (Medicaid, CHIP, Other public) <input type="checkbox"/> Medicare <input type="checkbox"/> No Insurance/Uninsured (including LA HAP & RW programs) <input type="checkbox"/> Other <input type="checkbox"/> VA, Tricare, and Other Military HIS <input type="checkbox"/> Private (Individual paid) <input type="checkbox"/> Private (Employer paid)	<input type="checkbox"/> Medicaid (Medicaid, CHIP, Other public) <input type="checkbox"/> Medicare <input type="checkbox"/> Other <input type="checkbox"/> Other Public <input type="checkbox"/> Private (Individual paid) <input type="checkbox"/> Private (Employer paid)	<input type="checkbox"/> Publicly-funded clinic or health department <input type="checkbox"/> Private practice <input type="checkbox"/> Hospital outpatient center <input type="checkbox"/> Emergency Room <input type="checkbox"/> No primary source of care <input type="checkbox"/> Other

<b>Housing/Living Arrangement</b> (last 6 months) Date: / /	<b>Annual Household Income:</b> Date: / /	<b>Was Client counseled about HIV transmission risks?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Date: / /	
<input type="checkbox"/> <b>Stable/Permanent</b> (apartments, houses, foster homes, long-term residences, and boarding homes) <input type="checkbox"/> <b>Temporary</b> (Transitional housing, temporary stay with family or friends, temporary placement in an institution (e.g., hospital, psychiatric facility, substance abuse treatment facility, or detoxification center), hotel or motel paid for <u>without</u> emergency shelter voucher. <input type="checkbox"/> <b>Unstable</b> (Emergency shelter, car, an abandoned building, a bus/train/subway station/airport, or outside, hotel or motel paid for <u>with</u> emergency shelter voucher.	Total per Month * 12 = \$	<b>If yes, Who counseled about transmission risks?</b> <input type="checkbox"/> Primary care clinician <input type="checkbox"/> Case mgr/social worker <input type="checkbox"/> Other trained counselor	
	<b>Household size:</b> Total number in household:		<b>Was client screened for mental health?</b> Date: / /
	<b>Poverty Level:</b> % in CAREWare:	<input type="checkbox"/> No <input type="checkbox"/> Not medically indicated	<b>Was client screened for substance abuse?</b> Date: / /
	<b>FPL category</b> (check one) <input type="checkbox"/> ≤ 100% (0-100%) <input type="checkbox"/> 200% (101-200%) <input type="checkbox"/> 300% (201-300%) <input type="checkbox"/> 400% (301-400%) <input type="checkbox"/> 500% (401-500%)	<input type="checkbox"/> Yes <input type="checkbox"/> Not medically indicated	

**ANNUAL REVIEW- Custom Annual**

<b>Enrollment/Anniversary Date:</b> / /	<b>Has the client been previously incarcerated?</b> <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes	
<b>Primary Medical Care</b>		
<input type="checkbox"/> East Jefferson Hospital <input type="checkbox"/> CrescentCare (FACES) <input type="checkbox"/> CrescentCare (Health and Wellness Center) <input type="checkbox"/> CrescentCare (NO/AIDS) <input type="checkbox"/> Our Lady of Angels <input type="checkbox"/> LSU-Lallie Kemp <input type="checkbox"/> Kenner Regional <input type="checkbox"/> <b>Not seeing a physician</b>	<input type="checkbox"/> Oschner Clinic and Hospital <input type="checkbox"/> Oschner- Westbank <input type="checkbox"/> Parish Health Units <input type="checkbox"/> Priority Health Care Center <input type="checkbox"/> Private Physician*: _____ <input type="checkbox"/> Touro <input type="checkbox"/> Tulane (T-Cell Clinic) <input type="checkbox"/> Orleans Family Practice	<input type="checkbox"/> Tulane Lakeside <input type="checkbox"/> Tulane downtown <input type="checkbox"/> Tulane Uptown Square <input type="checkbox"/> West Jefferson Hospital <input type="checkbox"/> VA hospital/clinic <input type="checkbox"/> St. Thomas Community Health Center <input type="checkbox"/> Louisiana Medical Center (HOP) <input type="checkbox"/> Other*: _____
<b>Referral Source:</b>		
<input type="checkbox"/> Counseling and Testing Site <input type="checkbox"/> Emergency Room <input type="checkbox"/> Health Center <input type="checkbox"/> Hospitalization	<input type="checkbox"/> Penal Institution <input type="checkbox"/> Primary Care Site <input type="checkbox"/> Private Physician <input type="checkbox"/> Self Referred	<input type="checkbox"/> STD Clinic <input type="checkbox"/> Another RW agency <input type="checkbox"/> Other (see LACAN/CAREWare): _____

\* Please contact OHP to add to the drop down list in CAREWare.

<b>Social Security Number</b> (For undocumented individuals, SSN is to be recorded as 999 plus the date of birth. For example: date of birth is 12/12/2001 then SSN would be 999-12-1201.)	- -
<b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other (specify): _____	

Initial date: \_\_\_\_\_  Update: \_\_\_\_\_ UIN

**ANNUAL REVIEW (Only need to be completed once per year; Enter in Quarter 1)**

	Substance Abuse		Mental Health	
History	<input type="checkbox"/> No <input type="checkbox"/> Yes, active history within last 3 months <input type="checkbox"/> Yes, but not active within last 3 months <input type="checkbox"/> Unknown		<input type="checkbox"/> No <input type="checkbox"/> Yes, active history within last 3 months <input type="checkbox"/> Yes, but not active within last 3 months <input type="checkbox"/> Unknown	
Treatment	<input type="checkbox"/> In Treatment <input type="checkbox"/> Waiting list for treatment <input type="checkbox"/> Refused Treatment <input type="checkbox"/> Completed Treatment <input type="checkbox"/> Pre-Treatment process <input type="checkbox"/> Dropped out of Treatment	<input type="checkbox"/> No active treatment or counseling <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable	<input type="checkbox"/> In Treatment <input type="checkbox"/> Waiting list for treatment <input type="checkbox"/> Refused Treatment <input type="checkbox"/> Completed Treatment <input type="checkbox"/> Pre-Treatment process <input type="checkbox"/> Dropped out of Treatment	<input type="checkbox"/> No active treatment or counseling <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable

<b>Case Manager:</b>		<b>Highest Education</b>	<b>Medical Record Number:</b>
<b>Marital Status/Living Situation</b>		<input type="checkbox"/> 9 <sup>th</sup> to 12 <sup>th</sup> grade (no diploma) <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Doctorate degree <input type="checkbox"/> High School graduate	<b>Agency Specific Number:</b>
<input type="checkbox"/> Common Law <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner (filed agreement) <input type="checkbox"/> Legally separated <input type="checkbox"/> Living In <input type="checkbox"/> Married, spouse absent			
<input type="checkbox"/> Married, spouse present <input type="checkbox"/> N/A Child <input type="checkbox"/> Other <input type="checkbox"/> Significant other <input type="checkbox"/> Single/Never Married <input type="checkbox"/> Widowed		<input type="checkbox"/> Less than 9 <sup>th</sup> grade <input type="checkbox"/> Master's degree <input type="checkbox"/> Professional degree <input type="checkbox"/> Some college, no degree	<b>Primary care provider (Required)</b>

**Client Enrollment Status (check one only):**

New to EMA  Newly diagnosed and New to Care/Services  Continuing (In Care)  Eligible (Returning to Care)

**RELATIONS (Affected clients)**

#	Name (first, last)	Birth Date	Gender	Relation	Race	UIN of Affected Client
1		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown			
2		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown			
3		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown			
4		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown			

**EMERGENCY INFORMATION**

**Emergency Contact 1:**

Name (First, Last)		Relationship:	
Street Address		City, State, Zip	
Phone:		Cell #:	
Email address:			
<b>Is this contact aware of your HIV status?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Is this person authorized to take custody of your children in an emergency?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Na	

**In the event of an emergency evacuation, how will client respond?**

- has his/her own transportation
- will access City of New Orleans 311 program
- will leave with agency's transportation system (for clients in housing facility)
- will leave with family/friends
- shelter in place
- Other: \_\_\_\_\_

Initial date: \_\_\_\_\_  Update: \_\_\_\_\_ UIN

**CONSENT TO CONTACT & ADDITIONAL INFORMATION**

**Consent contact (Check all that apply)**

- Yes, I consent to receive mail at the address listed on this application (Page 1).
- Yes, I consent to receive mail at this address: \_\_\_\_\_
- No, I do not consent to receive **mail** at any address.
- Yes, I consent to receive **emails**
- Yes, I consent to receive text **messaging**
- Yes, I consent to receive **phone calls**
- Yes, I consent to receive **voicemails**

**CLIENT CERTIFICATION AND CONSENT** (Please initial next to each line below.)

- \_\_\_\_\_ I understand that I have the right and freedom to select the service provider of my choice.
- \_\_\_\_\_ I certify that the intake worker has informed me of all existing Ryan White Part A service providers.
- \_\_\_\_\_ I understand that application to available third party payor is required in order to receive Ryan White Part A services.
- \_\_\_\_\_ I certify that the information I have provided to document eligibility is true and accurate.
- \_\_\_\_\_ I have been informed that all Ryan White Part A agencies to which I may be referred have a grievance policy and I may request a copy of grievance policy.
- \_\_\_\_\_ I have been informed of my rights and responsibilities as a Ryan White client receiving services.
- \_\_\_\_\_ I certify that I have been advised to have an emergency evacuation plan in the event of a mass departure.
- \_\_\_\_\_ I authorize my information to be released or received to/from the Ryan White Part A Grantee, Ryan White agencies, U.S. Department of Health and Human Services (HRSA), Louisiana Office of Public Health, STD/HIV Program and other agencies for the purpose of programmatic reporting, coordinating care or services, and/or health monitoring. I understand that this information may be faxed, mailed or shared through a network database system, including the Louisiana CAREWare Access Network system, or CAREWare to said agencies.
- \_\_\_\_\_ I consent to being contacted two years beyond the expiration date of this form for the purposes of health improvement, health monitoring and/or re-engagement in care or services.
- \_\_\_\_\_ I understand I can revoke this consent at any time prior to the receipt of these services.

\_\_\_\_\_  
Printed Name of Client or Guardian/Legal Representative Relationship to Client

\_\_\_\_\_  
Signature of Client or Guardian/Legal Representative Date of Signature

**AGENCY**

- \_\_\_\_\_ I certify that the client has been informed of the Ryan White Part A services.
- \_\_\_\_\_ I certify that the client has authorized referral to selected services.
- \_\_\_\_\_ I certify that the client has been assessed and is eligible to receive Ryan White Part A services.
- \_\_\_\_\_ I certify that the client has been screened for third party payors.

\_\_\_\_\_  
Agency Representative (Print) Agency Representative Signature Date

## CLIENT ELIGIBILITY REVIEW VERIFICATION FORM for **AFFECTED Clients**

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### **Purpose:**

The Client Annual Review Form for Affected Clients (CERV-AF) has been created for conducting Client Annual Reviews for individuals who are not HIV positive but is a support for the client who is HIV positive.

### **Policy:**

This form must be completed for each client who is Affected. The primary purpose is

- a. to enable the non-infected individual to participate in the care of someone with HIV disease or AIDS,
- b. enables an infected individual to receive needed medical or support services,
- c. and promotes family stability for coping with the unique challenges posed by HIV/AIDS

Services to non-infected clients that meet these criteria may not continue subsequent to the death of the HIV infected individual.

A copy of the CERV-AF form follows. Client eligibility must be verified every 6 months. Affected clients can only access Part A services for the purposes of helping the infected client to stay in care or improve health outcome.

Only psychosocial services can be utilized by affected clients.

### **Procedure:**

*\*\* See section on Unique Record Number to develop a URN for each client\*\**

- CERV-AF must be completed during the following times:
  - Annually
  - During the 6 month eligibility review based on the client's birthdate.
- CERV-AF must be completed by agencies where clients receive services if one is not available from a referring agency.
- All affected must also contain a copy of the CERV of the infected client.
- CERV-AF must be shared to referred agencies as needed.
- To avoid duplication,
  - ask client if he/she used another name or if there have been any changes in the last 12 months in the following: name, race, gender, SSN, birthdate
  - search in LACAN/CAREWare prior to adding the client.

### **Attachment:**

- CERV-AF Form

Effective: 1/01/20011

Revised: 3/24/2016



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**CLIENT CERTIFICATION AND CONSENT** (Please initial next to each line below.)

- \_\_\_\_\_ I understand that I have the right and freedom to select the service provider of my choice.
- \_\_\_\_\_ I certify that the intake worker has informed me of all existing Ryan White Part A service providers.
- \_\_\_\_\_ I understand that application to available third party payor is required in order to receive Ryan White Part A services.
- \_\_\_\_\_ I certify that the information I have provided to document eligibility is true and accurate.
- \_\_\_\_\_ I have been informed that all Ryan White Part A agencies to which I may be referred have a grievance policy and I may request a copy of grievance policy.
- \_\_\_\_\_ I have been informed of my rights and responsibilities as a Ryan White client receiving services.
- \_\_\_\_\_ I certify that I have been advised to have an emergency evacuation plan in the event of a mass departure.
- \_\_\_\_\_ I authorize my information to be released or received to/from the Ryan White Part A Grantee, Ryan White agencies, U.S. Department of Health and Human Services (HRSA), Louisiana Office of Public Health, STD/HIV Program and other agencies for the purpose of programmatic reporting, coordinating care or services, and/or health monitoring. I understand that this information may be faxed, mailed or shared through a network database system, including the Louisiana CAREWare Access Network system, or CAREWare to said agencies.
- \_\_\_\_\_ I consent to being contacted two years beyond the expiration date of this form for the purposes of health improvement, health monitoring and/or re-engagement in care or services.
- \_\_\_\_\_ I understand I can revoke this consent at any time prior to the receipt of these services.

\_\_\_\_\_  
Printed Name of Client or Guardian/Legal Representative

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Signature of Client or Guardian/Legal Representative

\_\_\_\_\_  
Date of Signature

Agency Representative (Print) \_\_\_\_\_

Agency Representative Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## SELF ATTESTATION FOR ELIGIBILITY FORM

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**Purpose:**

The Self Attestation for Eligibility Form was created for determining client eligibility for residency and income verification when no other documentation is available.

**Policy:**

This form must be completed for clients who do not have the documents listed in the Ryan White Client Documentation Checklist to support residential and financial eligibility. Client eligibility must be verified every six (6) months.

**Procedure:**

- Self attestation must be completed during the following times:
  - Annually
  - During the 6 month eligibility review.
- Self attestation must be completed by agencies where clients receive services if one is not available from a referring agency.
- A completed Self Attestation for Eligibility Form must be in the client's file.

**Attachment:**

- Self attestation for Eligibility Form

Effective: 3/01/2016

Revised: 3/24/2016

