CARE COORDINATION FOR PEOPLE WITH HIV

PROGRAM MANUAL
Version 4.2

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New York City Department of Health and Mental Hygiene
Bureau of HIV/AIDS Prevention and Control
Care and Treatment Program

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Policies

All HIV-infected persons, also referred to as Persons Living With HIV/AIDS (PLWHA), in NYC should have access to:
- Comprehensive and holistic healthcare situated in a medical home as defined by the American College of Physicians; and
- Health promotion to promote self-sufficiency, optimal health and risk reduction.

As needed, PLWHA should receive assistance:
- Navigating the healthcare and social services systems;
- Coordinating logistics such as transportation and childcare to ensure that they have ready access to their care providers;
- Reviewing their eligibility for government-funded benefits and programs to provide the best possible financial assistance, medical insurance and stable housing; and
- Overcoming personal and contextual barriers to antiretroviral treatment (ART) adherence.

All PLWHA could expect that critical health information is available to providers when PLWHA need it, and that adequate security measures are in place to safeguard PLWHA confidentiality.

Background

In the United States, the CDC estimates that 1,148,200 persons aged 13 years and older are living with HIV infection, including 207,600 (18.1%) who are unaware of their infection. New York City (NYC) continues to be at the epicenter of the U.S. epidemic, with 113,319 New Yorkers reported with HIV/AIDS as of December 31, 2011. While advances in medical care for PLWHA have been significant, disparities exist in health care access and health outcomes for PLWHAs. Factors associated with poorer health outcomes include belonging to a racial/ethnic minority group, being an injection drug user, having a mental

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illness, being of a lower socioeconomic status, and from other high-risk groups.4,5,6,7 Many of these factors coexist among persons belonging to racial/ethnic minority groups in NYC and accordingly these groups are more likely to be out of care and access care later.8 These factors make the facilitation of access to and maintenance in HIV primary care a priority.

In the past decade, advances in HIV/AIDS treatment have resulted in lower mortality and longer life expectancy for PLWHA.9 Greater disease prevalence in turn places greater demands on the HIV care system. At the individual level HIV/AIDS has evolved into a chronic illness; this requires a broad range of specialized services to meet patients’ needs and the development of skills among patients to better facilitate self-management of HIV infection.

Despite advances in treatment and increased life expectancy for PLWHA, HIV treatment remains challenging. A high level of adherence to ART is needed to achieve viral load suppression.10,11 A suppressed viral load is associated with better health outcomes and reduced potential for HIV transmission per risk encounter. The high adherence requirements of ART and the lifelong nature of HIV treatment are difficult and best met by those in stable life situations or with strong support systems.12,13 Golin et al. documented a mean ART adherence of 71% in a prospective study, demonstrating the critical need for ART adherence support.14

The complexity of HIV/AIDS-related services makes navigation of the system(s) and accessing services difficult for those who are unaccustomed to the system. The New York City Department of Health and Mental Hygiene (NYC DOHMH) Care Coordination Program (hereafter referred to as the “Program”) seeks to address HIV/AIDS healthcare disparities by facilitating access to care and other services via medical case management, navigation, promotion of self-reliance and patient education. It aims to combine elements

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12. Ibid.
of the HIV Navigation Model and the Chronic Care Model to define and implement an HIV-specific Care Coordination model within the integrated continuum of care.

With increased treatment efficacy, early and continuous engagement in medical care is more important than ever for improving patient outcomes. To that end, factors associated with poor adherence to medical care plan and antiretroviral medications need to be addressed. These factors include: mental illness; substance abuse; inadequate housing; lack of transportation; legal difficulties; inadequate access to food; being of racial/ethnic minority; social stigma; lack of knowledge about HIV/AIDS; health care provider bias and miscommunication; health care provider lack of knowledge or adherence to HIV/AIDS clinical guidelines. Once barriers to treatment have been eliminated and the patient is receiving adequate care, she/he would experience a decrease in viral load (VL), an increase in CD4 counts, and advances in disease stage would be reduced with adherence to their prescribed ART medication. By reducing VL in individuals and periodic assessment of HIV transmission risk with harm reduction counseling and partner notification where needed, HIV transmission may ultimately be reduced in the community.

PURPOSE

This program manual is intended to:

• Be a requirement for Ryan White Part A funded Care Coordination Programs per the terms of the contract (solicited through the Care Coordination Request for Proposal).
• Be a reference for medical case management or Care Coordination providers for the purpose of care coordination for PLWHA.
• Provide programmatic guidance to standardize the implementation of Care Coordination Programs.
• Provide instructions on documenting and reporting Care Coordination activities.
• Complement the Public Health Solutions contractual and fiscal documents.

OBJECTIVES OF HIV CARE COORDINATION

• Support and coach patients to become self-sufficient so that they are able to manage their medical and social needs autonomously.
• Provide linkage to care to PLWHA patients in a timely and coordinated manner and maintain medical stability and suppressed viral load.
• Provide patients with home-based navigation, coordination of medical and social services and provision of support and coaching.
• Work together with PLWHA to support treatment (medication) adherence.
• Assist patients with gaining skills and knowledge needed to maintain a stable health status.
ELEMENTS OF THE PROGRAM MANUAL

1.0 Practice Standards

1.1 Screen all patients for eligibility in the Care Coordination Program and coordinate with similar programs so patients receive streamlined services.

1.2 The Program and team ensures the execution of the care plan (appointments, referrals, medication adherence and entitlements/benefits) thereby facilitating access to a medical home by all patients.

1.3 Assess needs at intake and schedule follow up for medical and social services.

1.4 Maintain up-to-date contact information for patients.

1.5 Perform a detailed assessment of social services and benefits along with logistical needs in order to guide the comprehensive plan development.

1.6 Provide health education/promotion to all patients.

1.7 Incorporate treatment adherence interventions as needed.

1.8 Assist PLWHA to attain self-sufficiency and successfully graduate.

1.9 Provide one another with easy access to each other’s relevant patient information (PCP and Care Coordinator).

1.10 Ensure that a valid and current consent to release HIV information is on file for each patient in a networked Care Coordination Program in order to make sure that confidentiality laws or related institutional policies do not preclude ready transfer of sensitive personal health information.

1.11 Develop monitoring protocols and quality management activities.

1.12 Ensure all services delivered are documented and reported appropriately. All Care Coordination forms referred to in this program manual must be documented in eSHARE. Refer to Care Coordination eSHARE Mapping tool (Appendix KK).

1.12.1 Agencies must maintain paper copies of all Care Coordination forms in the patient chart if the information is not documented in an electronic medical record:

1.12.2 Regardless of usage of an electronic medical record, agencies must always maintain paper copies of the following Care Coordination forms in the patient chart:

- Ryan White Part A Care Coordination Program Agreement (Appendix N)
- HIPAA Compliant Authorization for Release of Medical Information (if needed) (Appendix P)
- Intake Assessment Form (only the General Well-Being section, also known as the SF-12) (Appendix U)
- Reassessment Form (only the General Well-Being section, also known as the SF-12) (Appendix GG)
1.12.3 eSHARE is not an electronic medical record system or a patient charting system; therefore, the system currently in place for charting patient services must be maintained. eSHARE is only for reporting data, not for documentation. Any data entered in eSHARE must have supporting documentation maintained in the patient chart.

2.0 Components of Care Coordination

2.1 Care Navigation

2.1.1 Care Navigation guides patients in knowing where, when, and how to access all health and related services, and increases access to appropriate resources.

2.1.2 Care Navigation services covered in this section include the coordination of:
- Primary medical care
- Specialty care
- Mental health care and substance abuse services
- Imaging and other diagnostic service
- Laboratory services
- Health insurance
- Housing
- Benefits/Entitlements/Public Assistance

2.1.3 The Program ensures that the patient has the requisite information for all relevant appointments and access to services by:

2.1.3.1 Reviewing the Comprehensive Care Plan with the patient and the provider, at the conclusion of every primary care visit.

2.1.3.2 Providing the patient with reminders of upcoming appointments or plans in the following ways:

2.1.3.2.1 From the moment a primary care appointment is scheduled, make sure the patient is aware of the date and time.

2.1.3.2.2 At every regular face-to-face contact the Program would remind the patient of all services planned for the upcoming period.

2.1.3.2.3 Patients receiving health promotion less frequently than once per week would receive at least three reminders by phone prior to each scheduled service:
- Seven days prior to the scheduled service
- Three days prior to the scheduled service
- The day of the scheduled service
2.1.3.2.4 Patients receiving health promotion *once per week* would receive at least two reminders by phone and/or face to face prior to each scheduled primary care appointment.

- Three days prior to the scheduled service
- The day of the scheduled service
- All reminders within three days are encouraged to be an actual conversation with the patient rather than a voicemail.
- If unable to successfully contact the patient within the three days prior to the scheduled service, a visit to the patient’s home should be attempted to locate and accompany the patient.

2.1.3.2.5 Detailed information relating to referrals is included on the Referrals/Appointments Tracking Log (Appendix Z).

2.1.3.2.6 Reminder phone calls are documented on the Services Tracking Log (Appendix JJ).

2.1.4 The Program ensures that the patient has the requisite resources for all relevant appointments and service access identified on the Comprehensive Care Plan (Appendix Y) by:

- Offering to accompany the patient every time a reminder is provided.
- Providing accompaniment to every routine primary care appointment for all enrollees receiving high-intensity services (refer to §7.3.5.1).
- Asking whether the patient requires assistance with transportation every time a reminder is provided.
- Asking whether the patient requires assistance with childcare every time a reminder is provided (if applicable).
- Asking whether the patient requires language interpretation services every time a reminder is provided (if applicable). Note: Minors (<18) are NOT ALLOWED to be used as interpreters.

2.1.5 The Program ensures appropriate transportation resources whenever they are required. These include but are not limited to:

- Access-A-Ride (van transport for the mobility impaired). Additional information is available in Appendix C. Metrocard provided by the Program for use on MTA buses and trains (Note: Medicaid fees include Metrocard costs. When the scheduled service is a Medicaid billable service the Program must ensure the provision of the benefits but not provide it directly).
- A taxi or car service voucher when justified. For instance, a patient could not wait for Access-A-Ride and urgently needs
transportation to go to a relevant appointment or service and could not schedule a ride in advance. It may not be an emergent situation in which a patient would need to call an ambulance.

- A ride in a vehicle owned or leased by the Program or Program staff. All regulatory and liability issues must be addressed in advance.

2.1.6 The Program would assist the patient in scheduling and rescheduling appointments, when necessary.

2.1.7 The Program ensures appropriate childcare resources whenever they are required. These include but are not limited to:

- Asking whether the patient requires assistance with childcare every time a reminder is provided.
- Appropriately credentialed childcare services at an affiliated agency location.
- Childcare may not be provided by Care Coordination Program staff.
- Refer to the Childcare information presented in Appendix D.
- Payment for childcare in the patient's home when circumstances do not allow bringing the child to the care center.
- HRSA prohibits payment to individual patients and therefore, Programs must develop a system to reimburse childcare providers.\(^{15}\)

2.1.8 The Program monitors its success at providing navigation service by following up with the service provider the same day as the scheduled service in all instances to ensure the patient attends their relevant appointments.

2.1.9 In order to ensure that confidentiality law or related institutional policies does not preclude ready transfer of sensitive personal health information, the Program must ensure that a valid consent to release of HIV information is always on file for each patient.

2.1.10 The Program corrects deficiencies – failures of the patient to access the service – by rescheduling the appointment. For details refer to Missed Appointments (§7.3.11).

2.1.11 The Program documents planned navigation and services by means of the optional Comprehensive Care Plan Form (Appendix Y) and/or electronic medical record.

2.2 Health Promotion (Education, Coaching and Medication Adherence)

2.2.1 The Program would ensure optimal health literacy for all patients by providing health promotion on the biology of HIV, disease management, communication with providers, risk reduction and healthy behavior, and ART adherence via a structured curriculum.

2.2.2 The NYC DOHMH would provide a standard health promotion curriculum.

2.2.2.1 The curriculum is a guide with topics that include conversations with key components which should be addressed, but it does not have to be delivered as a didactic script.

2.2.2.2 The curriculum should be delivered in a way that is suitable to meet your patient’s education, developmental, language, gender, sexual and cultural needs.

2.2.2.3 The curriculum consists of 16 topics: nine (9) are considered core topics, six (6) are considered discretionary, and one (1) is a final wrap up. Topics may be repeated or continued and are patient-driven to allow for flexibility in topic order. These topics are outlined in more detail in Health Promotion Topics Included in Curriculum (Appendix H).

2.2.2.4 The NYC DOHMH would review the health promotion curriculum every two years and include feedback from providers.

2.2.3 The Program would ensure that all service staff that provide health promotion and all direct or indirect supervisory staff receive ongoing trainings on the curriculum. The NYC DOHMH would train key staff who in turn would train other Program staff at their agencies.

2.2.3.1 Each agency should have a minimum of two trainers who completed Health Promotion Training of Trainer (TOT) and at least one trainer must be available to conduct each training.

2.2.3.2 These trainings should be ongoing and conducted at least once every two months. Each training should be at least 1 hour in length; however, 2 hours in length is recommended.

2.2.4 All health promotion sessions with patients are one-on-one, because the intent is to incorporate coaching and counseling content that is individualized to the patient. Group sessions are optional and may be added per Program preference, but not substituted for one-on-one sessions.

2.2.5 All patients with low intensity (refer to §7.3.6) needs receive at a minimum the following health promotion content.

2.2.5.1 Basic HIV disease information and disease management tailored to the patient’s circumstances.

2.2.5.2 Safer sex and prevention of HIV transmission to sex partners.
2.2.5.3 Guidance on how to make medical appointments and communicate effectively with medical providers

2.2.5.4 Habits for healthy living. (e.g., Diet and exercise)

2.2.5.5 For substance users, including injection drug users, harm reduction techniques including but not limited to non-sharing of injection equipment with fellow injectors. The Program would in addition provide access to sterile injecting equipment either via participating as an Expanded Syringe Access Program (ESAP) provider or via linkage (refer to Appendix F for a list of authorized needle exchange programs).

2.2.5.6 For persons on ART (i.e., Intervention service level Low-B), medication adherence techniques such as pill counting, and guidance on how to handle ART side effects and difficulties.

- While on initial assessment the patient may have been in the high intensity service level, a subsequent reassessment may step the patient down to low intensity services.

2.2.5.7 Health promotion should occur as frequently as the track in which the patient is enrolled indicates. It is recommended that health promotion occurs in conjunction with primary care visits. That should provide most patients in this category a minimum of 4 conversations within a calendar year. Each health promotion session (encounter) should be linked to a goal or goals in the patient’s Comprehensive Care Plan and last approximately 20-40 minutes.

2.2.5.7.1 It may take more than one session (encounter) to complete a topic, and at times different conversations could be incorporated into one session if it is determined that there is a need for the information to be presented.

2.2.5.7.2 Topics may be repeated.

2.2.5.7.3 Health promotion topics and conversations may be conducted in stand-alone sessions (encounters) focused solely on health promotion or may be incorporated into other service type encounters (e.g. accompaniment).

2.2.5.7.4 Enrollment durations should be taken on a case by case basis, but should generally not exceed one year for most patients.

2.2.5.7.5 Ideally, each patient would cycle through the curriculum once prior to graduation.
2.2.5.8 For patients who continue to receive Program services beyond the completion of all health promotion topics, content should be repeated with the patient’s needs in mind. Patient sexual risk behavior assessment is completed and safer sex education (Prevention with Positives) – except for the chronically abstinent – is delivered in abbreviated form optimally at every primary care encounter but at least once every 4 months. Risk behavior assessment and safer sex education should be augmented by brief counseling from PCP at every visit.

- The intervention would take place at a location of the patient’s choosing, which may be the patient’s residence or another location in the field. The patient may choose to receive the health promotion at the medical or care coordination site.

2.2.5.9 If necessary, a single health promotion topic could be covered over more than one session over the course of a calendar year.

2.2.6 All patients with high intensity (refer to §7.3.6) needs receive at a minimum the following health promotion content.

2.2.6.1 An expanded skills-based curriculum whose table of contents is included in Appendix H.

2.2.6.2 Each health promotion session includes pill counting (e.g., pillbox review) for all patients prescribed ART who are not receiving DOT.

2.2.6.3 All patients receiving high intensity services receive health promotion once per week.

2.2.6.4 After the induction phase of three months, those patients who have shown clinical and behavioral improvement with weekly interventions could transition to a less frequent intervention level (refer to Appendix G) to once per month (this is not an option during the induction phase).

2.2.6.5 Health promotion takes place in the patient’s home or place of patient’s choosing (mutually convenient location).

2.2.6.6 A health promotion session may be timed to coincide with a primary care visit and delivered on site in those instances.

2.2.6.7 Each health promotion session (encounter) should be linked to a goal or goals in the patient’s Comprehensive Care Plan and last approximately 20-40 minutes.

2.2.6.7.1 It may take more than one session (encounter) to complete a topic, and at times different conversations could be incorporated.
into one session if it is determined that there is a need for the information to be presented.

2.2.6.7.2 Ideally, each patient would cycle through the curriculum once prior to graduation.

2.2.7 Health promotion conversations are documented on the Services Tracking Log (Appendix JJ). The Curriculum Coverage Log (Appendix BB) is an optional form and may be used per agency discretion.

2.2.8 *For patients taking ART, pill counting is required* — knowing in advance the expected number of pills in the prescription (and in each compartment of the pillbox) and counting those that remain after their scheduled dosing time has elapsed.

2.2.9 See Table 2 on page 46 for a description of the Low Intensity and High Intensity service levels.

### 2.3 Social Services and Benefits Assessment

2.3.1 Overview: the Program is primarily responsible for assessing social services and benefits needs, in the event that no other clinic personnel have conducted such a review.

2.3.2 *Time Requirement*: the initial assessment of social services needs and benefits eligibility would occur within two weeks of enrollment into the Program.

2.3.3 The Program documents its assessment on the Intake Assessment Form (Appendix U).

2.3.4 Patients already receiving services from HASA at the time of enrollment need a more limited assessment (refer to §2.3.6.9).

2.3.5 Housing Assessment

2.3.5.1 Housing needs assessment:

- The Program must evaluate all enrollees with regard to the adequacy of their housing.
- A basic assessment – verification of last recorded address and stability of the housing arrangement takes place at the time of every primary care visit.
- Assess whether storage of ART and other medications is possible.
- Assess how an enrollee pays for housing and the stability of the payment source.
- Under no circumstances should a period greater than six months elapse without an assessment of housing status; if necessary the Program must conduct field outreach to ascertain housing stability.
- The content of the housing assessment should include at least whether the unit is in adequate repair and whether the patient faces any threat of eviction or
violence or any other force that would remove the patient from their home.

- The Program must conduct an assessment of housing need as described regardless of whether other programs provide similar benefits assistance.

2.3.5.2 Housing Eligibility assessment

- Any patient with an identified housing need would be evaluated for eligibility in a housing program. Programs could use AccessNYC for eligibility screening (refer to Appendix E).16

2.3.5.3 Housing program application:

- Patients found to be eligible for one or more housing or housing assistance programs would be assisted in completing all the forms and gathering the requisite support documentation that constitute application for the program.
- The Program would develop with the patient a plan for submitting the application and then follow through with the plan.
- In addition to confirming patient submission of an application, the Program must obtain confirmation that the patient is eligible for the program or benefit and assurance of enrollment OR
- If immediate confirmation of enrollment is not available, a timetable for the determination of the enrollment with documentation of the date of anticipated disposition and the outcome when that date arrives OR
- If the enrollment is rejected, reassessment for other eligibilities should be performed and continuation of the process from that point.
- Programs may consult with DOHMH’s HIV Housing Program in respect to such patients without further eligibility.17
- The above services – housing eligibility review, application and assurance of enrollment - must be completed by the Program or by one of its affiliates.

2.3.6 Health insurance and other benefits

2.3.6.1 Upon enrollment, all patients are evaluated for their eligibility for all NYC or local, State or Federal benefits programs. This could be accomplished by guiding the patient through the eligibility and referral services of

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17 Housing Opportunities for Persons with AIDS (HOPWA). Contact phone (347) 396-7454.
AccessNYC.\textsuperscript{18} Programs currently covered are listed in the Benefits Programs Listed through AccessNYC (Appendix E). Patients not already receiving benefits from the HIV/AIDS Services Administration (HASA) should also be assisted with an application.\textsuperscript{19}

2.3.6.2 Patients/families found to be eligible for one or more benefits and/or programs would be assisted in completing all the forms and gathering all the requisite support documentation that would constitute an application for the program.

2.3.6.3 The Program develops a plan with the patient for submitting the application and then follows through with the plan.

2.3.6.4 In addition to confirming patient submission of an application, the Program must obtain confirmation that the patient is eligible for the program or benefit and assurance of enrollment OR

2.3.6.5 If immediate confirmation of enrollment is not available, a timetable for the determination of the enrollment with documentation of the date of anticipated disposition and the outcome when that date arrives OR

2.3.6.6 If the enrollment is rejected, reassessment for other eligibilities should be performed and continuation of the process from that point.

2.3.6.7 All patients are reevaluated annually for the same benefits.

2.3.6.8 All screening and application for insurance and other benefits must be completed by the Program, an affiliate’s program or by a HASA case manager.

2.3.6.9 When the service is provided by a HASA case manager, at enrollment and annually thereafter, the Program must document the coordination of benefits assistance, including:

- HASA case manager identifier and locating information;
- Benefits currently provided to the patient or programs the patient is currently enrolled in;
- Plans with regard to other benefits or programs (e.g., applications submitted);
- Date of last communication with HASA; and
- Staff communicating and contact information.


2.3.7 Validation of documented needs assessments
   2.3.7.1 Review the current assessment(s) previously done by affiliated staff and ensure it is up-to-date and accurate.
   2.3.7.2 If information is up-to-date and accurate there is no need to duplicate the social services and benefits assessment.
   2.3.7.3 Perform a simplified assessment of housing needs, regardless of a current housing assessment, using the Reassessment Form (Appendix GG).

2.3.8 Reassessments are conducted within six (6) months of the previous assessment/reassessment) and are documented on the Reassessment Form (Appendix GG).

2.4 Directly Observed Therapy (DOT)
   2.4.1 In most instances, Care Coordination Programs provide modified DOT services, e.g., not seven (7) days a week. DOT must be offered to all patients indicated for ART and who meet the criteria for DOT outlined in the Criteria for Transition between Service Levels (Appendix G) in order to promote greater treatment adherence.
   2.4.1.1 For those who meet the DOT eligibility criteria at enrollment, the offer must be made at enrollment and if initially declined by the patient, then subsequent offers must be made at least once per quarter.
   2.4.1.2 For those who do not initially meet the DOT eligibility criteria, the patient should be continually assessed for DOT need and the offer should be made when the patient becomes eligible. Refer to Criteria for Transition between Service Levels (Appendix G).
   2.4.1.3 The offer of DOT and the outcome of the offer must be documented in the patient chart.
   2.4.2 DOT is a resource for those persons who are willing to take ART, and meet one of the following criteria:
   2.4.2.1 Currently on ART and have had difficulty adhering to regimen independently or with the support of intensive health promotion;
   2.4.2.2 Not currently on ART and have had difficulty adhering to psychotropic medications and/or opportunistic infection medications.
   2.4.3 DOT should be performed for patients in need of high intensity services. Patients receiving DOT for ART must be enrolled in Track D.
   2.4.4 DOT services should include an observation of patient pill consumption as well as any side effects reported or observed.
   2.4.5 DOT should be provided to serve patients in the setting that is most likely to yield clinical success. Appropriate settings include:
2.4.5.1 Field-based DOT occurs at the patient’s home or another field-based location of the patient’s choosing. Patients are responsible for the storage of their medications. DOT may be conducted by non-clinical Program Staff (e.g. DOT Specialist, Patient Navigator, etc.).

2.4.5.1.1 At a minimum, field-based DOT services are required to be available to all eligible patients.

2.4.5.2 Clinic-based DOT occurs at the Program location and/or the primary medical care site:

2.4.5.2.1 Medication dispensed on site – Programs must have proper medication storage facilities and licensed clinical staff to dispense medications.

2.4.5.2.1.1 In some primary care settings, regulation or policy may require that a licensed RN or LPN administer the medications delivered for DOT.

2.4.5.2.2 Medication not dispensed on site – Programs do not store or dispense medications. Patients may bring their medications to the site for DOT, which may be conducted by clinical or non-clinical Program Staff (e.g. DOT Specialist, Patient Navigator, etc.).

2.4.6 DOT must be conducted through face-to-face encounters and cannot be conducted via telephone.

2.4.7 A written or verbal agreement to participate in DOT is required to be documented in the patient record. The general procedure for DOT is as follows:

2.4.7.1 DOT is offered or encouraged when other interventions are not successful. Clinical guidelines for selecting DOT as an intervention – and for discontinuing DOT – are described in the Criteria for Transition between Levels of Service (refer to Appendix G).

2.4.7.2 Patients receiving DOT also receive weekly health promotion (refer to §2.2 – Health Promotion). After a sustained period of clinical (CD4 counts and VL) and behavioral improvement the patient may transition from Track D to another Track and continue receiving health promotion visits at the appropriate frequency based on the new Track of enrollment.

2.4.7.3 DOT should be provided at least five days per week. Practical limitations may allow a Program to devote staff to provide DOT during business hours only. Where possible, however, a Program should work extended
hours to accommodate those patients who take medication before leaving the house in the morning and those best served by taking them in the evening.

2.4.7.4 DOT may be provided fewer than five days per week on a case by case basis and with documented justification.

2.4.7.5 When ingestion of medications could not be observed directly by Program staff modifications to the intervention may be appropriate. These are listed from the most preferable – most comparable to true DOT – to less preferable options:

- For those patients on more than once-per-day regimens, one dose may be observed and recorded by a friend or family member.
- Program staff may directly observe one dose per day and record the outcome of another by means of a pillbox check at the next encounter.
- If a patient’s regimen is such that no dose could reasonably be observed by Program staff – for example, a patient who takes all medication at bedtime at 11 PM – the treatment team and the patient should consider the relative risks and benefits of DOT with an altered regimen versus the current regimen without DOT.

2.4.7.6 Any observation of an acute change of patient’s health or social circumstance necessitates a referral to his or her Care Coordinator or medical team as appropriate.

2.4.7.7 It is preferable for the Program Staff conducting DOT to be present at the patient’s medical appointments in the clinic. They should always document medication adherence, adverse effects or other issues that have arisen during the DOT encounter and may affect the patient’s ability to successfully adhere to the medical treatment plan.

2.4.7.8 A cycle of DOT should last six (6) to nine (9) months. When the patient completes the cycle and demonstrates adherence greater than 95%, the Program should transition the patient to a lower intensity service level.

2.4.8 The Program documents ART medication adherence by means of completing a Monthly DOT Log (Appendix EE) and Services Tracking Log (Appendix JJ).

2.5 Other social support
2.5.1 There are certain factors that help with Care Coordination. The Program should ensure that patients have maximal access to support from their community peers, and the Program should
maintain a formal relationship with community services agencies that provide center-based services such as:

- Access to a communal space where PLWHA could gather with peers
- Structured and unstructured social interaction
- Peer driven support groups

2.5.2 Counseling to assist with disclosure where feasible.

3.0 Roles and Responsibilities

3.1 Overview

3.1.1 The responsibilities described below may be arranged differently and staff titles may vary at each Program. One person may assume more than one role in some instances. For example, someone with the appropriate credentials and work experience might be appropriate for both the clinical supervisor and research support positions – generally a package of responsibilities should not be divided among individuals. For large programs, Directors and Supervisors may have deputies to subdivide the role.

3.1.2 The main purpose of this section is to specify roles and responsibilities of positions and provide an overview of activities.

3.1.3 The Recommended Staffing Plan (Appendix I) contains staff titles that conform to the role headings and provides more detail with regard to tasks.

3.2 Program Director

3.2.1 Has overall responsibility for operations of the Program.

3.2.2 Recruits, hires, and supervises all key personnel (with the exception of the Medical Center Liaison): the Care Coordinators and Center DOT Specialists directly, and Patient Navigators and Field DOT Specialists indirectly.

3.2.3 Reviews all Program enrollments, DOT enrollments, and case disposition actions.

3.2.4 Oversees all monitoring, reporting and quality management activities of the Program.

3.2.5 Ensures coordination of resources and logistics for staff training.

3.2.6 Coordinates Program activities with participating organizations and oversees the generation of all relevant protocols.

3.2.7 Produces summary reports of Program activities.

3.2.8 Acts as a liaison between the Program and NYC DOHMH and Public Health Solutions.
3.3 **Care Coordinator**

3.3.1 When Program services and the PCP are within the same agency or are co-located at the PCP site, the Care Coordinator:

3.3.1.1 Conducts orientation activities and enrolls the patient into the Program.

3.3.1.1.1 These services are the primary responsibility of the Care Coordinator but may be provided by a Patient Navigator on a limited basis as needed.

3.3.1.2 Verifies eligibility and conducts programmatic duplication checks to ensure that similar services are not already provided or available by another payer.

3.3.1.3 Performs the Intake Assessment including the initial social services, logistical and benefits assessment.

3.3.1.3.1 These services are the primary responsibility of the Care Coordinator but may be provided by a Patient Navigator on a limited basis as needed.

3.3.1.4 Obtains the medical treatment plan from the PCP and incorporates it into the Comprehensive Care Plan.

3.3.1.5 Facilitates the interdisciplinary conversation with the HIV care team.

3.3.1.6 Updates the Comprehensive Care Plan.

3.3.1.6.1 These services are the primary responsibility of the Care Coordinator but may be provided by a Patient Navigator on a limited basis as needed.

3.3.1.7 Assists patients with relevant applications and other paperwork for benefits and other support services.

3.3.1.8 Oversees the implementation of the Comprehensive Care Plan with the support of the Patient Navigator.

3.3.1.9 Provides clinic-based health promotion in conjunction with regularly scheduled primary care visits for low intensity patients.

3.3.1.10 Meets with patients after each HIV primary care appointment to review and update the Comprehensive Care Plan as long as they are enrolled in the Program.

3.3.1.11 Provides backup to Patient Navigator, as needed.

3.3.1.12 Conducts monthly reviews of all Patient Navigators and Field DOT Specialists. Reviews include face-to-face assessment of staff competency and chart-based review of staff work.

3.3.2 An appropriate supervisory responsibility is 3-5 Patient Navigators with a recommended caseload of 60-75 patients.
3.3.3 When Program services and PCP are not within the same agency AND the two are not co-located:

3.3.3.1 Some of the Care Coordinator’s duties may be completed by the Medical Center Liaison (MCL) (refer to §3.4) in order to maintain contact with the PCP, including:
- Generating and/or updating the clinical/medical sections of the Comprehensive Care Plan; and
- Clinic-based education for low-intensity patients.

3.3.3.2 Preferably the Care Coordinator should be able to meet with the PCP even when co-location is not possible.

3.3.3.3 The Care Coordinator would endorse the Comprehensive Care Plan and collaborate with the MCL on details of the plan. In health facilities where primary care case conferences are augmented by larger case reviews, the Care Coordinator must participate in quarterly case reviews to optimize interaction with the clinical team.

3.3.3.4 The Care Coordinator remains responsible for overseeing the Comprehensive Care Plan’s implementation.

3.4 Medical Center Liaison (MCL)

3.4.1 This position is intended for affiliation arrangements where the PCP could not arrange a dedicated or swing space. In such situations, the MCL:

3.4.1.1 Facilitates communication about patient management between primary care providers and Care Coordinators during orientation activities as well as on an ongoing basis.

3.4.1.2 Forwards informational reports (e.g., appointment dispositions, laboratory results, etc.) produced by clinical information systems to Care Coordinators.

3.4.1.3 Participates in the generation of and updates the medical/clinical sections of the Comprehensive Care Plan and forwards to Care Coordinators (refer to §3.3.3).

3.4.1.4 Collaborates with Care Coordinator on medical details of the Comprehensive Care Plan.

3.4.1.5 May conduct selected center-based Care Coordination activities such as health promotion for low-intensity PLWHA, as needed (refer to §3.3.3).

3.4.1.6 Collaborates with the clinical team to manage care coordination resources and target the neediest PLWHA for service.
3.4.1.7 May not provide back-up or supervision to the Patient Navigator.

3.4.1.8 Supervises a center-based DOT specialist, as needed.

3.4.1.9 A recommended caseload for an MCL may be in excess of 200.

3.4.2 If the Care Coordinator is based on-site at the PCP location, it is unnecessary to have a Medical Center Liaison.

### 3.5 Patient Navigator

3.5.1 Provides all home-based health promotion, support and skills building services to the patients on a quarterly, monthly or weekly basis.

3.5.2 Accompanies patients to routine primary care appointments and to other health care and social services encounters, as warranted.

3.5.3 Coordinates ongoing navigation and logistical support for appointment keeping reminders, transportation, childcare arrangements, or other barriers.

3.5.3.1 These services are the primary responsibility of the Patient Navigator but may be provided by another staff member on a limited basis as needed. Some responsibilities may be handled by the Medical Center Liaison, when applicable.

3.5.4 Is responsible for administering the health promotion curriculum and tracking the patient’s progress through the curriculum.

3.5.4.1 The curriculum is a guide with topics that include conversations with key components which should be addressed, but it does not have to be delivered as a didactic script.

3.5.4.2 It may take more than one session to complete a topic, and at times different conversations could be incorporated into one session if the Patient Navigator has assessed that there is a need for the information to be presented.

3.5.4.3 It is important to deliver this information in a way that is suitable to meet your patient’s education, developmental, language, gender, sexual and cultural needs.

3.5.5 Assists the Care Coordinator in conducting social services and benefits reassessment and follow-ups.

3.5.6 Provides critical feedback to other members of the health care team based on his/her observations in the field. The Patient Navigator’s feedback informs the development of the Comprehensive Care Plans.

3.5.7 Educates, coaches and empowers patients.

3.5.8 Depending on Program needs, may provide DOT services.
3.5.9 The recommended caseload is 14-20 patients, but this may be determined by each Program.

3.6 **DOT Specialist – Field**

3.6.1 Observes and records patient self-administration of ART and/or psychotropic medications and opportunistic infection medications.

3.6.2 Assesses for and reports any treatment related side-effects.

3.6.3 A recommended caseload is seven (7) patients, but this may be determined by each Program.

3.7 **DOT Specialist – Clinic**

3.7.1 Observes and records patient taking his/her ART and/or psychotropic medications and opportunistic infection medications.

3.7.2 Assesses for and reports any treatment related side-effects.

3.7.3 May administer the dose to the patient if allowed by law and institutional policy.

3.7.3.1 Clinic policy often requires a licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) to administer the dose.

3.7.4 A recommended caseload is 14-20 patients, but this may be determined by each Program.

3.8 **Clinical Supervisor**

3.8.1 The nature of Care Coordination and the close relationship that develops between direct-service staff members (Care Coordinators, Patient Navigators, DOT Specialists) and their patients, along with the challenging nature of their patients, create a need for staff to discuss their reactions to their work and to review the complex social, systemic, and emotional challenges that their patients face.

3.8.2 The Clinical Supervisor provides clinical or mental health guidance and the opportunity to review issues such as mental health and substance use, as they relate to particular patients. The Clinical Supervisor assists direct-service staff in identifying relational barriers to optimal patient engagement in care and strategies for proactive wellness and stress management for patients and staff members.

3.8.3 All staff providing services directly to patients (e.g., Care Coordinators, Patient Navigators, DOT specialists) should receive clinical supervision.

3.8.4 Clinical supervision should be provided by a licensed mental health provider (e.g., LCSW, LMSW, LMHC, psychiatrist, psychologist).

3.8.4.1 Clinical supervision sessions could be conducted individually and/or in groups.
3.8.4.2 It is strongly recommended that the frequency and length of sessions are as follows:
- Scheduled at least two times a month.
- Minimum of 60-120 total minutes per month.

3.8.5 It is strongly recommended that clinical supervision should not be provided to a staff person by his/her programmatic supervisor(s).

3.8.5.1 The clinical supervisor and programmatic supervisor will meet monthly to collaborate and support each other’s supervision of the team.

3.8.5.2 If the same individual is providing both programmatic and clinical supervision, clinical supervision should not be provided in conjunction with programmatic supervision, i.e. both types of supervision should not be provided in the same supervision session.

3.8.6 It is recommended that mental health clinicians who are Care Coordinators are provided with their own clinical supervision as required by their appropriate licensing requirements.

3.9 Medical Provider Roles and Responsibilities

3.9.1 Provides medical care to PLWHA participating in the Program.

3.9.2 Provides an affiliation agreement so that Program staff, if not employed by the PCP facility, could access all relevant patient health information necessary to do their job.

3.9.3 Participates in all referral and case conference activities as described. This includes:

3.9.3.1 Providing names of patients that have missed appointments or are lost to care.

3.9.3.2 Discussing Care Coordination with patients, encouraging enrollment for those who need the support, and making a referral at the time of the visit.

3.9.3.2.1 Referral responsibilities include completing the PCP Referral Disposition Form (Appendix M), handing off the patient to the Care Coordinator or Medical Center Liaison at the time of the appointment and discussing the reasons they are referring the patient to the program.

3.9.3.3 Participating in a minimum of quarterly formal case conferences for each patient with Care Coordination staff. Case conferences may include discussion of one patient or multiple patients (e.g. rounds).

3.9.4 Responds promptly to Program staff by relaying clinical concerns (e.g., patient non-adherence to ARV regimen).

3.9.5 Promptly apprises relevant Program staff of significant clinical events such as:
• Hospitalization;
• A new diagnosis; or
• Change in treatment regimen.

3.9.6 Documents the medical treatment plan in the patient’s medical record which should be accessible by the Program staff. The medical treatment plan is the basis of the Program’s Comprehensive Care Plan.

3.9.7 For patients who remain in care with the affiliated PCP after graduation from the Program, the PCP would continually assess the patient’s adherence to the treatment plan, clinical status and behavioral issues that may affect successful treatment of HIV.
• If appropriate, the PCP may refer the patient back to the Program.

3.10 NYC DOHMH
3.10.1 Funds the Care Coordination Program via Ryan White Part A funds.
3.10.2 Provides programmatic technical assistance.
3.10.3 Provides training/education of Program staff.
3.10.4 Monitors program implementation and data completeness.
3.10.5 Ensure that all required data is reported to Health Resources and Services Administration via the Ryan White HIV/AIDS Program Services Report (RSR).20
3.10.6 Evaluates program performance and health outcomes.
3.10.7 Provides quality management guidance and support.

3.11 Public Health Solutions
3.11.1 NYC DOHMH’s Master Contractor, managing Ryan White Part A funded contracts for DOHMH.
3.11.2 Provides contractual and fiscal technical assistance.
3.11.3 Monitors contract implementation and compliance.

4.0 Enrollment

4.1 Patient enrollment eligibility:

4.1.1 Patients must be at least 18 years of age (or emancipated minors) and meet one of the following criteria in order to be eligible for the DOHMH Care Coordination Program. Criteria include PLWHA who:

4.1.1.1 Are newly diagnosed with HIV;
4.1.1.2 Were lost to care as defined by having at least one primary care visit in the past two years at the facility and not having any primary care visits for the past nine months at the facility;
4.1.1.3 Have difficulty keeping appointments; or receive sporadic, irregular care; or have never been in care; or

Note: Appropriate appointment adherence is best left to the judgment of the medical provider due to the fact that appointments vary according to patient needs and the provider would have the best sense of appointment keeping behavior.

4.1.1.4 Have indications of ART challenges

4.1.1.4.1 ART naive and starting treatment AND have one or more of the following associated factors:\n
- High pretreatment or baseline viral load measures of HIV-1 RNA (depending on the specific regimen used), defined as > 100,000 copies/mL;
- Low pretreatment or nadir CD4 T-cell count < 200 cells/mm³;
- Prior AIDS diagnosis;
- Comorbidities (e.g., depression, active substance use); or
- Presence of drug-resistant virus.

4.1.1.4.2 ART experienced and re-starting ART with one or more of the factors listed in 4.1.3.1 OR one of the following:

- Prior treatment failure, with development of drug resistance or cross resistance;
- Earlier calendar year of starting therapy, when less potent regimens or less well-tolerated ART were used.

4.1.1.4.3 On ART and experience recurrent virologic rebound after successful suppression.

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• One definition of virologic failure is having two sequential viral load measures of HIV-1 RNA >1,000 copies/mL.

4.1.2 The duration of enrollment should be considered on a case by case basis, but should generally not exceed one year for most patients. It is up to your program to evaluate each patient for readiness for graduation. Patients who have been enrolled in Care Coordination for more than one year may continue to receive services at the appropriate intensity level at the discretion of the Program and medical provider and with documented justification. (Refer to §8.2 Graduation)

4.2 Referral source

4.2.1 Referral by an affiliated PCP who identifies a patient with a need for Care Coordination.

4.2.2 Referral by a source other than the affiliated PCP, examples include:

4.2.2.1 Referral by the Riker's Island Transitional Healthcare Coordination Consortium (THCC) linking a recent prison releasee to care or other similar programs.

4.2.2.2 Lateral transfer from another Care Coordination Program.

4.2.2.3 Patient self-referral or referral from another service provider.

4.2.2.4 Affiliated pediatric unit referring youth in need of care coordination services or other specialized units serving unique patient populations. The program is not designed for persons under the age of 18. **Emancipated minors, however, may be treated like adults with regard to the program and enrolled.**

4.2.2.5 The inpatient medical service or emergency department of an affiliated hospital identifying a patient with a need for these services.

4.2.2.6 External source linking a patient to care such as the DOHMH Field Services Unit (FSU) returning a patient who has been lost to follow-up or referring a newly diagnosed patient. FSU assists with partner notification and linkage to care.

4.2.2.7 The Program may recruit enrollees by outreaching to persons in the field after determination by chart or electronic health record review that they have been lost to follow-up (refer to §9.0).

4.2.2.8 An agency that provides HIV testing services.
4.2.3 Referrals received from the Emergency Department (ED) and similar programs that conduct HIV screening or may identify PLWHA during non-business hours.

4.2.3.1 Such programs should have dedicated staff – for example an HIV counselor – that would refer the patient.

4.2.3.2 The ED should ensure that patient identifying and locating information is optimal so that if the patient is discharged or leaves the facility the Program could reasonably find him or her the following business day. Collect the name and contact information of one individual who would always know where the patient is, if possible.

4.2.4 Direct referral—via outreach, Care Coordination medical provider, other service provider, patient self-referral or other Ryan White affiliated medical providers.

4.2.4.1 Referral from another source implies that the patient would receive primary HIV care services at one of the affiliated medical sites. The referral to the Program is presented as an ancillary service of the selected primary care practice.

4.2.4.2 The referring agency staff should either accompany the patient to the Program or PCP’s office, or make an appointment for the patient with the Program or PCP’s office.

4.2.4.3 The accepting Program or PCP would then meet with the patient and complete either a Pre-Referral to CC Program Form (Appendix L) and/or a PCP Referral Disposition Form (Appendix M).

4.2.4.4 Referral is considered complete when the accepting program acknowledges receipt of the referral.

4.2.4.4.1 The Program is obligated to ensure that the patient attends the initial PCP visit so that the PCP may determine if the patient is eligible for the Program.

4.2.4.4.2 The Program has no obligation to serve the patient until the PCP refers the patient to the Program and intake has been completed.

Note: Persons who are found to be ineligible for the Program after medical screening should be referred to a more appropriate program (e.g., mental health services, substance abuse treatment, etc.).

4.3 Referral process
4.3.1 The referral process should be as streamlined and secure as possible to ensure within reason the likelihood of its success.

4.3.2 Referral from a PCP

4.3.2.1 A provider who deems the Program clinically indicated for a patient should first obtain verbal assent from the patient to enroll and document the consent.

4.3.2.2 The PCP then completes the brief PCP Referral Disposition Form (Appendix M) documenting ART status and psycho-behavioral and clinical need. The provider needs written consent if referring outside of the PCP facility. This may be documented on the Care Coordination HIPAA Compliant Authorization for Release of Medical Information (Appendix P).

4.3.2.3 The PCP along with the Care Coordinator or the Medical Center Liaison meet with the patient after the primary care visit to review the treatment plan and patient goals and to introduce the Program. Further detail on the patient hand off is provided in §6.3.

4.3.3 Referral by a source other than the partner medical provider

4.3.3.1 All patients must enter the program with a PCP Referral Disposition Form (Appendix M) from their PCP. However, patients may be identified for the Care Coordination Program by persons other than their PCP prior to the official PCP referral. Patients should not be pressured to leave their current case management program or their current medical provider. Patients should be informed of provider options; however, their choice of provider is their own to make.

4.3.3.1.1 If the Care Coordination Program has a patient whom it believes would be appropriate for Care Coordination, or receives a direct referral from an outside agency, the Program should explain to the patient that they are choosing to receive primary care at one of the Program’s affiliated sites, and then complete the Pre-Referral to CC Program Form (Appendix L). This form should then be given to the Program-affiliated PCP that the patient has chosen so that the new PCP could evaluate the patient and complete the PCP Referral Disposition Form (Appendix M). The Program should check primary care appointment status and schedule as needed. At this point, the referral process should proceed as described in §4.3.2.2.
4.3.3.1.2 If the Care Coordination Program receives a referral from a non-Care Coordination affiliated site (e.g., rapid HIV testing provider, Riker’s Island Transitional Consortium, DOHMH STD or TB Clinic, etc.), a Pre-Referral to CC Program Form (Appendix L) should be completed, either by the referring agency or the Care Coordination Program. The Program should check primary care appointment status and schedule an appointment within 48 hours of referral to occur as soon as possible, but not more than two weeks from the date of referral.

4.3.3.1.2.1 This process should occur through a telephone discussion, working with the referring agency to ensure that the referred patient has a scheduled medical appointment prior to the patient leaving the referring agency’s office.

4.3.3.1.2.2 If the referring agency is making a referral based on a preliminary positive rapid HIV test result only, the Care Coordination Program and/or Medical provider collects a confirmatory test specimen and sends it for processing.

4.3.3.1.3 Once the patient has been engaged in medical care, the Care Coordination Program would share the required documentation of linkage with the referring agency. This documentation includes the date the appointment was kept by the referred patient, along with proof of the kept appointment (refer to §4.3.3.1.3.1). At this point, the referral process should proceed as described in §4.3.2.2.

4.3.3.1.3.1 Documentation required by DOHMH as proof of appropriate linkage must be one of the following:

- CD4 order, and/or result, from the agency to which the patient was referred
- Viral load order, and/or result, from the agency to which the patient was referred
• Copy of a medical note with the word ‘HIV’ or ‘AIDS’ in the context of the patient’s diagnosed condition, from the agency to which the patient was referred
• Orders and/or a prescription for any ARV, from the agency to which the patient was referred
• Letter or note from staff at the treating agency to which the patient was referred, stating that the medical visit was HIV and/or AIDS-related

4.3.3.2 The Program should address urgent and emergent needs and support appointment adherence.
4.3.3.3 PCP meets with the patient, confirms HIV status and evaluates the patient.
4.3.3.4 If the PCP determines the patient is in need of care coordination services, after obtaining verbal assent, then proceed as follows:
• The PCP then completes the PCP Referral Disposition Form (Appendix M) documenting reason for referral and recommended starting track.
• The PCP and Care Coordinator meet with the patient after the primary care visit to review Comprehensive Care Plan and patient goals.
4.3.3.5 If the PCP determines that care coordination services are not currently a good option for the patient, he/she completes the PCP Referral Disposition Form (Appendix M) documenting the reason for not referring the patient.
4.3.3.6 The accepting Program would track all referrals with regard to the disposition, e.g., enrolled, declined, lost to follow-up prior to enrollment.

4.4 Case finding prior to PCP referral (“Return to Care”)
4.4.1 The Program should conduct case finding activities to find patients lost to follow-up.
4.4.2 Patients lost to follow-up are those who have had a medical visit at the primary care facility within the last two years but not within the last nine months.
4.4.3 A list of such patients should be produced via a search of the provider’s medical records. One large list should be produced at the initiation of the program. This list should be updated on a quarterly basis with new patients that meet the Lost to Care definition.
4.4.4 Patient contact information is verified.

4.4.5 Patient contact initiated. The Missed Appointments procedures (§7.3.11) or a similar combination of outreach methods is suggested.

4.4.6 The Program should maintain a log of case finding activities and disposition. The Program may develop their own tracking tool or use the DOHMH's Return to Care Tracking Tool in Microsoft Excel. Contact your DOHMH Project Officer to receive this tracking tool electronically.

4.4.7 When the patient is enrolled in Care Coordination, the summation of the Return to Care activities for that patient can be documented in the Services Tracking Log (Appendix JJ) as a Case Finding service type.

4.4.7.1 The Case Finding service type is used to document the pre-enrollment case finding activities after the patient is enrolled. This service type is used once to sum the total amount of time spent on pre-enrollment case finding activities, and the Service Date should be on the same date as the Enrollment Date.

4.4.8 For more information, see §9.0.

4.5 Intake

4.5.1 As per HRSA guidelines, Ryan White Part A funds must be used as the payer of last resort. Only services that are NOT billable to other payers (such as Medicaid Health Homes) are reimbursable with Ryan White Part A funds.

4.5.2 At intake, Program staff must verify whether the client is enrolled in any of these NYC-funded and/or NYS-funded medical case management programs:
- Medicaid Health Homes;
- Comprehensive Medicaid Case Management Program including, but not limited to, the Community Follow-up Program (COBRA); or
- Another Ryan White funded Care Coordination Program (CCP).

4.5.3 As Clients may be dually enrolled in this CCP and Medicaid Health Homes or Comprehensive Medicaid Case Management Program/COBRA in these instances:
- Clients who are not eligible for Medicaid or are not enrolled in a Medicaid Health Home may continue to be served with the full range of CCP services.
- All eligible clients, regardless of their enrollment in Health Homes, may be provided specific and defined CCP services that are not provided by Health Homes.
- Clients who are enrolled in Health Homes and need additional support may be enrolled in CCP for limited services.
4.5.4 Clients may not be enrolled in this CCP and another identical Ryan White funded CCP. Program staff must ensure that this CCP is used as the payer of last resort.

4.5.4.1 Under no circumstance should a person receive an identical service from more than one agency. When such duplication is discovered, the Program and the provider of the other services should discuss with the patient which agency best suits his or her needs.

4.5.4.2 Programs would collaborate and coordinate with other CCP to ensure that PLWHA receive comprehensive, non-duplicative – but complementary – services. PLWHA with numerous complex social and/or health/mental health needs would be referred to other agencies that target those specific issues and coordination of services would continue.

4.5.5 Orientation

4.5.5.1 Orientation would begin at the PCP’s health facility. The Care Coordinator or the Medical Center Liaison conducts the orientation with the patient. The Patient Navigator may assist with orientation as needed.

4.5.5.2 The purpose of the orientation is to:

1. Explain the purpose, structure and benefits of the Program.
2. Introduce the Patient Navigator, if possible. If a formal introduction to the Patient Navigator is not possible, give the Navigator’s contact information to the patient and explain that a Patient Navigator would deliver most of the care coordination services. Also provide contact information for the Care Coordinator.
3. Ensure appropriate and complete contact information is on record (including a contact number at which the patient could be reached during business hours, cell phone, home number, etc.) and a friend or relative that would know the patient’s whereabouts and could be contacted in the event that communication with the patient is unsuccessful. The Contact Information Form (Appendix R) and the Common Demographics Form (Appendix T) should be used to document this information.
   - Find out if the patient’s HIV status has been disclosed to this contact person and use appropriate confidentiality procedures.
4. Explain the importance of notifying the Program and PCP in the event of a hospitalization or travel.
5. Address urgent needs such as need for housing, domestic violence, etc.
6. Ensure medical treatment follow-up is in place.
7. Ensure all the requisite elements for comprehensive assessment – including a benefits assessment - and plan are scheduled.
8. Check childcare and transportation needs with regard to care access up to and including the next scheduled encounter.

4.5.5.3 Orientation processes that allow the Program to begin services include:

4.5.5.3.1 Describe the needed services, obtain the patient's agreement to participate and document on the Ryan White Part A Care Coordination Program Agreement (Appendix N).

4.5.5.3.2 Obtain appropriate releases of information and document on the HIPAA Compliant Authorization for Release of Medical Information (Appendix P) if needed.

4.5.5.3.3 Record detailed contact information and document on the Contact Information Form (Appendix R).

4.5.5.3.4 Determine logistics for an initial home or field visit and document on the Logistics for Navigator Form (Appendix S).

4.5.5.3.5 This is accomplished immediately after the referral and hand off from the PCP. In some circumstances, the patient may not have the time necessary to complete this activity right away. In these instances, ensure that the Ryan White Part A Care Coordination Program Agreement (Appendix N) and the HIPAA Compliant Authorization for Release of Medical Information (Appendix P) are completed to allow Program to follow-up with patient.

4.5.5.4 During the first two weeks of enrollment, baseline assessments of clinical and psychosocial status (Intake Assessment Form), the completion of the baseline Adherence Assessment, as well as the development of a Comprehensive Care Plan, should be completed with the patient. These activities may be incorporated into the health promotion activities.

4.5.5.5 Primary care appointments
4.5.5.5.1 Patients referred through a source other than the affiliated medical provider should have a primary care appointment scheduled as soon as possible so that the affiliated PCP could evaluate the patient for the Care Coordination Program.

4.5.5.6 The Care Coordinator or the Medical Center Liaison at the clinical site is primarily responsible for the orientation to Care Coordination, the Intake Assessment, the initial Adherence Assessment, and the Comprehensive Care Plan. The Patient Navigator may assist with orientation as needed.

4.5.5.7 In addition to forms mentioned above in §4.6.5.3, essential items would be documented on the Intake Assessment Form (Appendix U), the Comprehensive Care Plan (Appendix Y), the Adherence Assessment Form (Appendix W or X), and Services Tracking Log (Appendix JJ).

5.0 Initial Interdisciplinary Comprehensive Assessment

5.1 Overview

5.1.1 The term “interdisciplinary comprehensive assessment” refers to the process of compiling and taking into consideration input from all relevant clinical and non-clinical service providers to develop the most comprehensive and beneficial care plan possible for the patient.

5.1.2 The comprehensive assessment is based on evaluations and assessments from clinical providers, social services providers, mental health professionals and the Care Coordinator. The interdisciplinary comprehensive assessment process should not duplicate assessments already conducted by other team members or other medical or benefits programs.

5.1.2.1 The interdisciplinary comprehensive assessment process starts when the referring PCP documents treatment interventions and goals.

5.1.2.2 The Care Coordinator compiles the assessment documentation from other programs and departments.

5.1.2.3 The information gathered during the Comprehensive Assessment leads to the development of the Comprehensive Care Plan (Appendix Y).

5.2 Medical assessment
5.2.1 A PCP must participate in the patient’s comprehensive assessments. The medical assessment generally includes the following:

5.2.1.1 List of medical conditions: HIV and non-HIV.

5.2.1.2 The list of medications and regimen detail: ART and non-ART.

5.2.1.3 Medical history
- Elements of the clinical status such as CD4 cell count trends, VL trends (i.e., lowest ever CD4 count, highest and lowest ever VL with doses), opportunistic infections (OI), evidence of drug resistance and other co-morbidities should be included in the medical history.

5.2.1.4 Mental health and substance abuse assessments.

5.2.1.5 If not on ART, whether clinical indication to start ART exists or not.

5.2.1.6 For patients on ART, a quantitative estimate of the patient’s adherence to the regimen over the past three months should be conducted by the PCP, nurse, or Care Coordinator and documented using the Adherence Assessment Form (Appendix W or X).

5.2.1.7 Assessment of current sexual and drug use risk behavior that could result in HIV transmission.
- This assessment need not be repeated if the PCP has performed this assessment in the past six months.

5.3 Social Services and Benefits Assessment

5.3.1 The Program is primarily responsible for assessing social services and benefits needs, in the event that no other clinic or social services (e.g., case manager) personnel have conducted such a review. See §2.3 for details on the assessment.

5.3.2 Time Requirement: The initial assessment of social services needs and benefits eligibility, using the Intake Assessment Form (Appendix U), should occur within two weeks of enrollment into the Program.

5.4 Logistical Assessment

5.4.1 The initial interdisciplinary comprehensive assessment process addresses the logistics of Care Coordination, which includes:

5.4.1.1 Family or social network available to provide support in helping the patient meet his/her healthcare needs.

5.4.1.2 Schedule and availability (e.g. employment, caretaking, education, other activities).

5.4.1.3 Childcare responsibilities impacting daily routine.
5.4.1.4 Patient’s preferred language.
5.4.1.5 Outstanding criminal justice issues (parole, etc.).
5.4.1.6 General or health literacy impediments.
5.4.1.7 Social barriers to delivering services in the home such as the risk of family violence and neighborhood safety.
5.4.1.8 Logistical assessment may make the treatment team aware of drug or sex partners to whom the patient has not yet disclosed risk of HIV infection.
5.4.1.9 Elements of the logistical assessment are documented on the following forms: Logistics for Navigator Form (Appendix S), Intake Assessment Form (Appendix U), Common Demographics Form (Appendix T), and the Contact Information Form (Appendix R).

6.0 Initial Comprehensive Care Plan

6.1 Overview
6.1.1 The initial Comprehensive Care Plan starts with the referral from the PCP and incorporates the interdisciplinary assessments described in §5.0. The Care Plan generates a timeline of care navigation activities and goals that cover the period until the next regularly scheduled primary care visit. The plan is patient-centered and incorporates the patient’s goals.
6.1.2 The plan must be documented in writing, clearly addressing each identified need. The Program may develop a care plan form or use the optional DOHMH Comprehensive Care Plan Form (Appendix Y). This Plan, as well as the Intake Assessment Form (Appendix U), identifies the service level and frequency of care coordination activities.
6.1.3 The Program staff completing the Care Plan (typically the Care Coordinator) must sign the form. Every activity on the Care Plan needs to list a responsible party, target date, outcome and outcome date.
6.1.4 The Care Coordinator is primarily responsible for implementing and following up with the Care Plan regardless of which program staff completes the Care Plan. The patient is an active participant in the creation of the Care Plan.
6.1.5 The plan incorporates behavioral health, nursing, and other specialist and allied health professional plans as indicated. The Care Plan:
   - Summarizes the medical plan in patient’s record
   - Summarizes the social worker’s plan, if available
   - Adds the support services and logistical plan
• Adds medical appointment, treatment adherence, health promotion curriculum, and other needs and goals

6.2 **Time Requirement:** The Comprehensive Care Plan is completed within two weeks of enrollment to the Program and may be updated at any point as needed but at a minimum of every six (6) months.

6.3 **Hand off, case conference, and case review**

6.3.1 Initial hand-off

6.3.1.1 A brief face-to-face meeting between the PCP and Care Coordination team is held for initial hand-off at the time of referral.

6.3.1.2 All relevant information (e.g. social services need, clinical status, behavioral health details such as current drug use, both patient’s and PCP’s perspectives of the barriers to care and treatment, etc.) is shared amongst the team during the hand-off.

6.3.1.3 At a minimum, attendance at the initial hand-off should include the PCP along with the Care Coordinator or the Medical Center Liaison, and if possible the Patient Navigator. If appropriate and possible, the patient should attend as well.

6.3.1.4 If a Patient Navigator or Care Coordinator was not assigned to the patient prior to the hand-off, the Program Director assigns Program staff as soon as possible.

6.3.1.5 Document the initial hand-off on the Services Tracking Log (Appendix JJ) using the eSHARE service type “Case Conference.”

6.3.2 Chart-based case review

6.3.2.1 Ongoing chart reviews

6.3.2.1.1 The purpose of chart reviews is for staff members to ensure that the program model is followed.

6.3.2.1.2 These could be done alone or with the supervisor and do not have to coincide with the PCP visit.

6.3.2.1.3 These reviews are used to inform or trigger a case conference when necessary.

6.3.2.1.4 All Care Coordinators meet with Patient Navigators no less than once per week to review cases. These chart reviews are not case conferences. They are considered supervision and quality improvement activities.
6.3.2.1.5 Patient Navigators select challenging cases from the prior week for review with Care Coordinator.

6.3.2.1.6 All cases should be reviewed by the Care Coordinator at least once per quarter.

6.3.2.1.7 The Program Director meets with Care Coordinators once per week and review cases selected from those in item 6.3.2.1.5.

6.3.2.2 Quarterly Reviews - The Program Director reviews all cases in the portfolio once per quarter. (Refer to §12.0.)

6.3.3 Case conference

6.3.3.1 A case conference occurs any time a clinical evaluation (e.g. a physician visit) generates new information that could impact the patient's care plan.

6.3.3.2 A status change that might impact the medical treatment plan also triggers a case conference (e.g. loss of housing, pregnancy, etc.).

6.3.3.3 In most instances, a face-to-face meeting (scheduled or unscheduled) between the PCP and the Program (e.g. the Care Coordinator or Patient Navigator accompanying the patient to his/her PCP visit) immediately following a visit satisfies the requirement for a formal case conference.

6.3.3.4 In some instances this is not feasible. For example:

6.3.3.4.1 The patient has active behavioral health problems, and the input of a mental health provider is required.

6.3.3.4.2 The patient has other medical needs (e.g. pregnancy), and the input of a medical specialist (e.g. obstetrician) is required.

6.3.3.4.3 In these cases, a conference may be deferred or it may be accomplished by phone/conference call or both, but it must be completed within ten (10) business days of the clinical evaluation.

6.3.3.5 A case conference is documented on the Case Conference Form (Appendix FF).

6.3.3.6 A formal case conference occurs for each patient at least once per quarter and includes any case conference where all elements included on the Case Conference Form (Appendix FF) are covered with required attendees present.

6.3.3.6.1 Required attendees include:
- Program Staff (CC and/or PN and/or MCL)
• Clinician (MD/DO/NP/PA)
6.3.3.6.2 Optional attendees include:
  • Patient

6.3.3.7 An informal case conference occurs as frequently as needed and does not require completion of the Case Conference Form (Appendix FF).
6.3.3.7.1 Required attendees include:
  • Program Staff (CC and/or PN and/or MCL)
  • Non-Program Staff (Clinician, Social Worker, Mental Health Provider, Nutritionist, etc.)
6.3.3.7.2 Optional attendees include:
  • Patient

6.3.3.8 Case conferences are structured, interdisciplinary meetings involving all parties providing direct service to the patient. Programs with network partners that are not co-located could consider allowing off-site team members to participate via telephone when an in-person case conference is not possible. In general, in-person case conferences are recommended.

6.3.3.9 Another option for formal case conferences is when a Patient Navigator accompanies a patient to a primary care visit, or whenever a primary care site has a care coordinator or a medical center liaison on site, patient visits should conclude with a meeting between at least one of the above (PN, CC, or MCL) and the PCP.
6.3.3.9.1 When no Care Coordination staff on the premises, the PCP instead contacts the Care Coordinator at the conclusion of the visit to update him/her. This should occur rarely.
6.3.3.9.2 When a status change occurs outside the context of PCP evaluation, the Care Coordination staff contact the PCP as soon as possible after they become aware of the status change. This should occur rarely.
6.3.3.9.3 If the medical provider already has a mechanism for interdisciplinary case conferences in place, the conversation may be deferred until the next meeting.

7.0 Management of Patients

7.1 Program flow at a glance
7.1.1 Phases
• Induction: The initial period after enrollment is a critical time to familiarize the patient with the program and begin health promotion discussions from the HIV curriculum facilitator’s guide. As such, it is recommended that for the three months after enrollment every patient indicated for ART start with at least weekly health promotion. Intensity could vary per patient need and program discretion. Patients enrolled initially in Track A are not subject to the induction period requirement.

• Ongoing: After the Induction period, the patient should be transitioned into his/her ongoing care level. It is anticipated that the majority of patients would continue receiving weekly health promotion visits until s/he demonstrates clinical and behavioral improvements.

7.1.2 Intervention Types (refer to Table 1 on page 43, Table 2 on page 45 and the Criteria for Transition in Appendix G)

- Low intensity: A, B
- High intensity: C1, C2, D

7.2 Induction into the Program

7.2.1 Duration: Induction into the Program phase consists of the first three months of service and allows the Program staff to more quickly and accurately evaluate the patient’s needs and abilities in the areas of medication and appointment adherence and health promotion. The end of the induction period should correspond to a regularly-scheduled medical appointment approximately three months from enrollment.

7.2.1.1 Prior program experience has shown that some patients may need additional time after enrollment to engage in the program. Examples of engagement include the patient answering a phone call from the program, opening the door when the program makes a home visit, etc.

7.2.2 Components: The Induction phase starts new patients on the Program and includes:

- Care Navigation;
- Health Promotion;
- Social Services and Benefits Assistance;
- DOT for high intensity patients. (Refer to §2.4)

7.2.3 Patients prescribed ART are guided as per the curriculum in transferring their pills to a pill box as early as possible. Other treatment adherence support/reminder tools (e.g. blister packs) may be used in lieu of pill box as appropriate.

7.2.4 Care Navigation Activities

7.2.4.1 Patients in the Induction phase receive health promotion by a Patient Navigator at least once per week.
7.2.4.2 Patients in the Induction phase are accompanied to all primary care appointments from his/her home. If the home is not a suitable location because of safety, disclosure concerns or other obstacles, the accompaniment originates at an alternative mutually-agreed upon location in the community (e.g., somewhere the patient hangs out, the patient’s favorite park, a set location near their home or work). More than ensuring attendance, this provides support and allows for building the skills necessary for the patient to become more self-sufficient in the healthcare environment.

7.2.4.3 Accompaniment to medical specialists and social services programs is beneficial and encouraged.

7.2.4.4 The Care Coordination staff tailors the approach according to patient successes and challenges.

7.2.5 Health Promotion (refer to §2.2)

7.2.5.1 During the Induction period, the list of topics for health promotion is suggested based upon patient clinical status and therefore intervention intensity, as described in Table 1 on page 43. The patient and Patient Navigator may decide together to prioritize conversations differently as well as postpone conversations to a later date.

7.2.5.2 ART pill counting is conducted weekly and documented monthly on the appropriate adherence assessment form that reflects expected, taken, and missed doses and/or pills for each medication.

<table>
<thead>
<tr>
<th>Intervention Intensity</th>
<th>Patient Characteristics</th>
<th>Suggested Health Promotion Topics</th>
<th>Frequency of Conversations</th>
</tr>
</thead>
</table>
| Low B & High C1, C2, and D | Prescribed ART or ART precluded by behavioral contraindication | • Me and HIV (Core)  
• What is HIV and How Does It Affect My Body (Core)  
• Medical Appointments and Providers (Core)  
• What is Adherence? (Core) | Delivered weekly or daily, generally in the patient’s home, but may also include the PCP’s office. |

7.2.6 DOT: See §2.4 –Directly Observed Therapy for details.

7.3 Ongoing Care Coordination

7.3.1 Following the induction phase of the Care Coordination program, the patient is served with respect to his/her level of need - high versus low intensity. Patients may stay in a high intensity weekly
track after the induction phase per program discretion. With each subsequent visit to the PCP, the patient’s health promotion and medication adherence needs should be re-assessed and the Comprehensive Care Plan updated accordingly.

7.3.2 Compared with the Induction phase, this maintenance phase allows for greater stratification of levels of service.

7.3.3 **Duration**: Ongoing care coordination services are administered until the case is closed (patient graduation).

7.3.4 **Components**: Ongoing care coordination includes the following:
- Care Navigation;
- Health Promotion;
- Social services and benefits assessment;
- DOT (as warranted).

7.3.5 Care Navigation Activities

7.3.5.1 Patients receiving high-intensity interventions would be accompanied from their homes (or an alternative mutually-agreed upon location in the community) to all medical appointments, as needed. This provides support and allows for the building of necessary skills to help the patient increase self-sufficiency in the healthcare environment.

7.3.5.2 Accompaniment activities include:
- Helping the patient prepare for a visit;
  - List problems, concerns, questions;
  - Role-play or practice discussing difficult topics with the doctor;
- Physically accompanying the patient from his/her home. If the home is not a suitable location because of safety, disclosure concerns or other obstacles, the accompaniment originates at an alternative mutually-agreed upon location in the community (e.g., somewhere the patient hangs out, the patient’s favorite park, a set location near their home or work). It is important to work with the patient to determine their willingness and need for accompaniment from their home. A crucial part of an accompaniment is attendance at the PCP visit with the patient.
- Supporting communication between patient and PCP in the exam room; this includes reviewing the doctor’s recommendations to determine if they are manageable for the patient and if not, how to alter them to work for the patient and the PCP.
- Reviewing the medical treatment plan immediately after the visit.
7.3.5.3 Similarly, accompaniment to social services agencies and programs is beneficial. The Patient Navigator and Care Coordinator should pay attention to patient successes and challenges and tailor his/her approach accordingly.

7.3.6 Health Promotion (See §2.2)

7.3.6.1 Pill counting and documentation for patients taking ART but not receiving DOT services is described in §2.2.5.6 and on the Pill Box Log (Appendix CC or DD).

7.3.6.2 Health promotion and treatment adherence activities for ongoing Care Coordination are outlined in Table 2. These activities are designed to explore the patient’s barriers to optimal medical care and health outcomes and identify opportunities, services, education, etc. that would assist the patient in overcoming these barriers.
### Table 2 – Intervention types for the duration of Care Coordination Program*

<table>
<thead>
<tr>
<th>Intervention Intensity</th>
<th>Service Level (Track)</th>
<th>Intervention Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Health Promotion Curriculum:</strong> Delivered <em>quarterly</em> in conjunction with primary care visits and at any home visits. Suggested topics include:</td>
</tr>
</tbody>
</table>
| **A** (limited to persons with no indication for ART or those who are not prescribed and/or will not be taking ART in the immediate future) | | • **Topic 1:** Introduction to the Health Promotion Curriculum (Core)  
• **Topic 2:** Me and HIV (Core)  
• **Topic 7:** What is HIV and How Does it Affect My Body (Core)  
• **Topic 8:** Identifying and Building Social Support Networks (Core)  
• **Topic 10:** Medical Appointments and Providers (Core)  
• **Topic 11:** Health Maintenance (Discretionary)  
• **Topic 12:** Harm Reduction – Sexual Behavior (Discretionary)  
• **Topic 13:** Harm Reduction – Substance Use (Discretionary)  
• **Topic 14:** Harm Reduction – Safety in Relationships (Discretionary)  
• **Topic 15:** Healthy Living – Diet and Exercise (Discretionary)  
• **Topic 16:** Wrap Up |
|                        |                        | Accompaniment to PCP appointments |
|                        |                        | **Medication Adherence:** None |

<table>
<thead>
<tr>
<th><strong>B</strong> (limited to persons prescribed ART)</th>
<th><strong>Health Promotion Curriculum:</strong> Delivered <em>quarterly</em> in conjunction with primary care visits and at any home visits. ALL health promotion curriculum topics are suggested, which include all of the topics listed for Low A, plus</th>
</tr>
</thead>
</table>
|                                        | • **Topic 3:** Using a Pillbox (Core)  
• **Topic 4:** Handling your ART Medications (Core)  
• **Topic 5:** What is Adherence? (Core)  
• **Topic 6:** Side Effects (Discretionary)  
• **Topic 9:** Adherence Strengths and Difficulties (Core) |
<p>|                                        | Accompaniment to PCP appointments |
|                                        | <strong>Medication Adherence:</strong> Quantitative measurement of adherence by self-report in conjunction with PCP and home visits |</p>
<table>
<thead>
<tr>
<th>Service Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C1</strong> (limited to persons prescribed ART)</td>
<td>Health Promotion Curriculum: Delivered <strong>monthly</strong>, generally in the patient’s home or other suitable site in the field. ALL health promotion curriculum topics are suggested. Accompaniment to PCP appointments Medication Adherence: Pill counting monthly</td>
</tr>
<tr>
<td><strong>C2</strong> (limited to persons prescribed ART)</td>
<td>Health Promotion Curriculum: Delivered <strong>weekly</strong>, generally in the patient’s home or other suitable site in the field. ALL health promotion curriculum topics are suggested. Accompaniment to PCP appointments Medication Adherence: Pill counting weekly</td>
</tr>
<tr>
<td><strong>D</strong> (limited to persons prescribed ART)</td>
<td>Health Promotion Curriculum: Delivered <strong>weekly</strong>, generally in the patient’s home or other suitable site in the field. ALL health promotion curriculum topics are suggested. Accompaniment to PCP appointments Medication Adherence: DOT <strong>daily</strong> (M-F)</td>
</tr>
</tbody>
</table>

*Service Levels (Tracks) are described in Criteria for Transition between Service Levels (refer to Appendix G)*

7.3.6.3 Decisions to scale back, maintain or intensify services

7.3.6.3.1 The clinical and Care Coordination team collaborate, at the point of clinical evaluation (usually a scheduled primary care visit), or during a case conference not associated with a clinical visit, to make decisions regarding services. Criteria for the decision include behavioral and clinical factors as well as social and life stressors.

7.3.6.3.2 In most circumstances a patient exhibiting improvement at a point of clinical reassessment would step down one level of service (track) while a patient with significant challenges (e.g., a big rebound in the viral load, a new OI, or another episode of a previous OI) may step up all the way to DOT if necessary.

7.3.6.3.3 The detailed criteria for movement between levels of service are laid out in Appendix G. These are guidelines and clinical nuance is warranted.

7.3.6.3.4 Any changes in intensity of Care Coordination services (track change) should be logged via
the Status Change Information Form (Track and Treatment Status) (Appendix HH).

- Intervention tracks are entered through the Patient Status Change form in eSHARE. Only track changes that have been entered into the Patient Status Change form would count toward payment calculations. Identification of the new track in a Case Conference Form is not sufficient to affect payment.

7.3.6.3.5 Patients with brief interruptions in their medication regimen (e.g., brief incarceration, rehabilitation, etc.) should continue with their previous service level (track).

7.3.6.3.6 If treatment is expected to discontinue for an indefinite period (e.g., long-term incarceration, mental health status change, etc.), the patient should transition to low intensity service in the A track.

7.3.6.3.7 Any medication interruptions should be noted on the Reassessment Form (Appendix GG) and the Status Change Information Form (Track and Treatment Status) (Appendix HH).

7.3.7 Social services and benefits assistance

7.3.7.1 Reassessment

7.3.7.1.1 The Program would review the plan with regard to social services and benefits assistance at least once every six (6) months, preferably coinciding with the patient’s primary care visits.

7.3.7.1.2 A brief housing reassessment should be conducted at every regularly scheduled medical visit.

7.3.7.1.3 Reassessment is documented on the Reassessment Form (Appendix GG).

7.3.7.1.4 Programs are responsible for assisting with recertification for HASA and Human Resources Administration (HRA)23.

7.3.7.1.4.1 When assisting with recertification, the Program documents on the Reassessment Form (Appendix GG).

7.3.8 Directly Observed Therapy (DOT): Refer to §2.4 for details.

7.3.9 Ongoing Comprehensive Care Plan updates

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7.3.9.1 The Care Coordinator (with support from Patient Navigator) meets with patients to either create a new Comprehensive Care Plan or update the current Comprehensive Care Plan at least once every six (6) months.

7.3.9.1.1 The PCP provides the medical treatment plan which is the basis of the Comprehensive Care Plan.

7.3.9.2 In addition to assessments that coincide with patient’s visit to the PCP, reassessments should also occur when the patient’s situation changes.

7.3.9.2.1 These changes are opportunities to discuss with the patient other related circumstances and needs, and may result in updates to the Comprehensive Care Plan. Changes that may necessitate an assessment and plan update may include:

- Homelessness;
- Substance use
- Any event that may require emotional support and counseling services;
- Patient deciding to adjust goals or priorities;
- Enrollment in other case management program (e.g. Medicaid Health Homes).

7.3.9.3 Check for duplication of services at least once every six (6) months, and the patient’s status is updated accordingly.

7.3.9.3.1 Patients enrolled in Medicaid services (e.g. COBRA case management or Health Homes) and who are ineligible for Ryan White funded services must be disenrolled from Care Coordination. This should be documented on the Status Change Information Form (Case Closure/Suspension) (Appendix II).

7.3.9.3.2 Patients enrolled in Medicaid services (e.g. COBRA case management or Health Homes) and who are eligible for Ryan White funded services may receive wraparound Care Coordination services. This should be documented immediately on the Reassessment Form (Appendix GG) and entered into eSHARE in order to have the new status count towards payment calculations. Refer to §4.5.1.
7.3.9.4 The Reassessment Form (Appendix GG) should be used to document the information collected during this process.

7.3.10 Common decisions regarding service levels

7.3.10.1 Patient declines ART despite indication
- The patient has engaged in the program but declines ART; declination of service warrants a change to intensity level Low A, but the patient should regularly be encouraged to initiate ART.

7.3.10.2 Frequency of patient engagement is less than recommended service level
- The patient has not substantially engaged in the program. If all efforts fail, it is preferable to move a patient on ART to intensity level Low B instead of disenrolling the patient. Reasons should be explored as to why the patient declines services and the patient should be encouraged to accept the recommended service level.

7.3.10.3 Patient declines recommended service level
- A patient may decline a higher intensity service and therefore continue to receive a lower intensity service than clinically indicated. *For example, a patient may continue to have unsuppressed viral load despite weekly health promotion, pill counting, and adherence to primary care encounters with accompaniment. The patient may decline DOT and therefore continue the current service level.*
  - When a patient declines a service level, re-offer that level at each primary care encounter if the indication continues.
  - If all efforts fail to effectively engage the patient after transitioning to a lower intensity service, then the Program may disenroll the patient and refer to a more appropriate program.

7.3.10.4 Progress toward graduation
- The duration of enrollment should be considered on a case by case basis, but should generally not exceed one year for most patients. It is anticipated that persons with indication for Low Intensity service would not require the service for more than one continuous year. Boundary or attachment concerns should be addressed with the patient in preparation for graduation.
7.3.11 Missed appointment procedure

7.3.11.1 Monitor each patient’s scheduled Comprehensive Care Plan activities (e.g. medical appointment, DOT session, health promotion session, etc.).

7.3.11.2 Document the outcome of each activity as it occurs.

7.3.11.3 When a patient misses an appointment or fails to adhere to any part of the medical treatment plan:

- A supervisor is notified;
- Missed appointment may be documented on the optional Referrals/Appointments Tracking Log (Appendix Z);
- At a minimum, daily telephone calls are made to the patient starting the day of the missed appointment;
- Phone calls should be made at different times of the day to better make contact with patient;
- A field/home visit is necessary after three sequential days of failed outreach by phone. However, the Program need not wait three days to initiate field outreach;
- Field/home visits continue at least once per week until the patient is located;
- Subsequent visits to the last listed address are not warranted if/when it becomes apparent that the patient has permanently moved;
- A letter to the patient is necessary after two sequential weeks of failed outreach by phone and home visit;
- The letter should not include any information that might disclose the patient’s protected health information24;
- The letter should express concern about the patient’s wellbeing and ask them to contact the Program;
- Internet-based searching for persons whose address may have changed:
  - Is warranted at any point where phone and field outreach seem unproductive;
  - Should be done when the patient has been absent for more than four weeks.
- Possible internet resources include, but are not limited to:
  - http://a072-web.nyc.gov/inmatelookup/
  - http://www.411.com/

7.4 ART Adherence

7.4.1 All patients in tracks B, C1, C2 and D who are continuously enrolled and not suspended in a 4-month period are expected to have at least ONE (1) adherence assessment entered in eSHARE for that period.

7.4.2 Follow the guidelines listed below regarding responsible parties, frequency, documentation and eSHARE reporting for each of the ART adherence assessment forms: Adherence Assessment Form, Pill Box Log Form, and Monthly DOT Log Form.

7.4.3 Adherence Assessment Form is used for patients in Tracks B, C1, C2 and D who are currently on ART to document the patient's self-reported adherence assessments.

7.4.3.1 Frequency – Complete the baseline assessment within the first two weeks of enrollment, then ongoing, at least once every three months in preparation for a formal case conference. The Case Conference Form requires information from the most recently completed Adherence Assessment Form.

7.4.3.2 Alternatively, for patients in Tracks B, C1 or C2 who do not use a pill box – Complete this paper form in lieu of the Pill Box Log and eSHARE entry at the frequency below:
- Track B: At every Quarterly visit.
- Track C1: At every Monthly visit.
- Track C2: Once per month at one of the Weekly visits.

7.4.3.3 Document the self-reported adherence assessment on the Services Tracking Log (Appendix JJ) and the Adherence Assessment Form (Appendix W or X).

7.4.4 Pill Box Log Form is used for patients in Tracks B, C1 and C2 who are currently on ART and not receiving DOT to document pill box
counts conducted by Care Coordination staff. Do not document patient’s self-reported adherence status on this paper form.

7.4.4.1 Blister packs may be used to measure adherence on the Pill Box Log, as long as the empty pack(s) to verify the number of pills taken each day against the number of pills prescribed each day could be reviewed.

7.4.4.2 Frequency – Complete pill counts at the frequency specified below:
• Track B: At every Quarterly visit, review the available pill boxes going back no more than 4 weeks.
• Track C1: At every Monthly visit, review the available pill boxes going back no more than 4 weeks.
• Track C2: Once per month at one of the Weekly visits, review the available pill boxes going back for the past week. Once per month, enter the adherence percentages calculated from the completed paper form into eSHARE.

7.4.4.3 Document the pill box count on the Services Tracking Log (Appendix JJ) and the Pill Box Log Form (Appendix CC or DD).

7.4.5 Monthly DOT Log Form is used for patients in Track D who are currently on ART and receiving DOT. This paper form is used at each DOT visit to document the direct or indirect observation by Care Coordination staff of pills taken. Do not document patient’s self-reported adherence status on this form.

7.4.5.1 Direct observation indicates encounters where the CC staff visually observe the patient take the medication dose.

7.4.5.2 Indirect observation indicates encounters where the CC staff do NOT visually observe the patient take the medication dose but DO visually observe that the medication dose was “gone” by conducting a pill count.
• Indirect observation includes unobserved doses or days that occur when CC staff are not present (e.g. weekends).

7.4.5.3 Frequency – Update this paper form at every DOT visit. Once per month, enter the adherence percentages calculated from the completed paper form into eSHARE.

7.4.6 Daily Forms and Non-Daily Forms are available for the Adherence Assessment Form and the Pill Box Log.

7.4.6.1 Use only one form (either Daily or Non-Daily form) per adherence assessment per patient. This would save time and result in a more accurate measurement of adherence percentage.
7.4.6.2 **ART Daily Regimens Only** form is used for patients who prescribed the same number of ART pills each day of the week.

7.4.6.3 **ART Non-Daily Regimens Only** form is used for patients who are prescribed a different number of ART pills on different days in the week.

7.4.6.3.1 If the patient is taking at least one Non-Daily ART in his/her regimen, then use the Non-Daily Forms (Adherence Assessment and/or Pill Box Log) to document the entire ART regimen of daily and non-daily ARTs. Please note that the number of doses or pills will vary each day for patients who are taking both daily and non-daily ARTs. You are able to document this on the Non-Daily forms.

### 8.0 Case Suspension and Closure

#### 8.1 Overview

8.1.1 Service ends when the Program and/or the patient: (1) suspends services temporarily; (2) graduates; (3) voluntarily withdraws or declines treatment; (4) transfers medical care to a non-affiliated medical provider; (5) experiences difficulty achieving success; (6) is permanently lost to follow-up; or (7) is permanently unable to participate.

8.1.2 All case closures and suspensions should be documented on the Status Change Information Form (Case Closure/Suspension) (Appendix II) and in eSHARE.

#### 8.2 Case Suspensions

8.2.1 Any anticipated or actual absence from the program for more than one (1) month should lead to the patient’s suspension (with the start date being whenever they became inactive, e.g., became incarcerated, moved to in-patient care, or could otherwise not be reached for services). Suspension should be done at the time the program learns of the patient’s move and/or absence. Enrollment may be suspended in eSHARE and easily resumed/reactivated without re-enrolling.

8.2.1.1 For patients who missed an appointment and received outreach follow-up activities (see §7.3.11) for at least two (2) months without successful contact, the suspension start date begins at the completion of outreach follow-up activities.
8.2.2 If the patient is lost to care and/or has been unable to return to care for a prolonged period of time (e.g., more than three (3) months), the case should be closed. After being closed, the patient may be eligible for re-enrollment at a later time.

8.3 Graduation

8.3.1 Graduation criteria for patients not receiving ART:

- Demonstrated the ability to navigate the health care system;
- Developed a sense of self-sufficiency (e.g., seeks resolutions to their needs, less dependent on others and shows initiative);
- Kept all scheduled medical and social services appointments;
- Showed evidence of being able to keep appointments in the future;
- Obtained and maintained needed services (e.g. housing, entitlements, benefits, medical, social, etc.);
- Resolved major issues identified in the Comprehensive Care Plan; and
- Developed a sustainable social support network.

Note: If substance abuse and mental health issues emerge or re-emerge, then refer to appropriate program.  

8.3.2 Graduation criteria for patients receiving ART:

- Maintained medication adherence >95%;
- Maintained an undetectable viral load for at least six (6) months;
- Demonstrated improvement with other clinical criteria (e.g. decreased hospitalizations, other medical conditions stabilized, no new OI diagnosis);
- Demonstrated the ability to navigate the health care system;
- Developed a sense of self-sufficiency (e.g., seeks resolutions to their needs, less dependent on others and shows initiative);
- Kept all scheduled medical and social services appointments;
- Obtained and maintained needed services (e.g. housing, entitlements, benefits, medical, social, etc.);
- Resolved major issues identified in the Comprehensive Care Plan; and
- Developed a sustainable social support network.

8.3.3 The patient may re-enroll in the Program after graduation, if needed.

8.4 Voluntary withdrawal

8.4.1 A patient may decline further service at any time. If a patient chooses to permanently disenroll from the Program the patient may continue to receive primary care at the HIV primary care site.

8.4.2 When patients are not ready for graduation, the Program must inquire why the patient wishes to terminate services and recommend remaining in the Program.

8.4.2.1 If an attempt to encourage continued engagement with the patient is not successful, the Program should:

- Notify the HIV PCP of the decision;
- Disenroll the patient from the Program;
- Document the reason for closing the case on the Status Change Information Form (Case Closure/Suspension) (Appendix II);
- Close the enrollment in eSHARE;
- Offer a referral to another program, as appropriate.

8.4.3 Lateral transfer – A patient may request transfer to another Care Coordination program in conjunction with a change in primary care provider.

8.4.3.1 Care Coordination services are always delivered within an integrated system. If at any time the patient prefers medical care at another health facility and transfer is arranged, the patient would subsequently receive Care Coordination services within the system of the accepting facility.

8.4.3.2 The Program must coordinate a lateral transfer with the current clinical provider, and assist in transfer of the patient’s medical records and Care Coordination records. The patient’s written consent must be documented on the HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information Form (Appendix P).

8.4.3.2.1 If the Program receives a request to transfer the patient’s medical records to another health facility without previous discussion with the patient, the Program should:

- Contact the patient to inquire why the patient is leaving the Program.
- Confirm the patient would like to transfer their case and records.
- Follow the steps outlined in §8.4.2.1.

8.4.3.3 The patient’s case remains open at the referring Program until the accepting Program acknowledges receipt of the relevant records and the patient attends
the first medical appointment with the accepting Program. At that point the referring Program closes the enrollment.

8.4.3.4 It is the responsibility of the referring Program to support the patient to keep all appointments until the lateral transfer is completed; however, if the accepting Program receives a referral it must continue outreach to the patient to complete the referral.

8.4.3.5 Document transfer to the accepting Program on the Status Change Information Form (Case Closure/Suspension) (Appendix II).

8.5 **Patient not benefiting from Program**

8.5.1 If a patient is not benefiting from enrollment in the Program, not improving, or not adherent with the plan the Program may disenroll the patient and refer to a more appropriate program such as drug treatment, residential care or adult day care.

8.6 **Lost to follow-up**

8.6.1 All efforts have been made to locate the patient and patient has not been located after two (2) sequential months of outreach, as described in §7.3.11.

8.6.2 At program discretion, the enrollment may be suspended or closed. Refer to §7.3.12.

8.7 **Permanently unable to participate**

8.7.1 Close the patient’s record if the patient is permanently unable to participate. Reasons may include:

- Death;
- Long term incarceration (>3 months) or commitment to other institution; or
- Moved out of area.

### 9.0 Case Finding to Return Persons to Primary Care (RTC)

#### 9.1 Frequency

9.1.1 The primary care roster must be reviewed at Program onset to identify persons whose care might have lapsed (i.e. missed appointments) and must be reviewed, at a minimum, every three months thereafter. This is to ensure that RTC procedures are conducted for patients who may have been lost to follow-up in the intervening quarter (despite following the missed appointment procedure).
• Initial RTC:
  o Review the primary care roster to list all patients with a primary care visit at the health facility in the last two years but not in the last nine months.
• Quarterly RTC:
  o Review those with missed appointments or who are failing treatment based on laboratory parameters in the last quarter and for whom the missed appointment procedure was unsuccessful, including those who have graduated from the program.

9.2 Eligible Patients:
• Had at least one visit to the facility with an affiliated Primary Care Provider (PCP) within the last two years; AND
• Have not been seen in primary medical care for the past nine months or more at the facility; OR
• Worsened laboratory parameters (refer to §4.2.1, which requires discussion with the PCP and a means of alerting them to make a referral at the next visit.

9.3 Case Record
9.3.1 Immediately after the roster review, the Program creates a case finding record for each eligible person and assigns each case to a Program staff member.
• Prioritize the list so that the most recently lost patients are outreached to first.
• Filter the list and remove persons who are permanently unable to participate (refer to 8.7.1).
9.3.2 The Program should maintain a log of case finding activities and disposition. The Program may develop their own tracking tool or use the DOHMH’s Return to Care Tracking Tool in Microsoft Excel. Contact your DOHMH Project Officer to receive this tracking tool electronically.

9.4 Case Finding Activities
9.4.1 Case finding activities proceed as described in the Missed Appointment Procedure outlined in §7.3.11.
9.4.2 Internet searching may be performed at any time. (Refer to §7.3.11)
9.4.3 As soon as possible, field outreach should commence or re-commence when an Internet search identifies an address that is more likely to be current.
9.4.4 For PLWHA who are located through this process, the Program determines whether they are engaged in medical care elsewhere, or whether they want to return to the Program.
9.4.5 For PLWHA engaged in medical care elsewhere, the Program should:
   • Receive written consent from the patient prior to releasing information to the other program by using the HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information Form (Appendix P).
   • Arrange transfer of the patient’s medical record to the new provider including information about the recent unexpected discontinuity of care. The records must be accompanied by a HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information Form (Appendix P).
   • Inform the affiliated PCP of the patient’s disposition and document in the tracking tool.

9.4.6 For PLWHA not engaged in medical care elsewhere and willing to return, the Program should:
   • Schedule a medical appointment;
   • Offer accompaniment to the medical appointment; and
   • Provide high intensity services. (Refer to §4.0)

9.4.7 For PLWHA temporarily unable to return to care at facility (e.g., temporarily moved out of NYC, institutionalized or incarcerated) but planning to return in the future:
   • Receive written consent from the patient prior to releasing patient information by using the HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information Form (Appendix P);
   • Arrange transfer of the patient’s medical and Program record to the new provider including information about the recent interruption in care;
   • Inform the affiliated PCP of the patient’s disposition and document in the tracking tool.

9.4.8 For PLWHA permanently unable to return to care (e.g., long term incarceration, death or permanently moved out of area)
   • Arrange transfer of the patient’s medical record to the new provider, as warranted and with the permission of the patient by using the HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information Form (Appendix P).
   • Inform the affiliated PCP of the patient’s disposition and document in the tracking tool.

9.4.9 For PLWHA not located after two months
   • Inform the affiliated PCP of the patient’s disposition and document in the tracking tool.

9.4.10 If the patient was found but is unwilling to return to care, explore the reason and recommend enrolling in the Program. If the patient
declines, note his/her disposition in the patient’s record and recommend a program that may better suit the patient.

9.4.11 For all patients regardless of whether they enroll in the Program, case finding activities should be documented in the Program’s own tracking tool or the DOHMH Return to Care Tracking Tool.

9.4.11.1 Once the patient is enrolled in the Program, the case finding activities should be documented in the Services Tracking Log (Appendix JJ) using the service type “Case Finding” to document the pre-enrollment case finding activities. This service type is used once in eSHARE to sum the total amount of time spent on pre-enrollment case finding activities, and the Service Date should be on the same date as the Enrollment Date.

10.0 Preventing Secondary Transmission of HIV

10.1 Overview

10.1.1 Preventing secondary transmission of HIV refers to any activity that helps PLWHA to avoid transmitting HIV to others, avoid becoming infected with other illnesses (e.g., hepatitis, sexually transmitted infections, and different strains of HIV) and live a healthy lifestyle.

10.1.2 The key components of preventing secondary transmission include:

- HIV risk behavior assessment;
- Partner notification; and
- Early treatment of HIV.

10.2 HIV risk behavior assessment

10.2.1 The PCP is expected to conduct an assessment of HIV risk behavior regularly for each patient. Regular assessment of HIV risk behavior is necessary as an individual’s social and environmental situations often change. The assessment should address the patient’s sexual, substance use and social behaviors.

10.2.2 The Program should conduct an assessment at the beginning of health promotion discussions on safer sex or substance use. Ongoing assessments should be conducted at least every six months. Elements of the sexual and behavioral health assessment are included in the Intake Assessment Form (Appendix U) and the Reassessment Form (Appendix GG).

10.2.2.1 Condoms should be available to patients. Patient Navigators should provide condoms to patients who request them.

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10.2.2.2 Condoms may be obtained from the free NYC condom distribution program.\textsuperscript{27}

10.3 Partner notification

10.3.1 If a patient discloses an HIV-negative sex and/or needle sharing partner, the Program should attempt to elicit the names and contact information of these partners, conduct domestic violence screening, and then refer the named partners to the DOHMH Contact Notification Assistance Program (CNAP).

10.3.2 For assistance with eliciting or referring partners to the health department, contact CNAP coordinator at (212) 693-1419.

10.4 Early treatment of HIV

10.4.1 DOHMH recommends offering ART to any person living with HIV, regardless of the person’s CD4 cell count. The recommendation is based on evidence that ART can improve the health of people living with HIV and that ART can prevent transmission of HIV from an HIV-infected person to an uninfected sexual partner.\textsuperscript{28}

11.0 HIV Patient Confidentiality

11.1 Funded providers/organizations must follow all applicable confidentiality and privacy laws, including Federal (e.g., HIPAA\textsuperscript{29}), State (e.g., Article 27-F\textsuperscript{30}) or local laws in order to protect patient privacy.

12.0 Quality Management

12.1 Expectations

12.1.1 Care Coordination Programs funded by Ryan White Part A must participate in the NYC DOHMH quality management program funded by Part A of the Ryan White Treatment Modernization Act.\textsuperscript{31}

12.1.2 The Program is expected to develop a Quality Management Program, which includes:
- Developing a Quality Management Plan;


\textsuperscript{31} For more information, refer to http://nationalqualitycenter.org.
Elements in the Quality Management Plan include Statement of Purpose, Structure, Quality Goals, Improvement Plans, Staff and Patient Involvement, Sustainability, and Evaluation.

- Participating in quality assurance activities as contractually required;
- Compliance with relevant Care Coordination quality indicators; and
- Collecting and reporting of data for use in measuring performance.

12.1.3 The Program Director is responsible for developing case review protocols, including format and content of case reviews.

12.1.4 Quality Assurance Chart Review

12.1.4.1 All charts must be reviewed once per quarter by the Program Director with the Care Coordinator and the Patient Navigator.

12.1.4.2 The following schedule for chart reviews is suggested:

<table>
<thead>
<tr>
<th>For patients enrolled in:</th>
<th>Review in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>March, June, September, December</td>
</tr>
<tr>
<td>February</td>
<td>April, July, October, January</td>
</tr>
<tr>
<td>March</td>
<td>May, August, November, February</td>
</tr>
<tr>
<td>April</td>
<td>June, September, December, March</td>
</tr>
<tr>
<td>May</td>
<td>July, October, January, April</td>
</tr>
<tr>
<td>June</td>
<td>August, November, February, May</td>
</tr>
<tr>
<td>July</td>
<td>September, December, March, June</td>
</tr>
<tr>
<td>August</td>
<td>October, January, April, July</td>
</tr>
<tr>
<td>September</td>
<td>November, February, May, August</td>
</tr>
<tr>
<td>October</td>
<td>December, March, June, September</td>
</tr>
<tr>
<td>November</td>
<td>January, April, July, October</td>
</tr>
<tr>
<td>December</td>
<td>February, May, August, November</td>
</tr>
</tbody>
</table>

12.1.5 The Program should continue to monitor patients who have graduated to ensure retention in care.

12.2 Client satisfaction

12.2.1 Client satisfaction surveys developed by DOHMH will be administered on a biennial basis. Minimum distribution and response expectations will be communicated by DOHMH during the survey implementation process.

12.2.2 Agencies may conduct their own client satisfaction activities (e.g. suggestion box, surveys, etc.) in addition to participating in the surveys developed by DOHMH.

12.3 Grievances

12.3.1 Each agency must have an established grievance procedure.
12.3.2 Grievances should be reviewed on a monthly basis to ensure they have been appropriately addressed.

### 13.0 Training Requirements

13.1 All staff will receive initial and ongoing training to orient them to organizational and program-specific information. All staff must receive the following types of trainings within one (1) month of being hired.

13.1.1 Employee orientation must include orientation to agency operations, policies and procedures, contract requirements, overview of HIV/AIDS, and HIV confidentiality and Health Insurance Portability and Accountability Act (HIPAA) training including the timeframe for completion.

13.1.2 All staff funded to provide direct service must participate in ongoing, (at least annual) training and education regarding:

- Essentials of medical case management training delivered by NYC DOHMH or designee (initial upon hire; annual refresher course);
- Program manual training delivered by NYC DOHMH or designee (initial upon hire; annual refresher course);
- Health Promotion Curriculum training delivered by your agency (ongoing, at least once every two months). (Refer to 2.2.3);
- New HIV/AIDS Treatments;
- Harm Reduction Approach for alcohol and other drug use;
- Mental Health Issues Experienced by the HIV+ Client Population (non-mental health and non-medical program staff must be properly trained to recognize and provide referrals); and
- Cultural Competency (capacity to be respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of the program’s client population).

13.2 Documentation of staff training is maintained on site and available for review during site visits.

13.3 Staff training needs should be identified by regular staff supervision and performance evaluation.

13.3.1 Additional training should be provided by Program Directors, as needs are identified. Examples of possible training topics include patient confidentiality, treatment adherence, motivational interviewing, vicarious trauma, condom application and use, etc.

13.4 DOHMH-sponsored programmatic or implementation-related trainings that are specific to the service category are mandatory. The program must allow staff to attend these trainings.
APPENDICES

APPENDIX A – Common Acronyms in HIV/AIDS Services

ADAP: AIDS Drug Assistance Program
ADHC: Adult Day Health Care
AI: AIDS Institute of the New York State Health Department
AIDS: Acquired Immunodeficiency Syndrome
AIRS: AIDS Institute Reporting System (released in 1996 as the URS - the Uniform Reporting System)
ART: Antiretroviral Therapy
BHIV: New York City Department of Health and Mental Hygiene's Bureau of HIV/AIDS Prevention and Control
CAP: Corrective Action Plan
CARE Act: Ryan White Comprehensive AIDS Resource Act
CC: Care Coordination
CD4 Count: A count of the CD4 type of T-helper lymphocyte, typically measured as a count of CD4 cells per cubic millimeter of blood.
CDC: Center for Disease Control and Prevention
CFP: Community Follow-up Program
CHAIN: The Community Health Advisory Information Network, the New York EMA's longitudinal survey of HIV-positive individuals, initiated in 1994 by the Columbia University Joseph L. Mailman School of Public Health.
CHW: Community Health Worker
CMS: Case Management Services
COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985 was used by New York State to create the Comprehensive Medicaid Case Management program known as COBRA Community Follow-up Program.
CTHP: New York City Department of Health and Mental Hygiene's HIV Care, Treatment and Housing Program
CTI: Critical Time Intervention
DAC: Designated AIDS Center
DOB: Date of Birth
DOHMH: New York City Department of Health and Mental Hygiene
DOT: Directly Observed Therapy
DV: Domestic Violence
**EIC: Engagement in care**

**EMA:** Eligible Metropolitan Area under Part A of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 ("the EMA" refers to the New York NY Eligible Metropolitan Area)

**FSU:** New York City Department of Health and Mental Hygiene's Field Services Unit of the Bureau of HIV/AIDS, Epidemiology Program

**HASA:** New York City Department of Social Services, Human Resources Administration, HIV/AIDS Services Administration

**HATMA:** Ryan White HIV/AIDS Treatment Modernization Act of 2006

**HH:** New York State Medicaid Health Homes

**HIV:** Human Immunodeficiency Virus

**HIVCS:** HIV Care Services of Public Health Solutions

**HIVQUAL:** HIV Quality guidelines of the New York State Department of Health

**HOPWA:** Housing Opportunities for People with AIDS program funded by Department of Housing and Urban Development's Office of HIV/AIDS Housing

**HP:** Health Promotion

**HPA:** Housing Placement Assistance

**HIPAA:** Health Insurance Probability and Accountability Act

**HRSA:** U.S. Health Resources and Services Administration

**IDU:** Injection Drug Use

**IOC:** Integration of Care Committee of the Planning Council

**LN:** New York State AIDS Institute Quality Learning Network

**MAI:** Minority AIDS Initiative from Ryan White Part F grants supported by U.S. Health Resources and Services Administration

**MCL:** Medical Center Liaison

**MCM:** Medical Case Management

**MCO:** Managed Care Organization

**DOT:** Modified DOT

**MOU:** Memorandum of Understanding

**MSM:** Men who have sex with men

**NAC:** Needs Assessment Committee of the New York City EMA’s HIV/AIDS Planning Council

**NDRI:** National Development and Research Institutes, Inc.

**NYCHSRO:** New York County Health Services Review Organization

**NYSDOH:** New York State Department of Health

**OBMC:** Outpatient Bridge Medical Care

**OI:** Opportunistic Infection
OMC: Outpatient Medical Care
PACT: Prevention and Access to Care and Treatment
PCP: Primary Care Provider
PCSM: Primary Care Status Measures
PHS: Public Health Solutions (formerly known as MHRA - Medical and Health research Association of New York City, Inc.; older documents may refer to what is now known as Public Health Solutions as MHRA.)
PLWHA: People Living With HIV/AIDS
PMPD: Per Member per Day
POLR: Payer of Last Resort
PSRA: Priority Setting and Resource Allocation Committee of the New York City EMA’s HIV/AIDS Planning Council
RITC: Rikers Island Transitional Consortium
RTC: Return to Care
RW: Ryan White
RWCC: Ryan White Care Coordination
RX: Prescription Medication
SNAP: Supplemental Nutrition Assistance Program (a.k.a. Food Stamps)
SNP: Medicaid Special Needs Plan for people living with HIV/AIDS
SRO: Single Room Occupancy
TA: Technical Assistant or Technical Assistance
VAS: Visual Analog Scale to measure ART adherence
VL: Viral load is a measure of HIV RNA in blood, typically measured as copies/ML of blood.
VLS: Viral load suppression
APPENDIX B – Definitions Referenced in the Program Manual

Accompaniment: A health promotion activity designed to increase adherence to a patient’s treatment plan. For example, a Patient Navigator accompanies the patient from his/her home to medical appointments. If the home is not a suitable location because of safety, disclosure concerns, or other obstacles, the accompaniment originates at an alternative, mutually-agreed upon location in the community (e.g., somewhere the patient hangs out, the patient’s favorite park, or other set location near his/her home or work). The most crucial part of an accompaniment is attendance at the PCP visit with the patient. Accompaniment is intended for PLWHA who struggle with conventional treatment regimens and who may be ambivalent about following through with the appointment. The goal is to provide social support and help the patient connect to medical care in order to improve patient health outcomes and reduce rates of hospitalization.32

Affiliate Provider: Any health care or related agency or organization with operational policies or protocols that address the logistical, ethical, and legal issues of - and therefore facilitate - sharing health information for the panel of patients that it shares with another provider.

Benefits: Publicly-funded services administered by local, State or Federal government to assist certain families or individuals in need. Services or cash assistance may include social security, Medicaid or Medicare, food stamps or housing assistance.

Care Coordination: The deliberate integration of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services, as defined by McDonald et al.33 The opposite of care coordination is fragmentation of care, which is often seen when the relationship between a single practitioner and a patient does not extend beyond specific episodes of illness or disease.34

Case Management: A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through using communication and available resources to promote quality cost-effective outcomes, as defined by the Case Management Society of America.35

Case Review: An internal process during which the Program Director reviews cases with significant activity or complexity on a weekly basis. The purpose of the case review is to ensure that navigation and health promotion activities are proceeding appropriately. Program Directors should perform a case review in a summary fashion for every patient at least once per quarter. Concerns or determinations arising from either of these case reviews should be brought to case conference with the rest of the team.

**Case Conference**: An interdisciplinary meeting during which all Care Coordination team members involved in providing care to the patient (e.g., clinician, Program Director, Care Coordinator, Medical Center Liaison, Patient Navigator, DOT Specialist, clinical specialists, clinical supervisor) participate and contribute to the process of reviewing documentation and developing the care plan for a patient. Each patient should be discussed at a case conference at least once per quarter. A case conference may also be an interdisciplinary meeting (scheduled or unscheduled) held directly following a medical appointment that includes the clinician, a Care Coordination staff member, and may also include the patient.

**Chronic Care Model**: This model uses a proactive disease management approach to support and empower individuals with chronic illnesses to gain and maintain independence in their health. The goal is to help improve the quality of life of the patient by building skills to promote adherence to a treatment regimen, prevent deterioration, reduce risk of complications, prevent associated illnesses, and in order to do this, the model encourages active participation from the patient. The model uses elements such as clinical information systems, self-management support and delivery system design to be consistent with established clinical practice guidelines in an effort to improve chronic disease care.  

**Coaching**: A health promotion activity that employs a counseling technique to help individuals improve or maintain their health status by empowering them to become self-sufficient. Coaching is intended to provide non-judgmental emotional and logistical support to the patient to encourage an increase of adherence to their medical plan.

**Community Health Worker (CHW)**: A person who establishes a relationship built on trust with their patients by bridging the gap between the clinic and the community. CHWs help health care systems overcome personnel and financial shortages by providing high-quality, cost-effective services to community members in their homes, and by catching serious conditions at an early stage, before they become more dangerous and expensive to treat. CHWs help patients overcome obstacles (e.g. lack of health information, social services, transportation, and social stigma). CHWs are known by various roles, such as Program Manager, Patient Navigator, Care Coordinator, DOT Specialist, Health Educator, Health Volunteer, Medical Provider, Social Worker, Nutritionist/Dietitian, and Outreach Specialist.

**Comprehensive Care Plan**: A written plan developed by the patient’s medical providers and Care Coordination team in order to achieve treatment goals. A service plan is one component of the care plan, which consists of activities (logistical and procedural) that the patient and care Coordination team would engage in to carry out the care plan. The care plan identifies activities, prospective dates for each planned activity and anticipated resources required to ensure care plan adherence.

**Cultural Competency**: Attitudes, behavior and policies of service providers which could accommodate language, values, beliefs, and behavioral differences of the individuals they serve in a cross-cultural setting.

**Directly Observed Therapy (DOT)**: A trained CHW (e.g. Patient Navigator or DOT Specialist) conducts daily observations of the patient taking his/her prescribed medications. DOT provides

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intensive and daily support to patients. The CHW encourages the patient to take the prescribed medication in the correct dosage and at the correct time. If the patient is not ready to take his/her medications, the Care Coordination Program’s goal is to help the patient explore their unique barriers to taking their medications as prescribed. DOT is a resource for those persons who are having great difficulty adhering to an anti-retroviral regimen independently or with the support of intensive health promotion but are willing to take ART. In most instances, Care Coordination Programs provide modified DOT services, e.g., not seven (7) days a week.

Health Literacy: “The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.”

Health Promotion: “Any planned combination of educational, political, regulatory and organizational supports for actions and conditions of living conducive to the health of individuals, groups or communities.” Health promotion may include activities such as medication adherence support, accompaniment, coaching, and teaching health education. The level of health promotion interventions would vary according to the patient’s intensity of needs.

Intensity, Low: The description of interventions that requires health promotion or a related activity at least once per quarter (i.e., every three months). This is appropriate for PLWHA who are not currently prescribed an ART regimen or have been stabilized for a period of time on ART and who consistently attend their HIV medical appointments.

Intensity, High: The description of interventions that requires health promotion or a related activity at least once per month and possibly as frequently as once per day. This is appropriate for PLWHA that are on ART.

Interdisciplinary Team: A team that includes professionals representing the disciplines required for a comprehensive approach to meeting the needs of the patient. At a minimum, the team consists of a clinical provider and the Care Coordinator/Navigator, who collaborate to improve patients’ health outcomes.

Logistical Support: The provision or arrangement of necessary services and resources in order to carry out the treatment plan including transportation and childcare services. Other factors that must be taken into consideration for the delivery of the care plan include health literacy, patient’s preferred language and social barriers (e.g., family violence).

Lost to Follow-up: A term that describes when a patient has not been located after two (2) sequential months of outreach efforts to locate the patient.

Medical Case Management: The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) defines medical case management as “a range of patient-centered services that link patients with health care, psychosocial, and other services. Coordination and follow-up of medical treatments are components of medical case management. Services ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of patients’ and key family members’ needs and personal support systems. The service includes treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS regimens. Key activities include (1) initial


assessment of service needs; (2) development of comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) patient monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the patient. It includes all types of case management, including face-to-face meetings, phone contact, and any other forms of communication.42

Medical Home Model: A model of care that links patients to a personal physician or other provider at the center of a complex health care system. The medical home model utilizes the chronic care model to promote self-sustaining health skills. The personal physician is the patient’s main point of entry to the health care system who then interfaces with the Care Coordination Program and the entire team of healthcare professionals to provide consistent integrated and appropriate medical care.43

Medical Treatment Plan Adherence: Adherence to all medical appointments and referrals and obtaining lab tests/imaging when ordered. This is distinct from the (medication) treatment adherence described below.

Medication Adherence: Adherence to the recommended treatment regimen by taking all prescribed medications as indicated by the prescriber. Medication adherence is described quantitatively as percentage of medication doses divided by dose prescribed taken over a period. Specific interventions are used to improve adherence.

Navigation Model: The navigation model aims to advocate for, communicate with, and identify resources for the patient, thereby coordinating the complex health care and social services necessary to ensure improved patient outcomes. Patient Navigators generally focus on partnering with and empowering the individual requiring services. The model also includes supportive counseling and coaching (i.e., active discussion and education, empowerment and encouragement).

NYC HIV Care Coordination: The NYC DOHMH HIV Care Coordination model combines elements of medical case management, navigation and chronic care models to both help patients in becoming self-sufficient and to assist them in accessing needed care and services. The four components of the Care Coordination model that work together for the client include Patient Navigation, Health Promotion, Treatment Adherence, and Benefits and Services Coordination. In addition, the three aspects of the Care Coordination model that are shared across all four components are Assessment and Planning, Information Sharing, and Outreach for Re-engagement. Various theory-based methods could be used to assist the patient to achieve set goals, such as strengths-based or trans-theoretical approaches, while the focus remains on navigating the system to obtain needed services and coaching for self-sufficiency.

Out of Care: A term used to define patients who have received primary care services with a provider within the last two years and have not been seen in primary care for the past nine months at that specific facility.

Outpatient Bridge Medical Care: Ryan White Part A OBMC was developed to provide outpatient medical care to HIV-infected individuals who are receiving sporadic or no medical care, and to link them to HIV primary care services at a HIV medical care clinics within an eight-month period.

OBMC services are meant to provide temporary primary care in an out-of-clinic setting and are not intended as a long-term primary medical care solution.

**Patient Advocacy:** Activities designed to help people protect their rights and help them obtain needed information, services and benefits (including medical, social, legal, and financial). Advocacy does not include coordination and follow-up of medical treatments. Advocacy should be done as part of Care Coordination in an effort to build upon cooperation and collaboration among providers.

**Primary Care Provider:** The primary medical care provider (i.e. physician, nurse practitioner, physician assistant) responsible for the patient’s comprehensive medical treatment plan including HIV care.

**Quality Management:** A method of program/service evaluation that is designed to assure the highest quality of service is provided.

**Ryan White Core Services:** Core medical services designated by the U.S. Health Resources and Services Administration that must collectively account for no less than 75% of each year’s Part A spending plan. Core medical services funded by the New York EMA include AIDS Drug Assistance Program; outpatient/ambulatory medical care; medical case management; mental health services; substance abuse services; early intervention services; home care; and health care.

**Ryan White Non-Core Services:** Non-core services provided through Part A by the New York EMA include Housing services, including emergency rental assistance, emergency transitional housing, and housing placement; legal services; food bank/home-delivered meals; psychosocial support services.
APPENDIX C – Access-A-Ride

The MTA New York City Access-A-Ride (AAR) program provides transportation for persons with disabilities who are unable to use public bus or subway services. This program offers shared ride, door-to-door paratransit service 24 hours a day, 7 days a week in all five boroughs of New York City.

In order to participate in this program, applicants must be assessed by a healthcare professional and if appropriate, undergo functional testing at a Transit Office Assessment Center. The certifier will send their assessment report to the Transit Office, who will notify the applicant of their decision within 21 days. If an applicant is denied eligibility or given conditional eligibility, they have a right to appeal the decision within 60 days of notification. Although most AAR customers need to be recertified every five years, those customers whose disability is unlikely to improve or for whom their disability will become more severe, can simply update their information in lieu of this process.

Once approved for the AAR program, customers can call the Paratransit Reservations Office one to two days in advance of their trip to make a reservation. Furthermore, for those customers who travel from the same location to the same destination at the same time of day for each trip, can arrange a subscription service and will only need to call if they would like to cancel their trip. Finally, customers pay for their trip the same fare they would pay on mass transit (i.e., exact change or TransitCheck coupons). Customers may be accompanied by one paying guest, as well as a personal care attendant (who rides free of charge), if needed and pre-approved by the Transit Office.

The role of the Care Coordination would be to assist PLWHAs with the following tasks:
- Applying and recertifying enrollment in the AAR program
- Appealing New York City Transit Office decisions
- Determining if a personal care attendant (relative, spouse, friend, or a professional attendant) is needed during their PLWHA’s travel
- Creating and canceling AAR reservations and subscriptions

Additional information about the AAR program can be found at http://www.mta.info/nyct/paratran/guide.htm.
APPENDIX D – Childcare Services

This section clarifies what is required of entities providing childcare services in New York City.

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Any entity providing child supervision services at the same location where the patient is receiving funded services does not have to apply for and receive a child care permit from New York City, pursuant to NYC Code 47.01(c)(2)(E). This exemption applies to any medical or social services provider providing child care to children of patients receiving medical case management services at the same premises. The medical or social services provider would fall under the definition of "Other Business".

In order to meet this exemption criterion, both of the following must be met:
1. The parent/guardian must remain at the same address as the site where the child care is being provided.
2. A particular child does not spend more than 8 hours per week in care.

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If a patient is receiving medical case management services at a medical provider, the funded program can provide daycare services at the patient's home while the patient is receiving services without a childcare permit as allowed under State regulation 18 NYC RR 415.1(2)(i) This would be classified as a "Legally Exempt In-Home Child Care Service".

In order to meet this criterion, the following must be met:
1. Child care must be furnished in the child's own home by a caregiver who is chosen and monitored by the child's caretaker.
2. The caregiver must be at least 18 years of age, or less than 18 years of age and meets the requirements for the employment of minors as set forth in article 4 of the New York State Labor Law; provided, however, that the child's caretaker must provide the caregiver with all employment benefits required by State and/or Federal law, and must pay the caregiver at least the minimum wage, if required.

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Care Coordination program staff members are not allowed to provide child care services.

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Any entity providing child supervision services must obtain a permit if the child care took place at a location other than where the parent/guardian is receiving services.
APPENDIX E – Benefits Programs Listed through AccessNYC

Families with Children
- Child Care
- Head Start
- Out-of-School Time (OST)
- Universal Prekindergarten (UPK)

Employment and Training Programs
- In-School Youth Employment Program (ISY)
- New York State Unemployment Insurance
- NYCHA Resident Employment Services (RES)
- Senior Employment Services (SES)
- Summer Youth Employment Program (SYEP)
- Workforce1

Financial Assistance Programs
- Cash Assistance
- Child and Dependent Care Tax Credit (Federal and New York State)/New York City Child Care Tax Credit
- Child Tax Credit (Federal)/Empire State Child Credit (New York State)
- Earned Income Tax Credit (EITC) (Federal, New York State and New York City)
- Home Energy Assistance Program (HEAP)

Food and Nutrition Programs
- Commodity Supplemental Food Program (CSFP)
- Food Stamps
- School Meals
- Summer Meals
- Women, Infants and Children (WIC)

Health Care Services
- Nurse-Family Partnership (for first time pregnant women)

Health Insurance Programs
- Child Health Plus B
- Family Health Plus/Medicaid
- Healthy NY
- Medicaid (coverage for adults)
- Medicaid (coverage for children)
- Medicaid Excess Income/Medicaid
- Prenatal Care Assistance Program/Medicaid

Housing Programs
- Disability Rent Increase Exemption (DRIE)
- Disabled Homeowners’ Exemption (DHE)
- School Tax Relief (STAR)
- Section 8 Housing Assistance
- Senior Citizen Homeowners’ Exemption (SCHE)
- Senior Citizen Rent Increase Exemption (SCRIE)
- Veterans’ Exemption

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APPENDIX F – New York City Harm Reduction Syringe Access Programs

New York City Harm Reduction Syringe Access Programs

A List of Services Offered

2014

Bureau of Alcohol & Drug Use Prevention, Care & Treatment

-New York City-

-BOOM! Health-

718-292-7718

- 9am-8:30pm M T Th F
- 12p-3:30pm Wed, 10a03p Sat
- SRO hotel outreach
- Case management
- Meals, showers, clothing
- Acupuncture
- Mental health services
- Housing services
- HIV testing
- Hepatitis testing and vaccines
- Educational and support groups
- Women’s and trans’ services

-VOCAL-

718-802-9540

- 12pm-6pm Mon-Fri
- Support groups
- Hep C testing
- Referrals

-NY Harm Reduction Educators-

718-842-6050

- 9am-5pm Mon-Fri
- HIV testing
- Support groups
- Mental health services
- Hep screening and vaccines
- Case management

-Staten Island-

-Community Health Action of SI-

718-808-1300

- Case management
- Housing services
- Food pantry
- Job counseling
- HIV testing
- Outpatient drug treatment
- HIV prevention and education
- Hep screening and vaccines

-Brooklyn-

-After Hours Project-

718-249-0755

- 10am-6pm M-Th, 9am-5p Fri
- Case management
- HIV testing
- Hep testing and vaccines

-Family Services Network of NY-

718-573-3358

- 8am-4pm MTWF, 10a-6p Th
- AIDS services
- Legal services
- Meal and nutrition services

-Vocal-

718-802-9540

- 12pm-6pm Mon-Fri
- Support groups
- Hep C testing
- Referrals

-Statn’s Corner of Harm Reduction-

718-585-5544

- 9am-5pm MTWF, -6:30p Th
- Mental health counseling
- Support groups
- Acupuncture and massage
- Showers, clothing, hot lunch
- HIV testing
- Educational groups

-NY Harm Reduction Educators-

718-842-6050

- 9am-5pm Mon-Fri
- HIV testing
- Support groups
- Mental health services
- Hep screening and vaccines
- Case management

-Stan’s Corner of Harm Reduction-

718-585-5544

- 9am-5pm MTWF, -6:30p Th
- Mental health counseling
- Support groups
- Acupuncture and massage
- Showers, clothing, hot lunch
- HIV testing
- Educational groups

-NY Harm Reduction Educators-

718-842-6050

- 9am-5pm Mon-Fri
- HIV testing
- Support groups
- Mental health services
- Hep screening and vaccines
- Case management

-Stan’s Corner of Harm Reduction-

718-585-5544

- 9am-5pm MTWF, -6:30p Th
- Mental health counseling
- Support groups
- Acupuncture and massage
- Showers, clothing, hot lunch
- HIV testing
- Educational groups

-NY Harm Reduction Educators-

718-842-6050

- 9am-5pm Mon-Fri
- HIV testing
- Support groups
- Mental health services
- Hep screening and vaccines
- Case management

-Stan’s Corner of Harm Reduction-

718-585-5544

- 9am-5pm MTWF, -6:30p Th
- Mental health counseling
- Support groups
- Acupuncture and massage
- Showers, clothing, hot lunch
- HIV testing
- Educational groups

-NY Harm Reduction Educators-

718-842-6050

- 9am-5pm Mon-Fri
- HIV testing
- Support groups
- Mental health services
- Hep screening and vaccines
- Case management

-Stan’s Corner of Harm Reduction-

718-585-5544

- 9am-5pm MTWF, -6:30p Th
- Mental health counseling
- Support groups
- Acupuncture and massage
- Showers, clothing, hot lunch
- HIV testing
- Educational groups
### MANHATTAN

**NY Harm Reduction Educators**  
718-842-6050  
- 9am-5pm Mon-Fri  
- HIV testing  
- Support groups  
- Mental health services  
- Hepatitis screening and vaccines  
- Acupuncture  
- Recovery readiness program  
- Case management  

**Housing Works (HW clients only)**  
212-966-0466 x 1167  
- 8am-5pm Mon-Fri and last 2 Saturdays of the month  
- Legal services  
- Transitional housing  
- Permanent housing  
- Health care  
- Dental care  
- Case management  
- Job training  
- Mental health services  
- Transgender services  

**Lower East Side Harm Reduction Center**  
212-226-6333  
- 9am-7:30pm  
- Case management  
- Mental health services  
- Housing specialist  
- Acupuncture  
- Hepatitis C testing  
- Hepatitis A/B vaccine  

### MANHATTAN

**Positive Health Project**  
212-465-8304  
- 12p-5pm Mon-Fri (7pm Th)  
- Mental health services  
- Case management  
- HIV and Hep C testing  
- Vaccinations  
- LGBTQI services  
- Acupuncture  

**Washington Hts CORNER Project**  
212-923-7600  
- 9a-5p MWF, -6p TTh, -3p S  
- Mental health services  
- Case management  
- Referrals to HIV testing  
- Hep C testing  
- Clothing  
- IDs  

**StreetWork LES (youth only)**  
646-602-6404  
- 3p-7pm TThF, 2-5pm M  
- Emergency shelter  
- Case management and groups  
- Psych and medical services  
- Meals, showers, supplies  

**Harlem United**  
212-924-3733  
- 9am-5pm Mon-Fri  
- Transitional housing  
- Access to medical care  
- Harm reduction counseling  
- HIV testing, ADAP  
- Mental health services  

### QUEENS

**AIDS Center of Queens County**  
718-472-9400  
- 9am-5pm Mon-Fri  
- Food and clothing  
- Acupuncture and massage  
- Buprenorphine  
- Case management  
- Housing services  
- Legal services  
- HIV, STI and Hep C testing  
- Mental health services  

For more information, call 1-800-LIFENET (1-800-543-3638)  

Para mas información, llama al 1-877-AYUDESE (1-877-298-3373)
## APPENDIX G – Criteria for Transition between Service Levels

### Instructions for use:
1. In the leftmost column find your patient’s current service level.
2. Move across the row until you find the criteria that best describe your patient’s current state.
3. The corresponding column heading identifies what service level should now be assigned to your patient.

<table>
<thead>
<tr>
<th>From</th>
<th>Low Intensity - A</th>
<th>Low Intensity - B</th>
<th>High Intensity – C1</th>
<th>High Intensity – C2</th>
<th>High Intensity - D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Intensity - A</td>
<td>Needs navigation support on behavioral grounds and needs continued health promotion</td>
<td>N/A</td>
<td>N/A</td>
<td>Starting ART</td>
<td>N/A</td>
</tr>
<tr>
<td>Low Intensity - B</td>
<td>ART is discontinued indefinitely.</td>
<td>Undetectable VL AND Treatment Adherence &gt;90%</td>
<td>Detectable VL &lt;10,000 AND social or behavioral indication that adherence may have waned</td>
<td>VL&gt;10,000 OR recent increase without resistance OR new opportunistic infection</td>
<td>VL&gt;10,000 OR recent increase without resistance OR new opportunistic infection</td>
</tr>
<tr>
<td>High Intensity – C1</td>
<td>ART is discontinued indefinitely.</td>
<td>Undetectable VL AND no clinical or social complications OR VL stable &gt;1=6 months on the same treatment, without more effective options</td>
<td>VL&lt;10,000 AND no clinical or social complications OR patient has been at this level for less than 75 days</td>
<td>VL&gt;10,000 or recent increase without resistance OR new opportunistic infection</td>
<td>VL&gt;10,000 OR recent increase without resistance OR new opportunistic infection</td>
</tr>
</tbody>
</table>

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46 Maintenance at this level is time limited; no patient should require more than 12 months.
<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Low Intensity - A</th>
<th>Low Intensity - B</th>
<th>High Intensity – C1</th>
<th>High Intensity – C2</th>
<th>High Intensity - D</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Intensity – C2</td>
<td>ART is discontinued indefinitely.</td>
<td>Patient refuses weekly health promotion</td>
<td>Undetectable VL AND no other clinical or social complications</td>
<td>VL&lt;10,000 AND no clinical or social complications OR VL &gt;10,000 AND patient refuses DOT OR patient has been at this level for less than 75 days</td>
<td>VL &gt;10,000 or recent increase without resistance</td>
<td></td>
</tr>
<tr>
<td>High Intensity - D</td>
<td>ART is discontinued indefinitely.</td>
<td>Patient refuses DOT and weekly intervention</td>
<td>VL&lt;1,000 AND no social or clinical complications AND mastered health promotion curriculum</td>
<td>VL &lt;10,000 AND patient has not yet mastered the curriculum</td>
<td>VL &gt;10,000 OR patient has been at this level for less than 75 days</td>
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</tbody>
</table>

Additional Factors Affecting Movement Between Levels of Care:

i. Adherence to scheduled medication regimens may influence decisions to change levels of care. An adherence of >95% may influence the care providers to decrease the level of care coordination services. An adherence of <80% may influence the care providers to increase the level of care coordination services.

ii. Patients may be moved directly to DOT at any point if the VL becomes 10,000 without any detectable resistance or if any clinical or social complications are present.

iii. Patients are assessed quarterly to determine eligibility for DOT. Patients who are eligible for DOT should receive an offer to participate in DOT (D).

iv. Patient who do not have lab results as a consequence of non-adherence with medical recommendations should be treated as if they had a VL>10,000.

v. Patients who decline DOT should generally receive weekly health promotion (C2); those who decline health promotion should still receive low intensity services (B) with frequent offers to intensify to the indicated level.

vi. Any of the following may be considered clinical or social complications for the purposes of determining level of care:
   1. New OI
   2. Clinical deterioration while on HIV medications
   3. Change in living situation such that patient’s medication adherence may be affected
   4. Recent increase or new onset in substance use that may affect medication adherence
## APPENDIX H – Health Promotion Topics Included in Curriculum

<table>
<thead>
<tr>
<th>Health Promotion Topic</th>
<th>Learning Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction to the Curriculum (Core)</td>
<td>• Introduce the curriculum</td>
</tr>
<tr>
<td></td>
<td>• Initial adherence assessment</td>
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<td>• Goal setting</td>
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<td></td>
<td>• Comprehensive Care Plan</td>
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<td></td>
<td>• Patient Workbook storage</td>
</tr>
<tr>
<td>2. Me and HIV (Core)</td>
<td>• Identify the patient’s life goals as they relate to HIV</td>
</tr>
<tr>
<td>3. Using a Pillbox (Core)</td>
<td>• Understand the proper use of a pillbox</td>
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<td></td>
<td>• Demonstrate the ability to organize medications and take ART medication correctly</td>
</tr>
<tr>
<td>4. Handling your ART medications (Core)</td>
<td>• Understand, discuss and demonstrate steps to be taken for medication refills, storage and preventing stock outs</td>
</tr>
<tr>
<td>5. What is Adherence? (Core)</td>
<td>• Understand the importance of medication adherence</td>
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<td>• Understand what adherence means for them</td>
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<td></td>
<td>• Understand and demonstrate ability to incorporate medication regimen into daily routine</td>
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<tr>
<td>6. Side Effects (Discretionary)</td>
<td>• Understand side effects of medications prescribed to patient</td>
</tr>
<tr>
<td></td>
<td>• Develop a plan for identification and management of side effects</td>
</tr>
<tr>
<td>7. What is HIV and how does it affect my body? (Core)</td>
<td>• Understand HIV as a disease, its transmission, difference between HIV and AIDS</td>
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<td></td>
<td>• Understand the immune system, CD4 count and HIV viral load</td>
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<td>• Understand opportunistic infections</td>
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<tr>
<td>8. Identifying and Building Social support networks (Core)</td>
<td>• Map a non-Program social support network</td>
</tr>
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<td>• Understand how to contact identified support people</td>
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<td>• Comprehend the role of his/her doctors</td>
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<td></td>
<td>• Understand what kind of support he/she can expect from each of these people</td>
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<tr>
<td>9. Adherence strengths and difficulties (Core)</td>
<td>• Identify 3 areas of strength in adherence based on time in health promotion</td>
</tr>
<tr>
<td></td>
<td>• Identify 3 areas of difficulty in adherence based on time in health promotion</td>
</tr>
<tr>
<td>10. Medical appointments and providers (Core)</td>
<td>• Understand the importance of communicating with the provider</td>
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<td>• Develop a plan for preparing for appointments</td>
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<td></td>
<td>• Manage a list of medical providers and their contact information</td>
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<tr>
<td>Health Promotion Topic</td>
<td>Learning Objectives</td>
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<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td>• Demonstrate how to schedule appointments</td>
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<td></td>
<td>• Understand how to coordinate transportation to all relevant appointments</td>
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<tr>
<td>11. Health maintenance (Discretionary)</td>
<td>• Introduction to health maintenance</td>
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<tr>
<td></td>
<td>• Routine questions and answers at the doctor’s office</td>
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<td></td>
<td>• Roles of different service providers</td>
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<tr>
<td>12. Harm Reduction – Sexual Behavior</td>
<td>• Understand harm reduction and the importance of safe sex</td>
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<tr>
<td>(Discretionary)</td>
<td>• Understand risks associated with various sexual behavior</td>
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<td></td>
<td>• Identify a plan for safer sex practices</td>
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<tr>
<td>(Discretionary)</td>
<td>• Develop a plan for staying adherent to ART when using substances</td>
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<td></td>
<td>• Know how to access available resources</td>
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<tr>
<td>14. Harm Reduction – Safety in Relationships (Discretionary)</td>
<td>• What is harm reduction?</td>
</tr>
<tr>
<td></td>
<td>• Healthy Relationships</td>
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<tr>
<td></td>
<td>• Identifying Safe/Unsafe situations</td>
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<td>• Personal Safety Plan</td>
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<tr>
<td>15. Healthy Living: Diet and Exercise</td>
<td>• Healthy eating assessment</td>
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<tr>
<td>(Discretionary)</td>
<td>• Why does eating health matter for HIV</td>
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<td></td>
<td>• Food safety</td>
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<td>• Setting healthy eating goals</td>
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<tr>
<td>16. Wrap Up</td>
<td>• Review Patient Workbook tools</td>
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<td></td>
<td>• Review goals</td>
</tr>
</tbody>
</table>
# APPENDIX I – Recommended Staffing Plan

<table>
<thead>
<tr>
<th>Staff Title</th>
<th>Function</th>
<th>Recommended Minimum Credentials</th>
<th>Supervises:</th>
<th>Supervised by:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Director</strong></td>
<td>• Provides oversight and management of the program.</td>
<td>• MPH, MSW, MPA, or MBA OR&lt;br&gt;• BSN, PA, NP with formal managerial training OR&lt;br&gt;• Other relevant Master’s degree with formal managerial training&lt;br&gt;• AND 3+ years of experience managing services similar to those described in RFP</td>
<td>Care Coordinator&lt;br&gt;Agency Decision</td>
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<td></td>
<td>• Oversees monitoring, reporting and quality assurance activities.</td>
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<tr>
<td><strong>Care Coordinator</strong></td>
<td>• Responsible for implementation of the service plan, supported by Patient Navigators.</td>
<td>• BA/BS, LMSW/LCSW/ LMHC or RN/LPN degree&lt;br&gt;• AND at least 2+ years of case management experience</td>
<td>Patient Navigators&lt;br&gt;Program Director</td>
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<td>• Coordinates and oversees the implementation of the comprehensive plan.</td>
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<td>• Provides clinic-based health promotion in conjunction with regularly scheduled primary care visits.</td>
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<td>• Performs the initial entitlements assessment and collates the comprehensive plan.</td>
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<td>• Facilitates interdisciplinary conversation and planning.</td>
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<td></td>
<td>• Provides backup to Patient Navigators as needed.</td>
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<tr>
<td></td>
<td>• Supervises Patient Navigator staff by chart review and face to face case discussions and performance reviews.</td>
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<tr>
<td><strong>Patient Navigators</strong></td>
<td>• Carries out tasks that are needed to execute the medical and support service plans, including the following:</td>
<td>• High school degree or some college education.&lt;br&gt;• Should have strong socio-cultural identification with the target population.&lt;br&gt;• Strongly discourage the hiring of actively enrolled patients from the program or partner medical provider to protect patient confidentiality.</td>
<td>None&lt;br&gt;Medical</td>
<td>Care Coordinator</td>
</tr>
<tr>
<td></td>
<td>• Accompanies patients to appointments when required.</td>
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<td></td>
<td>• Provides coaching to patients.</td>
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<td></td>
<td>• Delivers monthly or weekly health promotion encounters.</td>
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<td></td>
<td>• Performs entitlements reassessment.</td>
<td></td>
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<tr>
<td></td>
<td>• Coordinates logistics for plan adherence – reminders, transportation and childcare arrangements.</td>
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<td></td>
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</tr>
<tr>
<td><strong>Medical</strong></td>
<td>• Facilitates communication</td>
<td>• BA/BS, LMSW/LCSW/ LMHC&lt;br&gt; None&lt;br&gt;Medical</td>
<td>None&lt;br&gt;Medical</td>
<td></td>
</tr>
<tr>
<td>Staff Title</td>
<td>Function</td>
<td>Recommended Minimum Credentials</td>
<td>Supervises:</td>
<td>Supervised by:</td>
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<td>---------------------------------</td>
<td>----------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Center Liaison</td>
<td>about patient management between primary care providers and Care Coordinators.</td>
<td>or RN/LPN degree</td>
<td>Patient Navigators, Care Coordinators, DOT Specialists</td>
<td>Facility Decision</td>
</tr>
<tr>
<td></td>
<td>• Forwards data reports (e.g., appointment dispositions, laboratory results, etc.) produced by clinical information systems to Care Coordinators.</td>
<td>• AND at least 2+ years of case management experience.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Participates in the generation of and forwards the treatment plan and forwards to Care Coordinators.</td>
<td>• OR current satisfactory employment at the site of the medical provider as a case manager or social worker.</td>
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<tr>
<td></td>
<td>• Collaborates with the clinical team to manage care coordination resources and target the neediest PLWHA for service.</td>
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<tr>
<td></td>
<td>• May conduct selected center-based care coordination activities such as health promotion for low-intensity PLWHA as needed.</td>
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</tr>
<tr>
<td>DOT Specialist–Health Center</td>
<td>Provides clinic-based DOT.</td>
<td>BSN, LPN or RN, unlicensed MD, or another staff member with medical background</td>
<td>None</td>
<td>Program Director</td>
</tr>
<tr>
<td>DOT Specialist–Field</td>
<td>Responsible for field-based daily DOT.</td>
<td>High school degree or some college education.</td>
<td>None</td>
<td>Care Coordinator</td>
</tr>
<tr>
<td></td>
<td>• Field based DOT includes DOT delivered in the home, CBO, work or any other location that is convenient for PLWHA.</td>
<td>• Should have strong socio-cultural identification with the target population.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Strongly discourage the hiring of actively enrolled patients from the program or partner medical provider to protect patient confidentiality.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Provider</td>
<td>Provides HIV outpatient “bridge” medical care (OBMC).</td>
<td>NYS-licensed medical provider (MD, DO, NP PA,)</td>
<td>None</td>
<td>Agency Decision</td>
</tr>
<tr>
<td>Clinical Supervisor</td>
<td>Provides clinical supervision to all staff providing services directly to patients.</td>
<td>Licensed mental health provider (e.g., LCSW, LMSW, LMHC, psychiatrist, psychologist)</td>
<td>Patient Navigators, Care Coordinators, DOT Specialists</td>
<td>Agency Decision</td>
</tr>
<tr>
<td></td>
<td>• Provides clinical or mental health guidance and the opportunity to review mental health and substance use issues as they relate to particular patients.</td>
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</tbody>
</table>

47 This position is intended for affiliation arrangements where the medical organization could not arrange dedicated co-location of services and is not the applying agency.
# APPENDIX J – Training Resources

## NEW YORK CITY AND ONLINE

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Community Research Initiative of America (ACRIA)</td>
<td>230 West 38th Street, 17th Fl. New York, NY 10018</td>
<td>(212) 924-3934</td>
<td></td>
<td><a href="http://www.acria.org/training/introduction">http://www.acria.org/training/introduction</a></td>
<td></td>
</tr>
<tr>
<td>Centers For Disease Control and Prevention (CDC) Learning Connection</td>
<td>1600 Clifton Road, MS E-96 Atlantic, GA 30333</td>
<td>(808) CDC-INFO or (808) 232-4636</td>
<td></td>
<td><a href="http://www.cdc.gov/learning/?s_cid=phtnRetire">http://www.cdc.gov/learning/?s_cid=phtnRetire</a></td>
<td></td>
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<tr>
<td>Clinical Education Initiative (CEI)</td>
<td></td>
<td>(800) 233-5075</td>
<td></td>
<td><a href="http://www.ceitraining.org">http://www.ceitraining.org</a></td>
<td></td>
</tr>
<tr>
<td>Legal Action Center</td>
<td>225 Varick Street New York, NY 10014</td>
<td>(212) 243-1313</td>
<td>(212) 675-0286</td>
<td><a href="http://lac.org">http://lac.org</a></td>
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</tr>
<tr>
<td>Organization</td>
<td>Address</td>
<td>Phone</td>
<td>Fax</td>
<td>Website</td>
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<tr>
<td>Literacy Assistance Center (LAC)</td>
<td>39 Broadway, Suite 1250, New York, NY 10006</td>
<td>(212) 803-3300</td>
<td>(212) 785-3685</td>
<td><a href="http://lacnyc.org/">http://lacnyc.org</a></td>
<td></td>
</tr>
<tr>
<td>National Development and Research Institutes, Inc. (NDRI)</td>
<td>71 West 23rd Street, 8th Floor, New York, NY 10010</td>
<td>(212) 845-4400</td>
<td>(917) 438-0894</td>
<td><a href="http://www.ndri.org">http://www.ndri.org</a></td>
<td></td>
</tr>
<tr>
<td>New York City Department of Health and Mental Hygiene, TTAP</td>
<td>Bureau of HIV/AIDS Prevention &amp; Control, Training and Technical Assistance Program, 42-09 28th Street, CN#A-1, Floor 22, Long Island City, NY 11101</td>
<td>(347) 396-7701</td>
<td></td>
<td><a href="mailto:TTAP@health.nyc.gov">TTAP@health.nyc.gov</a></td>
<td></td>
</tr>
<tr>
<td>Planned Parenthood of New York City</td>
<td>26 Bleecker Street, New York, NY 10012</td>
<td>(212) 965-7000</td>
<td></td>
<td><a href="mailto:choicevoice@ppnyc.org">choicevoice@ppnyc.org</a></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX K – City, State and National Resource List

#### NEW YORK CITY

**HIV Care Coordination**
- Phone: Call 311
  - Website 2: [http://www.healthsolutions.org/HIVCare/?event=page.resources](http://www.healthsolutions.org/HIVCare/?event=page.resources)

**NYC DOHMH HIV Services Locator**
- Website: [https://a816-healthpsi.nyc.gov/DispensingSiteLocator/mainView.do](https://a816-healthpsi.nyc.gov/DispensingSiteLocator/mainView.do)

**The Positive Life Workshop**
- Phone: (347) 396-7596
  - Website: [http://www.healthsolutions.org/HIVCare/?event=page.resources](http://www.healthsolutions.org/HIVCare/?event=page.resources)

**Public Health Solutions**
- Website: [http://healthsolutions.org](http://healthsolutions.org)

#### NEW YORK STATE

**AIDS Drug Assistance Program for Medications (ADAP)**
- Phone: (800) 542-2437
  - Website: [http://www.health.state.ny.us/diseases/aids/resources/index.htm](http://www.health.state.ny.us/diseases/aids/resources/index.htm)

**AIDS Institute**
- Website 1: [http://www.theaidsinstitute.org/](http://www.theaidsinstitute.org/)
  - Website 2: [http://www.health.state.ny.us/diseases/aids/index.htm](http://www.health.state.ny.us/diseases/aids/index.htm)

**Housing Opportunities for Persons with AIDS (HOPWA)**

**Medicaid**
- Website: [http://www.health.state.ny.us/health_care/medicaid/medicaid/index.htm](http://www.health.state.ny.us/health_care/medicaid/medicaid/index.htm)

**Medicaid Health Homes**
- Website: [http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/)

#### NATIONAL

**Human Resources and Services Administration, HIV/AIDS Bureau (HRSA)**

**Centers for Disease Control and Prevention (CDC)**
- Phone: (800) CDC-INFO or (800) 232-4636
  - Website: [http://www.cdc.gov/hiv/](http://www.cdc.gov/hiv/)

**National Institutes of Health (NIH)**
APPENDIX L – Pre-Referral to CC Program Form
Complete this form with the pre-referring provider (e.g., external PCP, case manager, or other service provider) or individual based on their knowledge of the client's information. All required fields (set off by the special double border with thick outer line) should be completed at the time of pre-referral for all potentially eligible candidates, whether or not they consent to participate in the program.

PLEASE PRINT NEATLY AND RETAIN THIS FORM REGARDLESS OF CLIENT ENROLLMENT STATUS.

Type of pre-referral source:

- Testing Provider
- Outside Case Manager
- Self-referral
- Outside PCP
- Rikers Island Transitional Services Project
- Other Source (Specify: ______________________)

What is the client’s primary language?

What is the client’s current home address:

Text Box: __________________________

What is the client’s primary telephone number? (______) ________ - _______________

What is the client’s alternate telephone number? (______) ________ - _______________

Is client currently prescribed a regimen of ART:  ☐ Yes  ☐ No

What is the reason for referral to Care Coordination? (Check all that apply)

- Newly diagnosed
- History of non-adherence
- Current or recent substance use
- Recent incarceration (past 12 months)
- History of mental illness
- First time on an ART regimen OR recent change in regimen
- Possible ART resistance
- Barriers to care (e.g. domestic violence, homelessness, underinsurance, loss to care)
- Frequent missed appointments
- Transfer of care and services from another program

Did Program receive proof of HIV Diagnosis?  ☐ Yes  ☐ No

If Yes, What proof was given?

- M11Q
- ADAP Card
- PCP referral/letter
- HRA referral
- Other proof (Specify:______________________)

NYC Ryan White Part A Care Coordination Forms – Page 1 of 2 – Revision Date: 2/10/11
FOR OFFICE USE:

If Pre-Referral Source was a Testing Provider,

Was this a preliminary positive testing pre-referral?  ☐ Yes  ☐ No  ☐ Unknown

If Yes, Was a confirmatory test performed?  ☐ Yes  ☐ No  ☐ Unknown

Appointment Schedule:

Was an appointment set with PCP in Program?  ☐ Yes  ☐ No

If No,

Priority of Appointment Scheduling: (Check only one)

☐ Urgent (e.g., currently homeless, identified current threat to client, etc.)

If urgent, contact PCP within Program to set up appointment immediately, and contact necessary human services consistent with client needs.

☐ Standard

☐ De-prioritized (e.g., client ineligible, disinterested, or no longer living in the community)

☐ Other (Explain: ______________________________________)

Notes:
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Program Staff Completing or Verifying Form:  
Name: ____________________________  Signature: ____________________________  Date: __/___/__  m m / d d / y y

Primary Care Provider (PCP) Receiving Form:  
Name: ____________________________  Signature: ____________________________  Date: __/___/__  m m / d d / y y
APPENDIX M – PCP Referral Disposition Form
PCP REFERRAL DISPOSITION FORM

Client Name: _______________________________  Client Record #: _______________________________

Primary Care Provider: Please complete this form while the client is in your office. If you approve the client for Care Coordination, then directly hand off the client and form to CC program staff at the end of the visit. If client was pre-referred from an external source, check "Yes" under Pre-Referral Status and complete this form after reaching a decision to approve or decline the Pre-Referral to the Care Coordination program.

Pre-Referral Status:

Was the client pre-referred (by an outside provider or other individual)?  ☐ Yes  ☐ No

If declining the Pre-Referral, skip to Notes and then add your name, signature and date to this form to complete. If referring to Care Coordination, complete the double-bordered boxes (with thick outer line) below, and sign at bottom.

What are the reason(s) for referral?  (Check all that apply)

☐ Newly Diagnosed with HIV
☐ Lost to Care (i.e., at least one visit in last two years, w/o a visit at that facility in past 9 months)
☐ Sporadic/irregular care; difficulty keeping appointments
☐ History of non-adherence to ART
☐ First time on an ART regimen OR recent change in regimen
☐ ART experienced with:
  Prior Tx failure and drug resistance
  -OR-
  Recurrent virologic rebound after successful suppression

CC Intervention Track recommended:

☐ Intervention A: Non-ART Health Promotion – Quarterly
☐ Intervention C2: Weekly (standard recommendation at enrollment for all clients currently prescribed ART)
☐ Intervention D: DOT (highest intensity for clients currently prescribed ART)
☐ TBD (track to be determined)

Notes:
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

If referring to Care Coordination, BRING THE CLIENT AND REFERRAL DISPOSITION FORM DIRECTLY TO CC STAFF AT THE END OF VISIT.

Primary Care Provider (PCP) Completing Form:
Name _______________________________  Signature _______________________________  Date: __/__/____

m m / d d / y y

CC Staff Member Receiving Form:
Name _______________________________  Signature _______________________________  Date: __/__/____

m m / d d / y y

NYC Ryan White Part A Care Coordination Forms – Page 1 of 2 – Revision Date: 2/10/11
**FOR OFFICE USE (REQUIRED FOR PROGRAM MONITORING/TA AND QUALITY ASSURANCE, BUT NOT FOR DATA ENTRY IN eSHARE):**

### Outcome on PCP referral to Care Coordination:

- [ ] Client enrolled
- [ ] Client ineligible/inappropriate referral
  
  *If Checked, Explain why the client was ineligible or why the PCP referral was inappropriate:*
  
  ____________________________
  ____________________________

- [ ] Client Lost To Follow-Up (LTFU)
  
  *If Checked, Explain how and when the client was determined to be lost to follow-up:*
  
  ____________________________
  ____________________________

- [ ] Client declined
  
  *If Checked, Explain the client's reason for refusing or (if reason not known) how client refused:*
  
  ____________________________
  ____________________________

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### CC Staff Member Completing Section:

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date: mm/dd/yyyy</th>
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</table>
APPENDIX N – Ryan White Part A Care Coordination Program Agreement (English)
Before you agree to participate in this program, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You will be given a copy of this form to take with you.

**What is the purpose of Care Coordination?**
The mission of the Care Coordination Program is to improve the health of New Yorkers living with HIV. The Care Coordination Program will do that by helping you to obtain primary care, health education and support services. In this program, all your services will be managed under one primary care provider, the person who will be mainly responsible for your medical care. This helps to make sure that your primary care provider knows what is going on with you and can better meet your needs.

**How does the Care Coordination Program work?**
Staff members called Navigators and Care Coordinators or Medical Center Liaisons will help you with the activities of this program. Navigators will travel to your home or other meeting spot, while Care Coordinators or Medical Center Liaisons will stay in the office or clinic. Together, they will help you find and use resources to improve your health.

1) Your Navigator and Care Coordinator (or Medical Center Liaison) will:
   - Check if you are eligible for benefits and programs.
   - Help you find financial assistance, if needed.
   - Help you find medical insurance, if needed.
   - Help you find stable housing, if needed.
   - Make sure the care you receive is comprehensive and fits your needs.

2) Your Navigator will also offer Health Promotion. Health Promotion includes education and activities to build skills around HIV and other health issues. With new knowledge and skills, you can get more out of your appointments and medications.
   - If you do not have an antiretroviral (HIV) medication prescription, you will receive Health Promotion every three months.
   - If you do have an antiretroviral (HIV) medication prescription, you will receive treatment support as well as Health Promotion. Depending on your needs, you will receive these services every three months, every month or every week. A staff member may also visit you every day to help you take your medications.

**What is expected of people who enroll in this program?**
In order for you to succeed in the Care Coordination program you will be expected to:
- Go to all scheduled clinic visits or call to reschedule before your scheduled appointment if you cannot make it.
- Be available for and participate in visits with the Navigator or call to reschedule before your scheduled visit if you cannot make it.
- Work with your Navigator to learn more about HIV, your health and your care.
- Take your HIV medications to the best of your ability, if you are on them.
- Talk with your Navigator, Care Coordinator (or Medical Center Liaison) and Primary Care Provider about the things that may affect your health or your participation in the program.
You and the program staff will decide together on the medical and social services you need, and include whatever steps you agree on in a document called a care plan. The care plan will address your health-related needs and goals. To help you meet your needs and goals, the care plan will include referrals to other providers or organizations. While you are in the program, you will discuss needs with your Care Coordination team members on a regular basis. This will help them to make any necessary changes to your care plan and services.

It is important for everyone on your Care Coordination team to have up-to-date information about you. This is why information that you share with one member of your Care Coordination team may be shared with the other members. In addition to you, the team may include: your Primary Care Provider, a Medical Center Liaison, a Care Coordinator, a Navigator, and/or a peer worker to help you take your medications.

If you agree, your medications may be kept at the clinic where you receive primary care. This will help you and the Care Coordination team to keep track of your medications.

Care Coordination staff will collect information from you and from your medical charts. This information is needed to see how the program is doing and to check on the quality of services delivered. This information may include but is not limited to your medical history, dates and types of health-related appointments, services and benefits received, housing status, demographics (like race, ethnicity, gender, country of birth, schooling, and employment), risk behaviors, CD4 counts, viral loads, and medications. In addition, identifying information such as names, social security number*, date of birth, addresses, and phone numbers will be collected so that the New York City Department of Health and Mental Hygiene (DOHMH) can connect your records and keep track of how many different individuals the program is serving. The DOHMH is the agency that applies for, receives and distributes the federal funding for Ryan White Part A in New York City.

What are the possible benefits of being in this program?
The purpose of the Care Coordination Program is to help you:

- See a Primary Care Provider on a regular basis.
- Get the medical and social services you need when you need them.
- Get healthy and stay healthy, including keeping a low viral load.
- Take medications as prescribed, if you are taking medications.
- Become able to manage your own medical and social needs.

Programs like Care Coordination have been shown to boost people’s success taking HIV medications, and some have also been shown to improve signs of HIV-related health. However, there is no guarantee that you will benefit from this program or that it will affect you in the same way that it affects other people. By following the program, you will be taking advantage of one resource among many to support your health.

How will enrolling in this program affect my privacy?
Being in Care Coordination may create some intrusions into your life or routine. As part of this program, Navigators will meet you in your home or another agreed-upon meeting spot and, with your permission, will sit in on primary care visits. Also, you will be asked for

* Social security number is optional; you do not have to provide one in order to participate in this program.
Patient Name: _______________________________________

contact information for yourself and for your friends and/or family, so that program staff can use the contact information you provide to re-connect with you if you fall out of touch. Staff will be careful to protect your privacy and confidentiality, especially with regard to HIV. They will never use health-related or HIV-related words in communications with your friends or family. All information about your being in this Care Coordination program is strictly confidential. You will be given a separate form to sign to permit the release or exchange of your HIV and other medical information, for the purpose of this Care Coordination program.

What if I do not want to participate, or if I want to stop after I enroll?
This program is voluntary. You may end your participation at any time. If you decide to stop, please give your Primary Care Provider and Care Coordinator or Medical Center Liaison notice in writing.

Care Coordination program staff or your Primary Care Provider can also end your participation in the program at any time. They can end your enrollment for medical, program-related or administrative reasons. For example, you might be discharged from the program if all efforts to involve you in program activities had failed. You might also be discharged if your Care Coordination team agreed that the program was not the best way of supporting your care and treatment.

Ending your participation in the Care Coordination program will not affect you getting regular medical care or treatment. The only result of ending your participation will be that you will not receive the additional support available through the program. If your participation ends, your information up to that time will still be kept and reviewed by the program, and may be included in its reports. However, the program will not collect any new information about you after the date you stop being enrolled. Any reports made on this program will group together the information from different patients, and will not identify you by name or release any other information that could identify you.

Statement of Agreement
I, (print patient name) ________________________________, wish to enroll in the Care Coordination Program at (agency) ________________________________.

I understand that I can end my participation and stop being in this program at any time. I understand that doing this will not affect my access to regular medical care in any way.

I understand that major activities of this program include determining my eligibility and needs; providing me with requested services; and evaluating the coordination, effectiveness and quality of services received.

I understand that no information or records associated with my case will be knowingly released to anyone or any agency without my written consent except as otherwise provided for by law. By my signature below, I give permission for personally identified (named) information about my health, needs, demographics, and care and services to be entered into a database for use by my Care Coordination team and by the New York City Department of Health and Mental Hygiene (DOHMH), which pays for this program. In addition to being used for patient care, the database can be used by authorized DOHMH staff to review the Care Coordination program for planning, quality improvement, evaluation, reporting, and research purposes. These DOHMH staff are specially trained, certified and recertified yearly by DOHMH in confidentiality procedures.
Patient Name: _______________________________________
I am signing this agreement of my own free will.

If I have any further questions, I may call ___________________________ at 
(_____) ______-____________.

____________________________________  ______/______/_________
Patient Signature  Date (mm/dd/yyyy)

Care Coordination Staff administering consent:

_______________________________  _______ ______/______/_________
Staff Signature  Initials  Date (mm/dd/yyyy)
APPENDIX O – Ryan White Part A Care Coordination Program Agreement (Spanish)
Antes de aceptar participar en este programa, asegúrese de comprender la información que se provee a continuación. Si tiene algunas preguntas, tendremos mucho gusto en hablar con usted sobre ellas. Usted recibirá una copia de este formulario para llevarse.

¿Cuál es el propósito de la Coordinación de Cuidado Médica?
La misión del Programa de Coordinación de Cuidado Médica es mejorar la salud de los neoyorquinos que viven con el VIH. El Programa de Coordinación de la Cuidado hará eso ayudándole a obtener Atención Médica Primaria, educación sobre la salud y servicios de apoyo. En este programa, todos los servicios que reciba se administrarán a través de un solo proveedor de servicios médicos primarios, la persona que será principalmente responsable de su atención médica. Esto ayuda a garantizar que su proveedor de servicios médicos primario sepa lo que está pasando con usted y pueda satisfacer sus necesidades de una mejor manera.

¿Cómo funciona el Programa de Coordinación de Cuidado Médica?
Miembros del personal llamados Navegadores y Coordinadores de Cuidado Médica le ayudarán con las actividades de este programa. Los Navegadores viajarán hasta su casa u otro lugar de encuentro, mientras que los Coordinadores de Cuidado Médica o Enlaces con los Centros Médicos permanecerán en el consultorio o clínica. Juntos, ellos le ayudarán a encontrar y usar los recursos necesarios para mejorar su salud.

1) Su Navegador y Coordinador de Cuidado Médica hará lo siguiente:
   - Verificará si usted reúne los requisitos para recibir beneficios y programas.
   - Le ayudará a obtener asistencia financiera, si es necesario.
   - Le ayudará a obtener seguro médico, si es necesario.
   - Le ayudará a hallar alojamiento estable, si es necesario.
   - Se asegurará de que la atención médica que reciba sea integral y se ajuste a sus necesidades.

2) Su Navegador también le ofrecerá Promocion de Salud. Promocion de Salud incluye educación y actividades que incrementarán el conocimiento relacionados con el VIH y demás asuntos de la salud. Con nuevo conocimiento, usted podrá aprovechar más las citas y los medicamentos.
   - Si usted no tiene una receta médica antirretroviral (VIH), recibirá Promocion de Salud cada tres meses.
   - Si usted sí tiene una receta médica antirretroviral (VIH), recibirá apoyo para el tratamiento adicional de Promocion de Salud. Dependiendo de sus necesidades, usted recibirá estos servicios cada tres meses, cada mes o cada semana. Un miembro del personal también puede visitarlo todos los días para ayudarle a tomar sus medicamentos.
¿Qué se espera de la gente que se inscribe en este programa?
Para poder tener éxito en el Programa de Coordinación de la Cuidado Médica, se espera de usted lo siguiente:

- Que asista a todas las citas o si no puede asistir que llame con anticipación para cambiarlas.
- Que esté disponible y que participe en las visitas con el Navegador o si no puede asistir que llame con anticipación para cambiarlas.
- Que trabaje con su Navegador para aprender más sobre el VIH, su salud y su atención médica.
- Que tome sus medicamentos para el VIH de la mejor manera que pueda, si es que los está tomando.
- Que hable con su Navegador, con su Coordinador de Cuidado y con su Proveedor de Atención Médica Primaria sobre las cosas que puedan afectar su salud o su participación en el programa.

Usted y el personal del programa decidirán juntos cuáles son sus necesidades médicas y sociales, e incluirán los pasos que acuerden llevar a cabo en un documento llamado Plan de Cuidado Médica. El Plan de Cuidado Médica se ocupará de las necesidades y metas relacionadas con su salud. Para ayudarlo a cumplir sus necesidades y metas, el Plan de Cuidado Médica incluirá información de otros proveedores u organizaciones. Mientras usted participe del programa, conversará sobre sus necesidades con los miembros del equipo de Coordinación de Cuidado Médica periódicamente. Esto le ayudará a ellos con los cambios que tengan que hacer en su plan de atención médica y el plan de servicios.

Es importante que todo el equipo de Coordinación de Cuidado Médica tenga la información suya actualizada. La información que usted comparte con uno de los miembros de su equipo de Coordinación de Cuidado Médica se puede compartir con otros miembros para que todos estén de acuerdo. El equipo puede incluir: su Proveedor de Atención Médica Primaria, un Enlace con el Centro Médico, un Coordinador de Cuidado Médica, un Navegador, y/o un Especialista (DOT) que le ayude a tomar sus medicamentos.

Si usted está de acuerdo, sus medicamentos se pueden guardar en la clínica donde usted recibe la Atención Médica Primaria. Esto le ayudará a usted y al equipo de Coordinación de Cuidado Médica llevar el control de sus medicamentos.

El personal de Coordinación de Cuidado Médica recopilará información de usted y de sus historias clínicas. Esta información se necesita para ver cómo le está yendo con el programa y para controlar la calidad de los servicios proporcionados. Esta información puede incluir, aunque no se limita sólo a, su historia clínica, fechas y tipos de citas relacionadas con la salud, servicios y beneficios recibidos, estado de su vivienda, características demográficas (como raza, etnia, sexo, país de nacimiento, educación y empleo), conducta riesgosa, recuento de CD4, carga viral y medicamentos. Además, se recopilará su información personal como nombre, número de seguro social*, fecha de nacimiento, domicilios y números de teléfono para que el Departamento de Salud y Salud Mental (DOHMH, en inglés) de la Ciudad de Nueva York pueda conectar sus registros y controlar cuántas personas diferentes están atendiendo al programa. El DOHMH es la agencia que solicita,

* El número de seguro social es opcional; no debe proporcionar uno para participar en este programa.
Nombre del paciente: ________________________________

reciba y distribuye los fondos federales para la Parte A de Ryan White en la Ciudad de Nueva York.

¿Cuáles son los beneficios posibles de participar en este programa?
El propósito del Programa de Coordinación de la Cuidado es ayudarle a usted a:
- Ver a un Proveedor de Servicios Médicos Primario con frecuencia.
- Obtener los servicios médicos y sociales que necesite cuando los necesite.
- Estar sano y permanecer sano, lo cual incluye que se mantenga baja la carga viral
- Tomar los medicamentos según fueron recetados, si es que está tomando medicamentos.
- Volverse capaz de manejar sus propias necesidades médicas y sociales.

Los programas como la Coordinación de Cuidado Médica han demostrado que aumentan el éxito de las personas al tomar los medicamentos para el VIH, y se ha visto que algunos han mejorado las señales de salud relacionada con el VIH. Sin embargo, no hay ninguna garantía de que usted se beneficiará con este programa o de que le afectará de la misma manera que ha afectado a otras personas. Al seguir con el programa, usted aprovechará un recurso más de entre los varios que hay disponibles para mantener su salud.

¿Cómo afectará mi privacidad si me inscribo en este programa?
Al participar en el Programa de Coordinación de Cuidado Médica se pueden crear intromisiones en su vida o rutina. Como parte de este programa, los Navegadores se reunirán con usted en su casa o en otro sitio acordado por ambos y, con su permiso, estarán presentes en las visitas que tenga con el Médico de Atención Primaria. Además, se le pedirá información de contacto a usted y a sus amigos y/o familiares, para que el personal del programa pueda usar esta información que usted proporcione para ponerse en contacto con usted si usted pierde el contacto. El personal tendrá cuidado de proteger su privacidad y confidencialidad, especialmente en relación al VIH. Nunca usarán palabras relacionadas con la salud o con el VIH en comunicaciones que tengan con sus amigos o con su familia. Toda la información sobre su participación en este Programa de Coordinación de la Cuidado es estrictamente confidencial. Se le dará un formulario aparte para firmar que permitirá el acceso o intercambio de su información médica o sobre el VIH, con el objeto de este Programa de Coordinación de Cuidado Médica.

¿Qué pasa si no quiero participar o si quiero dejar de participar después de inscribirme?
Este programa es voluntario. Usted puede dejar de participar en cualquier momento. Si decide dejar de participar, entreguele una notificación por escrito a su Proveedor de Atención Médica Primaria y a su Coordinador de Cuidado Médica o Enlace con el Centro Médico.

El personal del programa de Coordinación de la Cuidado Médica o su Proveedor de Atención Médica Primaria también pueden cancelar su participación en cualquier momento. Ellos pueden cancelar su participación por razones médicas, administrativas o relacionadas con el programa. Por ejemplo, puede ser que se elija terminar el programa si todos los esfuerzos para hacerlo participar en las actividades del mismo no hubieran resultado. También se le puede dar de baja si su equipo de Coordinación de Cuidado Médica concuerda que el programa no fue la mejor manera de mantener su salud y tratamiento.
Nombre del paciente: _______________________________________

Si usted decide cancelar su participación en el Programa de Coordinación de la Cuidado, no se verá afectada su atención médica normal o su tratamiento. El único resultado de que usted deje de participar será que no recibirá el apoyo adicional disponible a través del programa. Si su participación termina, el programa seguirá guardando y revisando su información obtenida hasta ese momento, y es posible que se incluya en sus informes. Sin embargo, el programa no notará ninguna nueva información sobre usted después de la fecha en que ya no está más inscrito. Cualquier informe hecho sobre este programa agrupará la información de diferentes pacientes y no lo identificará a usted por su nombre o divulgará ninguna otra información que pudiera identificarlo a usted.

Declaración de conformidad
Yo, (nombre del paciente en letra de imprenta) ______________________________, deseo inscribirme en el Programa de Coordinación de Cuidado Médica en (Organización) ______________________________.

Entiendo que puedo cancelar mi participación y dejar de estar en este programa en cualquier momento. Entiendo que al hacer esto, de ninguna manera se verá afectado mi acceso a la atención médica normal.

Entiendo que las principales actividades de este programa incluyen determinar mi elegibilidad y mis necesidades; proporcionarme los servicios solicitados, y evaluar la coordinación, efectividad y la calidad de los servicios recibidos.

Entiendo que ninguna información de registros relacionados será divulgado a nadie o a ninguna organización sin mi consentimiento por escrito excepto de alguna otra manera prevista por la ley. Con mi firma abajo, autorizo a que se ingrese en una base de datos la información que me identifique (con nombre) sobre mi salud, necesidades, características demográficas, atención médica y servicios para que los use mi equipo de Coordinación de Cuidado Médica y el Departamento de Salud y Salud Mental (DOHMH, en inglés) de la Ciudad de Nueva York, quien paga por este programa. Además de usarse para la atención médica, la base de datos puede ser usada por personal autorizado del DOHMH para revisar el Programa de Coordinación de la Cuidado y planificar, mejorar la calidad, preparar informes e investigar. El personal del DOHMH está especialmente entrenado y certificado en procedimientos de confidencialidad y renuevan su certificación todos los años con el DOHMH.

Firmo esta conformidad por voluntad propia.

Si tengo más preguntas, puedo llamar a ______________________________ al (______) ______-__________.

____________________________________  ______/______/_______
Firma del paciente Fecha (mm/dd/aaaa)

Personal de la Coordinación de Cuidado Médica que gestiona el consentimiento:

____________________________________    _______ ______/______/_________
Firma del personal Iniciales Fecha (mm/dd/aaaa)
APPENDIX P – HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information (English)
This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidentiality of HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State law, HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two and three (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or provider disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- My HIV-related information
- Both (non-HIV medical and HIV-related information)
- My non-HIV medical information **

Information in the box below must be completed. Please make sure to cross out all unused fields by marking with an “X”.

Name and address of facility/provider disclosing HIV-related and/or medical information:

________________________________________________________________________________________

Name of person whose information will be released:

________________________________________________________________________________________

Name and address of person signing this form (if other than above):

________________________________________________________________________________________

Relationship to person whose information will be released:

________________________________________________________________________________________

Describe information to be released: Information on reason(s) for referral to the program, demographics, assessments, diagnoses, laboratory tests, medications, care plans, appointment-keeping, program services received, enrollment status, and reason for end of program services.

Reason for release of information: Coordination of Care between providers on HIV care team, when the team involves more than one agency.

Time Period During Which Release of Information is Authorized:

From: _____________________ To: _____________________

(today's date: mm/dd/yyyy) (1-3 years following today's date: mm/dd/yyyy)

Disclosures cannot be revoked once made. Additional exceptions to the right to revoke consent, if any:

The right to use the information already shared (for example, for program purposes such as to determine the quality of the services provided) cannot be revoked even if you are no longer participating in the program. Revoking consent requires notice in writing to the Care Coordinator (or Medical Liaison) and Primary Care Provider within this Care Coordination program.

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):

If a Care Coordination program is carried out by two or more agencies working together under one contract, failure to consent to the sharing of HIV-related information and general medical information between the primary care and Care Coordination providers will prevent enrollment in the Care Coordination program. However, failing to consent and/or revoking your consent will not affect your access to regular medical care or treatment at this facility, and you may still receive other services at the agencies listed in this release. You may even still receive Care Coordination, through another agency or network. This form is only necessary if you want to take part in the Care Coordination program in this facility.

Please sign below only if you wish to authorize all facilities/providers listed on pages 1, 2 (and 3 and 4, if used) of this form to share information among and between themselves for the purpose of providing medical care and services.

Signature ___________________________ Date ___________________________

* Human Immunodeficiency Virus that causes AIDS
** If releasing only non-HIV related medical information, you may use this form or another HIPAA-compliant general medical release form.

Please Complete Information on Page 2 and/or Pages 3 and 4.
HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

Complete information for each separate facility/provider within a Care Coordination network with which general medical and/or HIV-related information will be shared. A “separate” facility or provider is one based at an organization other than the organization of the enrolling primary care physician. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of all facilities/providers with which general medical and/or HIV-related information will be shared. General medical and/or HIV-related information will be shared by your primary care providers with the following Care Coordination network facilities/providers as necessary.

1) Name: ____________________________________________ Agency: ______________________________________________
Address: _____________________________________________________________________________________________________________
City/Borough: _________________________________________ State: __________ Zip Code: ________________________________
Phone #: (_________) _________-___________________

2) Name: ____________________________________________ Agency: ______________________________________________
Address: _____________________________________________________________________________________________________________
City/Borough: _________________________________________ State: __________ Zip Code: ________________________________
Phone #: (_________) _________-___________________

3) Name: ____________________________________________ Agency: ______________________________________________
Address: _____________________________________________________________________________________________________________
City/Borough: _________________________________________ State: __________ Zip Code: ________________________________
Phone #: (_________) _________-___________________

4) Name: ____________________________________________ Agency: ______________________________________________
Address: _____________________________________________________________________________________________________________
City/Borough: _________________________________________ State: __________ Zip Code: ________________________________
Phone #: (_________) _________-___________________

5) Name: ____________________________________________ Agency: ______________________________________________
Address: _____________________________________________________________________________________________________________
City/Borough: _________________________________________ State: __________ Zip Code: ________________________________
Phone #: (_________) _________-___________________

6) Name: ____________________________________________ Agency: ______________________________________________
Address: _____________________________________________________________________________________________________________
City/Borough: _________________________________________ State: __________ Zip Code: ________________________________
Phone #: (_________) _________-___________________

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to the facility/provider obtaining this release. I authorize the facility/provider(s) noted on page one to release medical and/or HIV-related information of the person named on page one to the facilities/provider(s) listed.

Signature ___________________________________________________________________________________ Date____________________

If legal representative, indicate relationship to subject: _______________________________________________

Print Name___________________________________________________________________________________
Client/Patient Number__________________________________________________________________________
HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

Complete information for each non-Care Coordination facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information.
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

Reason for release, if other than stated on page 1:
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

If information to be disclosed to this facility/person is limited, please specify:
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

Name and address of facility/person to be given general medical and/or HIV-related information.
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

Reason for release, if other than stated on page 1:
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

If information to be disclosed to this facility/person is limited, please specify:
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to the facility/provider obtaining this release. I authorize the facility/provider(s) noted on page one to release medical and/or HIV-related information of the person named on page one to the facilities/provider(s) listed.

Signature ___________________________________________________________________________________ Date____________________
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: ________________________________________________

Print Name___________________________________________________________________________________

Client/Patient Number__________________________________________________________________________
HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information

Complete information for each non-Care Coordination facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information.
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________
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Reason for release, if other than stated on page 1:
_____________________________________________________________________________________________________________________
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If information to be disclosed to this facility/person is limited, please specify:
_____________________________________________________________________________________________________________________
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Name and address of facility/person to be given general medical and/or HIV-related information.
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Reason for release, if other than stated on page 1:
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If information to be disclosed to this facility/person is limited, please specify:
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Name and address of facility/person to be given general medical and/or HIV-related information.
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Reason for release, if other than stated on page 1:
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If information to be disclosed to this facility/person is limited, please specify:
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If any/all of this page is completed, please sign below:
Signature ___________________________ Date ____________________
Client/Patient Number ___________________________
APPENDIX Q – HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information (Spanish)
Autorización para divulgar información médica e información confidencial relativa al VIH* conforme a la ley de Responsabilidad y Transferibilidad de Seguros Médicos (HIPAA)

Mediante este formulario se autoriza la divulgación de información médica, incluso de datos relativos al VIH. Usted puede optar por permitir la divulgación de información relacionada con el VIH únicamente, información ajena al VIH únicamente o ambos tipos. La divulgación de tal información puede estar protegida por leyes de confidencialidad federales y estatales. Se considera “información confidencial relativa al VIH” toda información que indique que una persona se ha hecho una prueba relativa al VIH, está infectada con el VIH o tiene SIDA u otra enfermedad relacionada con el VIH, y toda otra information que podría indicar que una persona ha estado potencialmente expuesta al VIH.

Según las leyes del Estado de Nueva York, sólo se puede divulgar información relativa al VIH a aquellas personas a quien usted autorice mediante la firma de un permiso escrito. También puede divulgarlo a las siguientes personas y organizaciones: profesionales de la salud a cargo de su atención o la de su hijo expuesto; funcionarios de salud cuando lo exija la ley; aseguradores (para poder efectuar pagos); personas que participen en el proceso de adopción o colocación en hogares sustitutos; personal oficial correccional o afectado al proceso de libertad condicional; personal de salud o atención de emergencias que haya estado expuesto accidentalmente a su sangre; o a personas autorizadas mediante una orden judicial especial. Según lo estipulado por las leyes estatales, cualquier persona que ilegalmente revele información relacionada con el VIH puede ser sancionada con una multa de hasta $5,000 o encarcelada por un período de hasta un año. No obstante, las leyes estatales no protegen las divulgaciones repetidas de cierta información médica o relacionada con el VIH. Para obtener más información acerca de la confidencialidad de la información relativa al VIH, llame a la línea directa de confidencialidad sobre el VIH del Departamento de Salud del Estado de Nueva York al 1 800 962 5065. Si desea obtener información acerca de la protección federal de la privacidad, llame a la Oficina de Derechos Civiles al 1 800 368 1019.

Al marcar las casillas que se encuentran a continuación y firmar este formulario, se autoriza la divulgación de información médica o relativa al VIH a las personas que figuran en la página dos y tres de este formulario (o en páginas adicionales según corresponda), por las razones enumeradas. Cuando usted lo solicite, el establecimiento o el proveedor que reveló su información médica le deberá proporcionar una copia del formulario.

Complete la información en el siguiente cuadro. El establecimiento o la persona que divulgue la información debe completar el recuadro que se encuentra a continuación:

Nombre y dirección del establecimiento/ proveedor que divulga la información médica o relativa al VIH:

Nombre y dirección de la persona que firma este formulario (si difiere de la persona mencionada anteriormente):

Relación con la persona cuya información será divulgada:

Descrita la información que se ha de divulgar: La información sobre la razón o las razones por las cuales se refiere al programa, la demográfica, evaluaciones, diagnóstico, exámenes de laboratorio, medicamentos, planes de cuidados, citas, los servicios del programa recibidos, estatus de matriculación, y la razón por la cual terminó el programa.

Motive de la divulgación: Coordinación de Cuidado entre proveedores en el equipo de cuidado del VIH, cuando el equipo involucra a más de una agencia.

Período de tiempo durante el cual se autoriza la divulgación de la información:

Desde: ___________________ Hasta: ___________________ O ☐ hasta que se cierre el caso de este programa (seleccione si aplica)

(fecha de hoy: mm/dd/aaaaa)   (1-3 años después del día de hoy: mm/dd/aaaaa)

Una vez que la información ha sido divulgada, la autorización no podrá ser revocada. Excepciones adicionales al derecho de revocar una autorización, de existirlas:

El derecho de usar la información ya compartida (por ejemplo, para propósitos del programa como para determinar la calidad de los servicios ofrecidos) no se puede revocar aunque usted ya no esté participando en el programa. Para consentir una revocación, se requiere una nota escrita y dirigida al Coordinador de Cuidado (o Enlace Médico) y al Proveedor de Cuidado Primario dentro de este programa de Cuidado Coordinado.

Descripción de las consecuencias que la prohibición de la divulgación puede traer al momento del tratamiento, el pago, la inscripción o la elegibilidad para beneficios (Observaciones: Las reglamentaciones federales sobre privacidad pueden restringir algunas consecuencias):

Si un programa de Cuidado Coordinado se leva a cabo por dos o más agencias trabajando juntas bajo un contrato, y no se obtiene consentimiento sobre la colaboración entre los proveedores de cuidado primario y los del Cuidado Coordinado sobre la información relacionada con el VIH y la información médica general, no se podrá matricular en el programa de Cuidado Coordinado. Sin embargo, si no consiente y / o si revoca su consentimiento, su acceso al cuidado médico normal o al tratamiento en esta instalación no será afectado, y todavía puede que reciba otros servicios por parte de las agencias enumeradas en esta publicación. Puede que aún todavía reciba Cuidado Coordinado a través otra agencia o red. Este formulario solo es necesario si usted desea participar en el programa de Cuidado Coordinado en esta instalación.

Todas las establecimientos/proveedor incluidas en las páginas 1, 2 (y 3 y 4 si se la utiliza) de este formulario podrán compartir información entre sí con el propósito de prestar atención y servicios médicos. Firme a continuación para autorizar.

Firma __________________________________________ Fecha _______________________________________________________________________

*Virus de la inmunodeficiencia humana que causa el SIDA
** Si sólo se divulga información médica no relacionada con el VIH, puede utilizar este formulario u otro formulario de divulgación médica conforme a la HIPAA.
Autorización para divulgar información médica e información confidencial relativa al VIH* conforme a la ley de Responsabilidad y Transferibilidad de Seguros Médicos (HIPAA)

Complete la información para cada establecimiento / proveedor dentro de una red de Cuidado Coordinado con la cual se compartirá la información médica general y / o la información relacionada con el VIH. Un establecimiento o proveedor “separado” es uno basado en una organización además de la organización perteneciente al médico de cuidado primario matriculado. Adjunte hojas adicionales según sea necesario. Se recomienda tachar las líneas dejadas en blanco antes de firmar.

Nombre y dirección del establecimiento/ proveedor a quien se le brindará la información médica general o relativa al VIH. La información médica general y / o la información relacionada con el VIH la compartirá sus proveedores de cuidado primario con las siguientes establecimientos / proveedores de Cuidado Coordinado a como sea necesario.

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</tr>
<tr>
<td></td>
<td>No° Teléfono: (<em><strong><strong><strong><strong>) <strong><strong><strong><strong><strong>-</strong></strong></strong></strong></strong></strong></strong></strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Nombre: ___________________________</td>
<td>Establecimiento: ___________________________</td>
</tr>
<tr>
<td></td>
<td>Dirección: ____________________________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ciudad/Municipio: ___________________________ Estado: ________ Código postal: ___________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No° Teléfono: (<em><strong><strong><strong><strong>) <strong><strong><strong><strong><strong>-</strong></strong></strong></strong></strong></strong></strong></strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Nombre: ___________________________</td>
<td>Establecimiento: ___________________________</td>
</tr>
<tr>
<td></td>
<td>Dirección: ____________________________________________</td>
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</tr>
<tr>
<td></td>
<td>Ciudad/Municipio: ___________________________ Estado: ________ Código postal: ___________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No° Teléfono: (<em><strong><strong><strong><strong>) <strong><strong><strong><strong><strong>-</strong></strong></strong></strong></strong></strong></strong></strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Nombre: ___________________________</td>
<td>Establecimiento: ___________________________</td>
</tr>
<tr>
<td></td>
<td>Dirección: ____________________________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ciudad/Municipio: ___________________________ Estado: ________ Código postal: ___________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No° Teléfono: (<em><strong><strong><strong><strong>) <strong><strong><strong><strong><strong>-</strong></strong></strong></strong></strong></strong></strong></strong></strong></em></td>
<td></td>
</tr>
</tbody>
</table>

Las leyes lo protegen de la discriminación relativa al VIH en lo referente a servicios de vivienda, trabajo, atención médica, etc. Para obtener más información, llame a la División de Derechos Humanos del Estado de Nueva York, Oficina para Asuntos de Discriminación a Pacientes con SIDA al 1800 523 2437 o al (212) 480-2522, o bien comuníquese con la Comisión de Derechos Humanos de la Ciudad de Nueva York al (212) 306 7500. Estas agencias son las encargados de proteger sus derechos.

He recibido respuestas a mis preguntas referidas a este formulario. Sé que no tengo la obligación de autorizar la divulgación de mi información médica o relativa al VIH y que puedo cambiar de parecer en cualquier momento y revocar mi autorización enviando una solicitud por escrito al establecimiento o profesional que corresponda. Autorizo al establecimiento o a la persona indicada en la página uno a divulgar información médica o relativa al VIH de la persona también mencionada en la página uno a las organizaciones o personas enumeradas.

Firma __________________________________________________ Fecha ____________________

(Persona a la que se le hará la prueba o representante legal autorizado)

Si es un representante legal, indique la relación con el paciente: ____________________________

Nombre (en letra de imprenta) _________________________________________________________

Número de paciente o cliente ________________________________________________________
Autorización para divulgar información médica e información confidencial relativa al VIH* conforme a la ley de Responsabilidad y Transferibilidad de Seguros Médicos (HIPAA)

Complete la información para cada establecimiento / persona que no sea de Cuidado Coordinado con la que se vaya a compartir información médica general y / o información relacionada con el VIH Adjunte hojas adicionales según sea necesario. Se recomienda tachar las líneas dejadas en blanco antes de firmar.

Nombre y dirección del establecimiento o la persona a quien se le brindará la información médica general o relativa al VIH:
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________

Motivo de la divulgación, si difiere de lo indicado en la página 1:
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________

Si se debe limitar la información que se ha de revelar a este establecimiento o a esta persona, especifique las restricciones.
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________

Nombre y dirección del establecimiento o la persona a quien se le brindará la información médica general o relativa al VIH:
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________

Motivo de la divulgación, si difiere de lo indicado en la página 1:
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________

Si se debe limitar la información que se ha de revelar a este establecimiento o a esta persona, especifique las restricciones.
_________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________

Las leyes lo protegen de la discriminación relativa al VIH en lo referente a servicios de vivienda, trabajo, atención médica, etc. Para obtener más información, llame a la División de Derechos Humanos del Estado de Nueva York, Oficina para Asuntos de Discriminación a Pacientes con SIDA al 1 800 523 2437 o al (212) 480-2522, o bien comuníquese con la Comisión de Derechos Humanos de la Ciudad de Nueva York al (212) 306 7500. Estas agencias son las encargadas de proteger sus derechos.

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Firma  ___________________________________________________________________________________   Fecha ____________________
(Persona a la que se le hará la prueba o representante legal autorizado)

Si es un representante legal, indique la relación con el paciente: __________________________________________________________________________________

Nombre (en letra de imprenta) ___________________________________________________________________________________

Número de paciente o cliente ___________________________________________________________________________________

________________________________________________________________________________________
Autorización para divulgar información médica e información confidencial relativa al VIH* conforme a la ley de Responsabilidad y Transferibilidad de Seguros Médicos (HIPAA)

Complete la información para cada establecimiento / persona que no sea de Cuidado Coordinado con la que se vaya a compartir información médica general y / o información relacionada con el VIH Adjunte hojas adicionales según sea necesario. Se recomienda tachar las líneas dejadas en blanco antes de firmar.

Nombre y dirección del establecimiento o la persona a quien se le brindará la información médica general o relativa al VIH:

_____________________________________________________________________________________________________________________________________________________

Motivo de la divulgación, si difiere de lo indicado en la página 1:

_____________________________________________________________________________________________________________________________________________________

Si se debe limitar la información que se ha de develar a este establecimiento o a esta persona, especifique las restricciones.

_____________________________________________________________________________________________________________________________________________________

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_____________________________________________________________________________________________________________________________________________________

Motivo de la divulgación, si difiere de lo indicado en la página 1:

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_____________________________________________________________________________________________________________________________________________________

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_____________________________________________________________________________________________________________________________________________________

Motivo de la divulgación, si difiere de lo indicado en la página 1:

_____________________________________________________________________________________________________________________________________________________

Si se debe limitar la información que se ha de develar a este establecimiento o a esta persona, especifique las restricciones.

_____________________________________________________________________________________________________________________________________________________ 

Si alguno o todos los de esta página se completa, por favor firme abajo:

Firma ____________________________________________________________________________________  Fecha _______________________

Número de paciente o cliente ________________________________________________________________
APPENDIX R – Contact Information Form
**CONTACT INFORMATION FORM**

Patient Name: ___________________________  Patient Record #: ___________________________

---

**Care Coordinator:** Complete this form at baseline and any time there is a change in address or alternate contact. **This form is to be used solely for the purpose of locating a care coordination patient if the patient falls out of contact. Do not reveal patient health, program, or HIV status information to any contact listed below. PLEASE PRINT NEATLY.**

**Current Home Address:**

<table>
<thead>
<tr>
<th>Street</th>
<th>Apartment/Unit</th>
<th>City</th>
<th>State</th>
<th>Home ZIP Code</th>
</tr>
</thead>
</table>

**Mailing Address:**

- [ ] Same as Current Home Address

<table>
<thead>
<tr>
<th>Street</th>
<th>Apartment/Unit</th>
<th>City</th>
<th>State</th>
<th>Mail ZIP Code</th>
</tr>
</thead>
</table>

**Home Visit Location:**

- [ ] Same as Current Home Address
- [ ] Same as Mailing Address

<table>
<thead>
<tr>
<th>Street</th>
<th>Apartment/Unit</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

**Primary telephone number:** (_______) _______ -___________

**Alternate telephone number:** (_______) _______ -___________

**Primary E-mail:**

---

**ALTERNATIVE CONTACTS** **Read to Patient:**

One of the goals of this program is to help you remain in good health. For this purpose, we may need to attempt to contact you in places other than your home. I'm going to ask you a few questions about how I may contact you in case we lose touch while you are enrolled in this program. If and when we reach out to you through these contacts, we will not reveal any information about your health.

1) Other than home, where (or with whom) do you “hang out” most often?

<table>
<thead>
<tr>
<th>Contact 1 Name or Location:</th>
<th>Relationship, if applicable:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street or Intersection:</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Primary telephone number:** (_______) _______ -___________

**Alternate telephone number:** (_______) _______ -___________

**Primary E-mail:**

---

2) **If applicable, Could we contact the person you identified as someone who is routinely involved in your care?** If yes, what is their information?

<table>
<thead>
<tr>
<th>Contact 2 Name:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street:</td>
<td>Apartment/Unit:</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Primary telephone number:** (_______) _______ -___________

**Alternate telephone number:** (_______) _______ -___________

**Primary E-mail:**
3) **Who would often know where you are when you are not at home? (This could include any parole/probation officer)**

<table>
<thead>
<tr>
<th>Contact 3 Name:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street:</td>
<td>Apartment/Unit:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Primary telephone number:</td>
<td>(_____) _____ - _________</td>
</tr>
<tr>
<td>Alternate telephone number:</td>
<td>(_____) _____ - _________</td>
</tr>
<tr>
<td>Primary E-mail:</td>
<td></td>
</tr>
</tbody>
</table>

4) **Who do you expect to continue to know you and where you live/hang out, one year from now?**

<table>
<thead>
<tr>
<th>Contact 4 Name:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street:</td>
<td>Apartment/Unit:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Primary telephone number:</td>
<td>(_____) _____ - _________</td>
</tr>
<tr>
<td>Alternate telephone number:</td>
<td>(_____) _____ - _________</td>
</tr>
<tr>
<td>Primary E-mail:</td>
<td></td>
</tr>
</tbody>
</table>

5) **Is there anyone else who is close to you and could help us get in touch with you?**

<table>
<thead>
<tr>
<th>Contact 5 Name:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street:</td>
<td>Apartment/Unit:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Primary telephone number:</td>
<td>(_____) _____ - _________</td>
</tr>
<tr>
<td>Alternate telephone number:</td>
<td>(_____) _____ - _________</td>
</tr>
<tr>
<td>Primary E-mail:</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX S – Logistics for Navigator Form
**LOGISTICS FOR NAVIGATOR**

Patient Name: ___________________________  Patient Record #: ___________________________

**Complete this form with the patient at the time of introducing the program and conducting informed consent in your office or at the first scheduled visit. Update as needed, with any major changes affecting the logistics for Navigator encounters.**

**INTRO:** Before you begin your work with the staff for this home-based support program, we have a few questions that will help us meet your needs for privacy and comfort as a patient.

---

1. **Patient will be enrolled in:**  
   - Quarterly HP (No ART)  
   - Quarterly HP  
   - Monthly HP  
   - Weekly HP  
   - DOT

2. **What days and times are best for you to meet with someone from this program?**  
   Check as many days as patient says he/she could meet, and fill in available times for each checked day. For patients enrolled in DOT at intake, identify time(s) for every day of the week.

<table>
<thead>
<tr>
<th>Day(s) of Week:</th>
<th>Time(s) of Day:</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Monday</td>
<td></td>
</tr>
<tr>
<td>❑ Tuesday</td>
<td></td>
</tr>
<tr>
<td>❑ Wednesday</td>
<td></td>
</tr>
<tr>
<td>❑ Thursday</td>
<td></td>
</tr>
<tr>
<td>❑ Friday</td>
<td></td>
</tr>
<tr>
<td>❑ Saturday</td>
<td></td>
</tr>
<tr>
<td>❑ Sunday</td>
<td></td>
</tr>
<tr>
<td>❑ Other answer (Specify: ________________________)</td>
<td></td>
</tr>
</tbody>
</table>

If the patient is not enrolled in Weekly or Daily:
2a. **Which week of the month is best for your Navigator visit?**  
   - Any  
   - First  
   - Second  
   - Third  
   - Fourth  
   - Last

3. **Are there any days or times when you will not be available for a meeting with someone from this program?**  
   __________________________________________________________________________________________
   __________________________________________________________________________________________

4. **Where would you most like to meet for adherence support?**  
   - Read choices:  
   - At home  
   - At another person’s home (Specify the home and relationship: ____________________________)*  
   - Patient’s PCP clinic within the Care Coordination Program  
   - Other location (Specify: __________________________________________)*  
   *Please specify location on the Contact Information Form

5. **Where do you store your medications?**  
   ____________________________

6. **Is anyone routinely involved in your care who could support your participation in this program?**  
   - YES  
   - NO

6a. **If YES, who is that person?**  
   **First Name: ______________________ Relationship to Patient: __________________**  
   **If named, please refer back to person when completing contact information form**
If patient prefers to meet in their own or someone else’s home, ask questions below. Otherwise, SKIP to QUESTION 11.

7. In the home where you would like to meet, is there anyone who does NOT know your HIV status?  
☐ YES ☐ NO

7a. If YES, what is their relationship to you? ____________________________________________

7b. Should we be trying to visit you at home WITHOUT that person or those people?  
☐ YES ☐ NO

7bi. If YES, what times and days are appropriate?
________________________________________________________________________________________
________________________________________________________________________________________

8. Where in the home do you want to do the visits?  
☐ Living Room ☐ Kitchen ☐ Other (Specify: ____________________________________________)

9. For reasons of confidentiality, how would you like the Navigator to identify him or herself, when calling you or visiting you? (For example, should they go by their first name, say they are a “friend,” or say they “work with so-and-so?”)
________________________________________________________________________________________

10. What else would you like us to know about how to work with you at home and protect your confidentiality?
________________________________________________________________________________________
________________________________________________________________________________________

INTRO: I have a few additional questions, which will help us to tailor our work with you in a way that should fit your needs and comfort level. By giving your most honest answers, you will help us to better serve you.

11. How comfortable are you reading English?  
☐ Not at all ☐ Somewhat ☐ Very

12. How comfortable are you writing in English?  
☐ Not at all ☐ Somewhat ☐ Very

13. How comfortable are you reading Spanish?  
☐ Not at all ☐ Somewhat ☐ Very

14. How comfortable are you writing in Spanish?  
☐ Not at all ☐ Somewhat ☐ Very

NAVIGATOR ASSIGNMENT QUESTIONS:
Please ask Questions 15 and 16 only if a Navigator has not yet been assigned. Otherwise, SKIP to QUESTION 17.

15. Do you have a preference for gender of your Navigator?  
☐ No Preference ☐ Male ☐ Female ☐ Other (Specify: _____________________________)

16. What language do you prefer for regular communication with your Navigator?  
☐ English ☐ Spanish ☐ Other (Specify: ____________________________________________)

17. Navigator Assigned (Name): ____________________________________________ as of ______/______/______

Program Staff Completing Form: ______________________________  ______________________________ Date: ______/______/______

Name Signature mm / dd / yy
APPENDIX T – Common Demographics Form
**Program Staff:** Use current client chart and complete or update remaining questions via client interview.

**Date:** ________/_______/__________  **Client Chart/Record #:** __________________

**TC ID/AIRS ID #:** __________________  **If applicable, NYSID:** __________________

**Suffix:** *(Circle one, if applicable)*  Sr  Jr  III  IV  V  Other (Specify: __________________________)

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Name:</th>
</tr>
</thead>
</table>

**Aliases/A.K.A. Names** *(Include any other first names, middle names, or last names used)*

<table>
<thead>
<tr>
<th>Alias First Names</th>
<th>Alias Middle Names</th>
<th>Alias Last Names</th>
</tr>
</thead>
</table>

**Social Security #:** _______ - _______ - _______  **Date of Birth:** ________/_______/__________ (mm/dd/yyyy)

**Sex at Birth:** *(Check only one)*

- Male
- Female
- Intersex/ambiguous

**Current Self-identified Gender:** *(Check only one)*

- Male
- Female
- Transgender (M→F)
- Transgender (F→M)

**Currently Homeless?**

- Yes
- No
- Declined

*(If Yes to “Currently Homeless,” please enter the required ZIP based on where the client spends the most time.)*

**CURRENT HOME ADDRESS**

- Street: __________________
- Apt./Unit: __________________
- City: __________________
- State: __________________
- ZIP: __________________

**PERMANENT/MAILING ADDRESS**

- Street: __________________
- Apt./Unit: __________________
- City: __________________
- State: __________________
- ZIP: __________________

**Primary telephone number:** (____) ____ - ________  **Alternate telephone number:** (____) ____ - ________

**Email address:** __________________

**Contact Preferences:** *(Check all that apply)*

- Current residence address
- Permanent/mailing address
- Primary phone number
- Alternate phone number
- Email address

**Race:** *(Check all that apply)*

- Black
- White
- Asian
- Native Hawaiian/Pacific Islander
- American Indian/Alaskan Native
- Other (Specify: ____________________________)
- Unknown
- Declined

*(If “Asian” selected)*

**Asian Detail:** *(Check all that apply)*

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian

*(If “Native Hawaiian/Pacific Islander” selected)*

**Native Hawaiian/Pacific Islander Detail:** *(Check all that apply)*

- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander

**Ethnicity:** *(Check only one)*

- Hispanic
- Non-Hispanic
- Unknown
- Declined

*(If “Hispanic” selected)*

**Hispanic Ethnicity Detail:** *(Check all that apply)*

- Mexican, Mexican-American, Chicano/a
- Puerto Rican
- Dominican
- Cuban
- Another Hispanic, Latino/a, or Spanish origin

**Marital/relationship status:** *(Check only one)*

- Single, never married
- Married
- Married, separated
- Partnered
- Divorced
- Widowed
- Other (Specify: ____________________________)

**Read question without responses, and then verify answer:**

**How would you identify your sexual orientation?** *(Check only one)*

- Gay/Lesbian/Homosexual
- Straight/Heterosexual
- Bisexual
- Queer
- Questioning
- Other (Specify: ____________________________)
- Declined

**Program Staff**

**Completing Form:** __________________

**Name** __________________  **Signature** __________________

**Date:** ________/_______/__________  **Client Chart/Record #:** __________________

**TC ID/AIRS ID #:** __________________  **If applicable, NYSID:** __________________

**Suffix:** *(Circle one, if applicable)*  Sr  Jr  III  IV  V  Other (Specify: __________________________)

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Name:</th>
</tr>
</thead>
</table>

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<th>Alias Middle Names</th>
<th>Alias Last Names</th>
</tr>
</thead>
</table>

**Social Security #:** _______ - _______ - _______  **Date of Birth:** ________/_______/__________ (mm/dd/yyyy)

**Sex at Birth:** *(Check only one)*

- Male
- Female
- Intersex/ambiguous

**Current Self-identified Gender:** *(Check only one)*

- Male
- Female
- Transgender (M→F)
- Transgender (F→M)

**Currently Homeless?**

- Yes
- No
- Declined

*(If Yes to “Currently Homeless,” please enter the required ZIP based on where the client spends the most time.)*

**CURRENT HOME ADDRESS**

- Street: __________________
- Apt./Unit: __________________
- City: __________________
- State: __________________
- ZIP: __________________

**PERMANENT/MAILING ADDRESS**

- Street: __________________
- Apt./Unit: __________________
- City: __________________
- State: __________________
- ZIP: __________________

**Primary telephone number:** (____) ____ - ________  **Alternate telephone number:** (____) ____ - ________

**Email address:** __________________

**Contact Preferences:** *(Check all that apply)*

- Current residence address
- Permanent/mailing address
- Primary phone number
- Alternate phone number
- Email address

**Race:** *(Check all that apply)*

- Black
- White
- Asian
- Native Hawaiian/Pacific Islander
- American Indian/Alaskan Native
- Other (Specify: ____________________________)
- Unknown
- Declined

*(If “Asian” selected)*

**Asian Detail:** *(Check all that apply)*

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian

*(If “Native Hawaiian/Pacific Islander” selected)*

**Native Hawaiian/Pacific Islander Detail:** *(Check all that apply)*

- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander

**Ethnicity:** *(Check only one)*

- Hispanic
- Non-Hispanic
- Unknown
- Declined

*(If “Hispanic” selected)*

**Hispanic Ethnicity Detail:** *(Check all that apply)*

- Mexican, Mexican-American, Chicano/a
- Puerto Rican
- Dominican
- Cuban
- Another Hispanic, Latino/a, or Spanish origin

**Marital/relationship status:** *(Check only one)*

- Single, never married
- Married
- Married, separated
- Partnered
- Divorced
- Widowed
- Other (Specify: ____________________________)

**Read question without responses, and then verify answer:**

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- Gay/Lesbian/Homosexual
- Straight/Heterosexual
- Bisexual
- Queer
- Questioning
- Other (Specify: ____________________________)
- Declined

**Program Staff**

**Completing Form:** __________________

**Name** __________________  **Signature** __________________

**Date:** ________/_______/__________  **Client Chart/Record #:** __________________

**TC ID/AIRS ID #:** __________________  **If applicable, NYSID:** __________________

**Suffix:** *(Circle one, if applicable)*  Sr  Jr  III  IV  V  Other (Specify: __________________________)

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</tr>
</thead>
</table>

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**Sex at Birth:** *(Check only one)*

- Male
- Female
- Intersex/ambiguous

**Current Self-identified Gender:** *(Check only one)*

- Male
- Female
- Transgender (M→F)
- Transgender (F→M)

**Currently Homeless?**

- Yes
- No
- Declined

*(If Yes to “Currently Homeless,” please enter the required ZIP based on where the client spends the most time.)*

**CURRENT HOME ADDRESS**

- Street: __________________
- Apt./Unit: __________________
- City: __________________
- State: __________________
- ZIP: __________________

**PERMANENT/MAILING ADDRESS**

- Street: __________________
- Apt./Unit: __________________
- City: __________________
- State: __________________
- ZIP: __________________

**Primary telephone number:** (____) ____ - ________  **Alternate telephone number:** (____) ____ - ________

**Email address:** __________________

**Contact Preferences:** *(Check all that apply)*

- Current residence address
- Permanent/mailing address
- Primary phone number
- Alternate phone number
- Email address

**Race:** *(Check all that apply)*

- Black
- White
- Asian
- Native Hawaiian/Pacific Islander
- American Indian/Alaskan Native
- Other (Specify: ____________________________)
- Unknown
- Declined

*(If “Asian” selected)*

**Asian Detail:** *(Check all that apply)*

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian

*(If “Native Hawaiian/Pacific Islander” selected)*

**Native Hawaiian/Pacific Islander Detail:** *(Check all that apply)*

- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander

**Ethnicity:** *(Check only one)*

- Hispanic
- Non-Hispanic
- Unknown
- Declined

*(If “Hispanic” selected)*

**Hispanic Ethnicity Detail:** *(Check all that apply)*

- Mexican, Mexican-American, Chicano/a
- Puerto Rican
- Dominican
- Cuban
- Another Hispanic, Latino/a, or Spanish origin

**Marital/relationship status:** *(Check only one)*

- Single, never married
- Married
- Married, separated
- Partnered
- Divorced
- Widowed
- Other (Specify: ____________________________)

**Read question without responses, and then verify answer:**

**How would you identify your sexual orientation?** *(Check only one)*

- Gay/Lesbian/Homosexual
- Straight/Heterosexual
- Bisexual
- Queer
- Questioning
- Other (Specify: ____________________________)
- Declined

**Program Staff**

**Completing Form:** __________________

**Name** __________________  **Signature** __________________

**Date:** ________/_______/__________  **Client Chart/Record #:** __________________

**TC ID/AIRS ID #:** __________________  **If applicable, NYSID:** __________________
APPENDIX U – Intake Assessment Form
### Intake Assessment (MCM, MCM-W, TCC)

**Client Name:** ____________________________  
**Intake Date:** __________ / __________ / ________ (mm/dd/yyyy)  
**Client Record #:** ____________________________

**Program Staff:** Complete this form through a combination of client interview and chart review at intake. Please note that this form is used for multiple service categories. Not all data elements contained in this form are expected for each service category. To identify which questions are required for your service category, please find the data element requirement codes in the grey section header bar or to the left of individual questions.

**Data Element Requirement Codes:**  
1 = Required; 1 = Optional

**Service Category Codes:**  
ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W

### I. Clinical Information

#### Chart Review or Client Interview

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Required or Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of first known visit to this agency for any service:</td>
<td></td>
</tr>
<tr>
<td>Date of first known outpatient/ambulatory care visit at this agency:</td>
<td></td>
</tr>
</tbody>
</table>
| HIV Status: | (Check only one)  
| HIV Diagnosis Date: | (mm/dd/yyyy)  
| AIDS Diagnosis Date: | (mm/dd/yyyy)  
| HIV Risk Factor: | (Check all that apply)  
| Do you currently have a Primary Care Physician (PCP) / HIV primary care provider? |  
| Last PCP visit prior to enrollment: | (mm/dd/yyyy)  
| Initial/referral visit with PCP within this program: | (mm/dd/yyyy)  

**Most recent CD4 counts and Viral Load measures from on or before the program enrollment date:**  
(Start with the most recent)

#### CD4 Records

<table>
<thead>
<tr>
<th>CD4 count</th>
<th>CD4 % (optional)</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If none are available, check box at right:**  
- No CD4 count on record

#### Viral Load Records

<table>
<thead>
<tr>
<th>Viral Load count</th>
<th>Viral Load Undetectable</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If none are available, check box at right:**  
- No viral load count on record

**Legend:**  
1 = Required; 1 = Optional

**Service Category Codes:**  
ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W

NYC Ryan White Part A Forms MCM/TCC  
Revision Date: 4/16/14
### Hospitalizations & ED Visits

If client had any ED or inpatient care in year before enrollment, fill in table.

<table>
<thead>
<tr>
<th># of Events</th>
<th>Start Date (mm/dd/yyyy)</th>
<th>End Date (mm/dd/yyyy)</th>
<th>Reason/Discharge Dx</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Hospitalizations:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If none, enter “0”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of ED Visits:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If none, enter “0”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Does client have any other medical conditions requiring treatment?

If Yes, What condition(s)? (Check all that apply)

- Cancer
- Kidney disease
- Diabetes
- Hepatitis C
- Heart disease/hypertension
- Tuberculosis (TB)
- Liver disease
- Other (Specify: ___________________________)

### Has client ever received a mental health diagnosis?

If Yes, What diagnosis or diagnoses? (Check all that apply)

- Depression
- Psychosis (Schizophrenia, etc.)
- Anxiety Disorder (Panic, GAD, etc.)
- HIV-associated Dementia
- PTSD
- Other (Specify: ___________________________)

### Pregnant

If Yes, Date of report of client’s pregnancy to program: _______/______/______ (mm/dd/yyyy)

Is client enrolled in prenatal care?

If Yes, When was client enrolled in prenatal care:

- First trimester
- Second trimester
- Third trimester
- At time of delivery
- N/A
- Unknown

Estimated Due Date: _______/______/______

Is client prescribed ART to prevent maternal-to-child (vertical) transmission of HIV?

- Yes
- No
- N/A
- Unknown
### II. Antiretroviral Treatment (ART) Review

**Chart Review or Client Interview**

<table>
<thead>
<tr>
<th>HIV medication names</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Date Started (mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># per Dose</td>
<td>Dose Unit (pills, ccs, mls)</td>
<td># Doses</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td>Daily</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td>Daily</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td>Daily</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td>Daily</td>
</tr>
</tbody>
</table>

**ALL** If client is not on ART, Why is the client not currently prescribed ART? *(Check only one)*
- Not medically indicated
- Not ready – by PCP determination
- Intolerance/side effects/toxicity
- Payment/insurance/cost issue
- Client refused
- Other reason
- Unknown

I. III. Client Information

**Chart Review or Client Interview**

**ALL** Total number in household *(including the client)*: __________

**ALL** Current employment status: *(Check only one)*
- Full-time
- Part-time
- Unemployed
- Unpaid volunteer/peer worker
- Out of workforce
- Other (Specify: _________________________)

**ALL** Highest level of education achieved: *(Check only one)*
- No schooling
- 8th grade or less
- Some high school
- High School/GED or equivalent
- Some college
- Bachelors/technical degree
- Postgraduate

**ALL** Primary Language Spoken (i.e., at home): *(Check only one)*
- English
- Spanish
- Other (Specify: _________________________)

**ALL** If Primary Language is not English: Secondary Language Spoken: *(Check only one)*
- English
- Spanish
- Other (Specify: _________________________)

**ALL** Country of Birth: *(Check only one)*
- USA
- US territory/dependency (Ø Puerto Rico Ø Other – Specify: _________________________)
- Other country (Specify: _________________________)

**ALL** If not USA, ask: In what month and year did you first come to the US? _____ / ______ (mm/yyyy)  

### IV. Insurance Information

**Chart Review or Client Interview**

**ALL** Insurance Status:  
- Uninsured
- Insured

*(If Insured, complete insurance details below. Otherwise, skip to Section V.)*
Check all that apply, and complete the related details/dates on each checked insurance type:

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Insurance details</th>
<th>Effective Date (mm/dd/yyyy)</th>
<th>End/Expiration Date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>(Check only one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Employer plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Individual plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADAP/ADAP+</td>
<td>(Check all that apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ ADAP (Rx Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ ADAP Plus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid or CHIP</td>
<td>(Check only one plan type)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ SNP (special needs plan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ MCO (managed care organization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ FFS (fee-for-service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Not sure which type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Military, VA, HIS, Tricare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Public Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

V. Financial Information

What is your annual household income? $______________ per year

We will be asking you questions in the next two sections about substance use and sexual behaviors. Some of these questions may seem personal in nature, but we ask them of everyone in this program.

- Please answer honestly. You may refuse to answer a question; refusing will not affect your care.
- Please feel free to ask if you need any of the questions explained to you.
- If you do not want to answer a question now, please tell me and we will return to it another time.

VI. Use of Prescriptions, Injectables and Other Substances

Have you used any of the following substances? Read the list starting with tobacco.

<table>
<thead>
<tr>
<th>Substance</th>
<th>...have you ever used this?</th>
<th>If ever used it, then ask: In the past 3 months?</th>
<th>For use in past 3 months, ask: How often do you use?</th>
<th>For use in past 3 months, ask: How have you taken this? (Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>___ times (units) weekly or ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Smoked ☐ Inhaled/snorted ☐ Declined (no answer)</td>
</tr>
<tr>
<td></td>
<td>☐ No</td>
<td>☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Declined</td>
<td>☐ Declined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>___ times (units) weekly or ☐ &lt; weekly ☐ Declined</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ No</td>
<td>☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Declined</td>
<td>☐ Declined</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend:

- Required; 1= Optional
- Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

NYC Ryan White Part A Forms MCM/TCC – Page 4 of 10 – Revision Date: 4/16/14
<table>
<thead>
<tr>
<th>Substance</th>
<th>...have you ever used this?</th>
<th>If ever used it, then ask:</th>
<th>For use in past 3 months, ask: How often do you use?</th>
<th>For use in past 3 months, ask: How have you taken this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>Yes</td>
<td>Yes</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>Declined</td>
<td>Declined</td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>PCP/Hallucinogens</td>
<td>Yes</td>
<td>Yes</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>Declined</td>
<td>Declined</td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Crystal Meth</td>
<td>Yes</td>
<td>Yes</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>Declined</td>
<td>Declined</td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Cocaine/ Crack</td>
<td>Yes</td>
<td>Yes</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>Declined</td>
<td>Declined</td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Heroin</td>
<td>Yes</td>
<td>Yes</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>Declined</td>
<td>Declined</td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Rx Pills to get high</td>
<td>Yes</td>
<td>Yes</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>Declined</td>
<td>Declined</td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Hormones/ steroids</td>
<td>Yes</td>
<td>Yes</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>Declined</td>
<td>Declined</td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Anything else:</td>
<td>Yes</td>
<td>Yes</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>___ times weekly or ___ times weekly or ___ times weekly or ___ times weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>Declined</td>
<td>Declined</td>
<td>Declined (no answer)</td>
</tr>
</tbody>
</table>

If client has, at this interview, reported injecting any substance in the table above, select “Yes” to the question below and select “in the past 3 months” beneath that. Ask the client directly about sharing injection equipment.

| ALL Have you ever injected any drug or substance? If No, go to Section VII. |
|-----------------------------|-----------------------------|-----------------------------|------------------------------------------------------|-------------------------------------------------------|
| Yes                        | No                          | Declined (no answer)         |

| ALL If Yes, When was the last time you injected any substance? |
|---------------------------------------------------------------|---------------------------------------------------------------|
| in the past 3 months                                          | between 3 and 12 months ago                                   |
| more than 12 months ago                                       | Declined                                                      |

| ALL If the client reported any injection behavior in the past 3 months, ask: |
| Do you currently receive clean syringes from a syringe exchange program or pharmacy? |
| Yes                          | No                          | Declined                                                      |

Legend:
- Required; 1 Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

NYC Ryan White Part A Forms mcm/tcc  – Page 5 of 10 –  Revision Date: 4/16/14
### VII. Behavioral Risk Reduction

In the past 12 months, did you have sex with anyone (oral, anal, or vaginal sex)?

- [ ] Yes
- [ ] No
- [ ] Declined

**If Yes, skip to Section VIII.**

If Yes to the above question, please ask the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many sexual partners have you had in the last 12 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had vaginal sex with a male?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had vaginal sex with a female?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had vaginal sex with a transgender person?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Yes to any vaginal sex, then ask:

- In the past 12 months, have you had vaginal sex without a condom?

If Yes to any anal sex, then ask:

- In the past 12 months, have you had anal sex without a condom, dental dam or other barrier?

If Yes to any oral sex, then ask:

- In the past 12 months, have you had oral sex without a condom, dental dam or other barrier?

It is optional to ask this question if the client is biologically male.

It is optional to ask this question if the client is biologically female.

---

Legend:

- [ ] Required; 1= Optional

Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W
### VIII. General Health and Well-Being

**Client Name: ______________________________**

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| SF-12® a registered trademark of Medical Outcomes Trust. | **SF12v2 Standard, US Version 2.0** |

NYC Ryan White Part A Forms MCM/TCC – Page 7 of 10 – **Revision Date: 4/16/14**

#### 1. In general, would you say your health is:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### 2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

- **Moderate activities**, such as moving a table, pushing a vacuum cleaner, sweeping a floor or walking...
  - [ ]
  - [ ]
  - [ ]
  - [ ]

- **Climbing several flights of stairs**...
  - [ ]
  - [ ]
  - [ ]
  - [ ]

#### 3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

- **Accomplished less than you would like**...
  - [ ]
  - [ ]
  - [ ]
  - [ ]

- **Were limited in the kind of work or other activities**...
  - [ ]
  - [ ]
  - [ ]
  - [ ]

#### 4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

- **Accomplished less than you would like**...
  - [ ]
  - [ ]
  - [ ]
  - [ ]

- **Did work or other activities less carefully than usual**...
  - [ ]
  - [ ]
  - [ ]
  - [ ]

#### 5. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, family visits, etc.)?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### 6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

- **Have you felt calm and peaceful**...
  - [ ]
  - [ ]
  - [ ]
  - [ ]

- **Did you have a lot of energy**...
  - [ ]
  - [ ]
  - [ ]
  - [ ]

- **Have you felt downhearted and depressed**...
  - [ ]
  - [ ]
  - [ ]
  - [ ]

#### 7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, family visits, etc.)?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
### IX. Disability Status  

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not Asked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you deaf or do you have serious difficulty hearing?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you blind or do you have serious difficulty seeing, even when wearing glasses (or contact lenses)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OR  
- Client’s age is less than 5 years old (If checked, skip to Living Arrangement/Housing Information)

If the response to EITHER question 2a or 2b in Section VIII. General Health and Well-Being was “Yes, limited a lot” then select “Yes” for the next question; if the response to BOTH of those questions (2a and 2b) was “No, not limited at all” then select “No” for the next question. Under these two scenarios, the client does not need to be asked about difficulty walking or climbing stairs.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not Asked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have serious difficulty walking or climbing stairs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have difficulty dressing or bathing?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OR  
- Client’s age is less than 15 years old

### X. Living Arrangement/Housing Information

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not Asked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently enrolled in a housing assistance program?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Yes, Agency: ____________________________  OR  Unknown

What is your current living situation? (Check only one box at left)

- Homeless/Place not meant for human habitation (such as a vehicle, abandoned building, or outside)
- Emergency shelter (non-SRO hotel)
- Single Room Occupancy (SRO) hotel
- Other hotel or motel (paid for without emergency shelter voucher or rental subsidy)
- Supportive Housing Program If checked, complete the indented detail questions below:
  - Transitional Congregate  
  - Transitional Scattered-Site  
  - Permanent Congregate  
  - Permanent Scattered-Site  

<table>
<thead>
<tr>
<th>HIV housing program?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- Room, apartment, or house that you rent (not affiliated with a supportive housing program)
- Staying or living in someone else’s (family’s or friend’s) room, apartment, or house
- Hospital, institution, long-term care facility, or substance abuse treatment/detox center
- Jail, prison, or juvenile detention facility
- Foster care home or foster care group home
- Apartment or house that you own

Since what date (month and year) have you been living in your current situation?  

_____ / _____ (mm/yyyy)  OR select one of the following: Unknown  Declined

---

Legend:  
- Required: 1= Optional  
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W

NYC Ryan White Part A Forms  
MCM/TCC  
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Revision Date: 4/16/14
How long do you expect to be in your current living situation? If you do not know, what is your best guess? (Check only one)

- at least 1 year
- 6 months - <12 months
- 1 month - <6 months
- < 1 month

Were you ever homeless? Do not ask if client is homeless.

- Yes
- No
- Declined

If Yes, When were you last homeless?

---

Do not ask if client is homeless.

What are your current housing issues? (Check all that apply)

- Cost
- Eviction or pending eviction
- Doubling-up in the unit
- Expanding household (e.g. newborn)
- Health or safety concerns
- Space/configuration (e.g. too small)
- Conflict with others in household
- Release from institutional setting
- Other (Specify: )

---

Have you ever served any time in jail, prison, or juvenile detention (JD)?

- Yes
- No
- Declined

If Yes, Have you served any time in the past 12 months?

- Yes
- No
- Declined

Are you currently on parole/probation?

- Yes
- No
- Declined

---

If client served any time in New York State, enter the NYSID [unique identifier assigned by the New York State Division of Criminal Justice Services (DCJS)]. This is an eight-digit number followed by one-character alpha (letter). Note: if the client has an old NYSID (with only 7 digits plus the letter at the end), insert a zero (0) at the start to reach 8 digits.

NYSID:

Entered via eSHARE Common Demographics screen

---

Currently Enrolled? Referral Needed? Service Category:

- ADHC
- SNP
- Medicaid Health Home
- Other Medicaid Case Management
- HASA
- Outpatient Bridge Medical Care
- No to all of the above

Legend:

= Required; 1= Optional

Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W
For program staff:
During the induction period, every client should be seen weekly in this program, unless the client is otherwise indicated for Intervention D: DOT at enrollment. If a client is indicated for Intervention D: DOT, the client will receive weekly health promotion and daily or near-daily DOT. Clients who are not prescribed ART should be assigned to Intervention A: Non-ARV HP-Quarterly, but receive weekly health promotion throughout the induction period. eSHARE will permit tracking of service frequency during induction.

BASELINE CARE COORDINATION PROGRAM TRACK

Client is enrolling in:

- Intervention A: Non-ARV HP – Quarterly
- Intervention B: ARV HP – Quarterly
- Intervention C1: Monthly
- Intervention C2: Weekly
- Intervention D: DOT

Notes:
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
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_________________________________________________________________________________________

Staff Member Completing Form:

Name: ____________________________
Signature: ________________________
Date: __/__/____

Legend:
- Required; 1= Optional
Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=MCM-W
APPENDIX V – SF-12v2™ General Health and Wellbeing Survey
(Spanish)
Su Salud y Bienestar

Esta encuesta le pide sus opiniones acerca de su salud. Esta información permitirá saber cómo se siente y qué tan bien puede hacer usted sus actividades normales. ¡Gracias por contestar estas preguntas!

Para cada una de las siguientes preguntas, por favor marque con una ☐ la casilla que mejor describa su respuesta.

1. En general, ¿diría que su salud es:

   Excelente Muy buena Buena Pasable Mala
   ☐ ☐ ☐ ☐ ☐

2. Las siguientes preguntas se refieren a actividades que usted podría hacer durante un día típico. ¿Su estado de salud actual lo/la limita para hacer estas actividades? Si es así, ¿cuánto?

   Sí, me limita mucho Sí, me limita un poco No, no me limita en absoluto
   ☐ ☐ ☐

   a Actividades moderadas, como moviendo una mesa, empujando la aspiradora, barriendo el piso o caminando ...................... ☐ ☐ ☐

   b Subir varios pisos por la escalera .................................................... ☐ ☐ ☐

3. Durante las últimas 4 semanas, ¿cuánto tiempo ha tenido usted alguno de los siguientes problemas con el trabajo u otras actividades diarias regulares a causa de su salud física?

   Siempre Casi siempre Algunas veces Casi nunca Nunca
   ☐ ☐ ☐ ☐ ☐

   a Ha logrado hacer menos de lo que le hubiera gustado....................... ☐ ☐ ☐ ☐ ☐

   b Ha tenido limitaciones en cuanto al tipo de trabajo u otras actividades ........................................... ☐ ☐ ☐ ☐ ☐
4. Durante las últimas 4 semanas, ¿cuánto tiempo ha tenido usted alguno de los siguientes problemas con el trabajo u otras actividades diarias regulares a causa de algún problema emocional (como sentirse deprimido/a o ansioso/a)?

<table>
<thead>
<tr>
<th>Siempre</th>
<th>Casi siempre</th>
<th>Algunas veces</th>
<th>Casi nunca</th>
<th>Nunca</th>
</tr>
</thead>
<tbody>
<tr>
<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>▼</td>
</tr>
</tbody>
</table>

b. Ha logrado hacer menos de lo que le hubiera gustado ..................... □ 1 □ 2 □ 3 □ 4 □ 5

c. Ha hecho el trabajo u otras actividades con menos cuidado de lo usual ..................... □ 1 □ 2 □ 3 □ 4 □ 5

5. Durante las últimas 4 semanas, ¿cuánto ha interferido el dolor con su trabajo normal (incluyendo el trabajo adentro y afuera del lugar donde usted vive)?

<table>
<thead>
<tr>
<th>Nada en absoluto</th>
<th>Un poco</th>
<th>Medianamente</th>
<th>Bastante</th>
<th>Extremadamente</th>
</tr>
</thead>
<tbody>
<tr>
<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>▼</td>
</tr>
</tbody>
</table>

□ 1 □ 2 □ 3 □ 4 □ 5

6. Estas preguntas se refieren a cómo se siente usted y a cómo le han ido las cosas durante las últimas 4 semanas. Para cada pregunta, por favor dé la respuesta que más se acerca a la manera como se ha sentido usted. ¿Cuánto tiempo durante las últimas 4 semanas...

<table>
<thead>
<tr>
<th>Siempre</th>
<th>Casi siempre</th>
<th>Algunas veces</th>
<th>Casi nunca</th>
<th>Nunca</th>
</tr>
</thead>
<tbody>
<tr>
<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>▼</td>
</tr>
</tbody>
</table>

a. se ha sentido tranquilo/a y sosegado/a? ..................................... □ 1 □ 2 □ 3 □ 4 □ 5

b. ha tenido mucha energía? ..................................................... □ 1 □ 2 □ 3 □ 4 □ 5

c. se ha sentido desanimado/a y deprimido/a? ................................. □ 1 □ 2 □ 3 □ 4 □ 5

7. Durante las últimas 4 semanas, ¿cuánto tiempo ha interferido su salud física o sus problemas emocionales con sus actividades sociales (como visitas con amigos, parientes, familia, etc.)?

<table>
<thead>
<tr>
<th>Siempre</th>
<th>Casi siempre</th>
<th>Algunas veces</th>
<th>Casi nunca</th>
<th>Nunca</th>
</tr>
</thead>
<tbody>
<tr>
<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>▼</td>
<td>▼</td>
</tr>
</tbody>
</table>

□ 1 □ 2 □ 3 □ 4 □ 5
APPENDIX W – Adherence Assessment (ART Daily Regimens Only)
**ADHERENCE ASSESSMENT (ART DAILY REGIMENS ONLY)**

Client Name: ___________________________________________  Client Record #: ____________________________

**Adherence Assessment Self-Report Date:** _____ / _____ / _____ (mm/dd/yyyy)

NYC-MCM Only: Client is enrolled in:  
- B: Quarterly HP  
- C1: Monthly HP  
- C2: Weekly HP  
- D: DOT

**NOTE:** THIS INTERVIEW SHOULD ONLY BE CONDUCTED WITH CLIENTS WHO ARE CURRENTLY ON ART.

**INTRO:** The purpose of this form is to learn about pill-taking and the issues that affect pill-taking, or adherence.  
- Please answer all questions honestly; you will not be “judged” based on your responses.  
- Please feel free to ask if you need any of the questions explained to you.

The answers you give in this interview will be used to plan ways to help other people who must take pills on a difficult schedule. Many people find it hard to always remember their pills:
- Some people get busy and forget to carry their pills with them.
- Some people find it hard to take their pills according to all the instructions, such as “with meals,” “on an empty stomach,” or “with plenty of fluids.”
- Some people decide to skip pills to avoid side effects or to just not be taking pills that day.

We need to understand how people with HIV are really managing their pills. Please tell us what you are actually doing. Don’t worry about telling us that you don’t take all your pills. We need to know what is really happening, not what you think we “want to hear.”

Complete this page with your client. Be prepared to help the client remember and name medications in his/her regimen, as needed. Please refer to separate list for names and pictures of all HIV medications.

1. Please indicate the name of the daily HIV medications you take, the number of pills in each dose, number of doses each day, and any doses that you may have missed.
   Include only daily ART prescriptions here; special calculations are required for less-than-daily ARTs.

<table>
<thead>
<tr>
<th>MEDICATION REGIMEN</th>
<th>HOW MANY DOSES DID YOU MISS ...</th>
</tr>
</thead>
</table>
| **Step 1.**  
Names of your HIV drugs (eg. Kaletra) | # Pills/dose | Step 2.  
# Dose/day | Yesterday? | Day before yesterday? | 3 days ago? | 4 days ago? | **Step 3.**  
Total Doses Missed |
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |

**Total doses/day, across ART medications:**

For each row (each HIV drug), add up the missed doses and place # in far right column. Then enter column total (the sum across ART drugs) in the outlined box at right.

---

**For program staff:** (Adherence Assessment Form)  
ONLY COUNT ART ADHERENCE

| A. Number of ART drugs in regimen (count the rows completed in Step 1 above) | B. Prescribed # ART doses in 4-day period  
Multiply: 4 x total in outlined box from Step 2 = | C. Total doses missed (total in outlined box from Step 3 above) | D. 4-Day Adherence Percentage (%)  
[(b-c)/b] x 100 =  
(Verified by Supervisor) | (Verified by Supervisor) | (Verified by Supervisor) |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>b</td>
<td>c</td>
<td>d</td>
<td>%</td>
<td></td>
</tr>
</tbody>
</table>

(Verified by Supervisor)
2. When was the last time you missed any of your HIV medications? **Check only one**

- [ ] 5 Within the past week
- [ ] 4 1-2 weeks ago
- [ ] 3 2-4 weeks ago
- [ ] 2 1-3 months ago
- [ ] 1 More than 3 months ago
- [ ] 0 Never skip medications

3. People may miss taking their medications for various reasons. Here is a list of possible reasons why you may miss taking your medications. Have you missed taking your HIV medications because you:

**Read choices aloud, and check as many as apply.**

**Reasons for non-adherence:**
- [ ] Yes  [ ] No Simply forgot
- [ ] Yes  [ ] No Were away from home
- [ ] Yes  [ ] No Were busy with other things
- [ ] Yes  [ ] No Had change in daily routine
- [ ] Yes  [ ] No Fell asleep/slept through dose time
- [ ] Yes  [ ] No Felt ill or sick
- [ ] Yes  [ ] No Wanted to avoid side effects
- [ ] Yes  [ ] No Felt depressed/overwhelmed
- [ ] Yes  [ ] No Felt there were too many pills
- [ ] Yes  [ ] No Did not want others to notice you taking pills
- [ ] Yes  [ ] No Felt like the drug was toxic/harmful
- [ ] Yes  [ ] No Ran out of pills
- [ ] Yes  [ ] No Felt good
- [ ] Yes  [ ] No Other (Specify: ______________________)

4. Self-assessed Adherence Visual Analog Scale (VAS): *(Show VAS to client during and after question.)*

In general over the past 4 weeks, how much of the time did you take all of your HIV medication as prescribed by your doctor? Put an “X” on the line below at the point that shows about how much of the medication you have taken. 0% means you have taken none. 50% means you have taken about half of the prescribed amount of HIV medications. 100% means you have taken every single prescribed dose of your medications.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

For program staff:

4a. Best estimate based on VAS: __________ %

5. What adherence support tools or reminders is this client using now?

- [ ] Pillbox/organizer
- [ ] Pharmacy support (e.g., delivery and/or automatic refill)
- [ ] DOT
- [ ] Electronic reminder (e.g., text/email/calendar alerts, PillStation, alarm, or MEMS caps)
- [ ] Other: ______________________
- [ ] None

5a. If one of the tools listed above was used as another adherence measurement at this visit, what is the result (as a percentage)? ________ %

6. Adherence Problem Identified: [ ] Yes  [ ] No  *(If Yes, PCP Notified: [ ] Care Coordinator Notified: [ ])*

6a. If Yes, Was Adherence Section in Client Care Plan updated? [ ] Yes  [ ] No  *(If Yes, Date: _____/____/____)*

<table>
<thead>
<tr>
<th>Staff Member Completing Form:</th>
<th>Date: mm/dd/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________________</td>
<td>____________________________</td>
</tr>
<tr>
<td>Name</td>
<td>Signature</td>
</tr>
</tbody>
</table>
APPENDIX X – Adherence Assessment (ART Non-Daily Regiments Only)
**ADHERENCE ASSESSMENT (ART NON-DAILY REGIMENS ONLY)**

Client Name: ___________________________  Client Record #: ___________________________

---

### Adherence Assessment Self-Report Date:

___ / ____ / _____ (mm/dd/yyyy)

---

**NYC-MCM Only:** Client is enrolled in:

- [ ] B: Quarterly HP
- [ ] C1: Monthly HP
- [ ] C2: Weekly HP
- [ ] D: DOT

**NOTE:** THIS INTERVIEW SHOULD ONLY BE CONDUCTED WITH CLIENTS WHO ARE CURRENTLY ON ART.

---

**INTRO:** The purpose of this form is to learn about pill-taking and the issues that affect pill-taking, or adherence. This form is used if any of the medications in the regimen is prescribed for less-than-daily use.

- Please answer all questions honestly; you will not be “judged” based on your responses.
- Please feel free to ask if you need any of the questions explained to you.

The answers you give in this interview will be used to plan ways to help other people who must take pills on a difficult schedule. Many people find it hard to always remember their pills:

- Some people get busy and forget to carry their pills with them.
- Some people find it hard to take their pills according to all the instructions, such as “with meals,” “on an empty stomach,” or “with plenty of fluids.”
- Some people decide to skip pills to avoid side effects or to just not be taking pills that day.

We need to understand how people with HIV are really managing their pills. Please tell us what you are actually doing. Don’t worry about telling us that you don’t take all your pills. We need to know what is really happening, not what you think we “want to hear.”

Complete this page with your client. Be prepared to help the client remember and name medications in his/her regimen, as needed. Please refer to separate list for names and pictures of all HIV medications.

---

1. Please indicate the name of the daily HIV medications you take, the number of pills in each dose, number of doses each day, and any doses that you may have missed.

<table>
<thead>
<tr>
<th>MEDICATION REGIMEN</th>
<th>HOW MANY DOSES DID YOU MISS …</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1.</strong> Names of your HIV drugs (eg. Kaletra)</td>
<td># Pills/dose</td>
</tr>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

For each row (each HIV drug), add up the missed doses and place # in far right column. Then enter column total (the sum across ART drugs) in the outlined box at right.

---

**Step 2 (non-daily): Prescribed Doses Across ART Medications**

(ONLY use and sum this row if the patient has an ART regimen in which the number of doses per day varies)

<table>
<thead>
<tr>
<th>Total Rx’d doses (verified by supervisor)</th>
</tr>
</thead>
</table>

---

For program staff: (Adherence Assessment Form) **ONLY COUNT ART ADHERENCE**

- **A. Number of ART drugs in regimen (count the rows completed in Step 1 above)**
- **B. Prescribed # ART doses in 4-day period (Total Rx’d doses from Step 2 above)**
- **C. Total doses missed (total in outlined box from Step 3 above)**
- **D. 4-Day Adherence Percentage (%)**

\[
\text{D. 4-Day Adherence Percentage (\%) } = \frac{(b-c)/b}{a} \times 100 = d
\]

(Verified by Supervisor) (Verified by Supervisor) (Verified by Supervisor)
1. **Name**

2. **When was the last time you missed any of your HIV medications?** Check only one

- ☐ 5 Within the past week
- ☐ 4 1-2 weeks ago
- ☐ 3 2-4 weeks ago
- ☐ 2 1-3 months ago
- ☐ 1 More than 3 months ago
- ☐ 0 Never skip medications

3. People may miss taking their medications for various reasons. Here is a list of possible reasons why you may miss taking your medications. Have you missed taking your HIV medications because you:

   *(Read choices aloud, and check as many as apply.)*

   - Simply forgot (☐ Yes ☐ No)
   - Were away from home (☐ Yes ☐ No)
   - Were busy with other things (☐ Yes ☐ No)
   - Had change in daily routine (☐ Yes ☐ No)
   - Fell asleep/slept through dose time (☐ Yes ☐ No)
   - Felt ill or sick (☐ Yes ☐ No)
   - Wanted to avoid side effects (☐ Yes ☐ No)
   - Felt depressed/overwhelmed (☐ Yes ☐ No)
   - Felt there were too many pills (☐ Yes ☐ No)
   - Did not want others to notice you taking pills (☐ Yes ☐ No)
   - Felt like the drug was toxic/harmful (☐ Yes ☐ No)
   - Ran out of pills (☐ Yes ☐ No)
   - Felt good (☐ Yes ☐ No)
   - Other (Specify: ________________________)

4. **Self-assessed Adherence Visual Analog Scale (VAS):** *(Show VAS to client during and after question.)*

   In general over the past 4 weeks, how much of the time did you take all of your HIV medication as prescribed by your doctor? Put an “X” on the line below at the point that shows about how much of the medication you have taken. 0% means you have taken none. 50% means you have taken about half of the prescribed amount of HIV medications. 100% means you have taken every single prescribed dose of your medications.

   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

   ![VAS Diagram]

   For program staff:

   4a. Best estimate based on VAS: [ ] %

5. **What adherence support tools or reminders is this client using now?**

   - Pillbox/organizer
   - Pharmacy support (e.g., delivery and/or automatic refill)
   - DOT
   - Electronic reminder (e.g., text/email/calendar alerts, PillStation, alarm, or MEMS caps)

   Other: ____________________ ☐ None

   5a. If one of the tools listed above was used as another adherence measurement at this visit, what is the result (as a percentage)? ________ %

6. **Adherence Problem Identified:** ☐ Yes ☐ No *(If Yes, PCP Notified: ☐ Care Coordinator Notified: ☐)*

   6a. If Yes, Was Adherence Section in Client Care Plan updated? ☐ Yes ☐ No If Yes, Date: ___/___/_____

---

**Staff Member Completing Form:** ________________________________ ________________________________

**Name** ________________________________ **Signature** ________________________________

**Date:** ___/___/_____ m m / d d / y y

NYC Ryan White Part A Forms – Page 2 of 2 – Revision Date: 9/20/12
APPENDIX Y – Comprehensive Care Plan
**SECTION 1: COORDINATION OF CARE**

1a: PCP VISIT ATTENDANCE ISSUE OR GOAL: _______________________________________________________________ DATE RESOLVED: ____/____/_____

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
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<td>PCP</td>
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<td>Other: __________</td>
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Completed?:
- Yes
- No
- N/A or Other

Notes: ____/____/_____

1b: OTHER MEDICAL, PROGRAM OR SERVICE (MEDICAL OR SOCIAL) ISSUE OR GOAL:

<table>
<thead>
<tr>
<th>Action Steps</th>
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<td>Other: __________</td>
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Completed?:
- Yes
- No
- N/A or Other

Notes: ____/____/_____

NYC Ryan White Part A Forms
### 1c: OTHER MEDICAL, PROGRAM OR SERVICE (MEDICAL OR SOCIAL) ISSUE OR GOAL:

_______________________________________________________________________________________ DATE RESOLVED: ____/____/_____

<table>
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</thead>
</table>
|              | PCP | CC | Navigator | Completed?: Yes ☐ | No ☐ | N/A or Other ☐ | Notes: | ____/____/_____
|              | PCP | Client | Other: _________ | Completed?: Yes ☐ | No ☐ | N/A or Other ☐ | Notes: | ____/____/_____
|              | PCP | CC | Navigator | Completed?: Yes ☐ | No ☐ | N/A or Other ☐ | Notes: | ____/____/_____
|              | PCP | CC | Navigator | Completed?: Yes ☐ | No ☐ | N/A or Other ☐ | Notes: | ____/____/_____

### SECTION 2: CURRICULUM

For programs covering health promotion/education topics

#### 2a. CURRICULUM TOPICS TO BE COVERED

*Please list topics to be completed before next plan update*

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<tr>
<th>Target Date</th>
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SECTION 3: ADHERENCE

Please complete Adherence section only if the client is currently prescribed ART.

3a. ADHERENCE ISSUE/GOAL 1: _________________________________________________________________  DATE RESOLVED: ____/____/_____

<table>
<thead>
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Completed?:  □ Yes  □ No  □ N/A or Other
Notes:  _____/____/_____  Outcome Date  _____/____/_____

3b. ADHERENCE ISSUE/GOAL 2: _________________________________________________________________  DATE RESOLVED: ____/____/_____

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Completed?:  □ Yes  □ No  □ N/A or Other
Notes:  _____/____/_____  Outcome Date  _____/____/_____

Client:  ____________________________________________  Date:  _____/____/_____
Signature  m m / d d / y y

Program Staff:  ____________________________________________  Date:  _____/____/_____
Name  Signature  m m / d d / y y

PCP:  ____________________________________________  Date:  _____/____/_____
Name  Signature  m m / d d / y y
**SECTION 4: OTHER NEEDS AND GOALS**

In this section, please identify other (and new/emerging) issues or goals and the steps taken to address them.

4a. OTHER ISSUE/GOAL 1: _____________________________________________________________________

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<tr>
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<th>Outcome</th>
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4b. OTHER ISSUE/GOAL 2: _____________________________________________________________________

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4c. OTHER ISSUE/GOAL 3: _____________________________________________________________________

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Client Name: _______________________________________

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Program Staff Completing Section 4: _________________________ _________________________ Date: __________ / ______ / ______
Name: _________________________ Signature: _________________________ m m / d d / y y
APPENDIX Z – Referrals/Appointments Tracking Log
This form facilitates tracking of referrals to and appointments with internal and external service providers. Appointment details entered in eSHARE will feed into the Services/Forms Scheduling Report, which can serve as a reminder and help to prioritize clients for follow-up. Please note that eSHARE will offer an option to associate the referral or PCP appointment with an entered service in the system (for example, “Assistance with health care”). This option to link the referral or appointment to an already-entered service is reflected in the second column of the tables below. Not all referrals/appointments need to be linked.

<table>
<thead>
<tr>
<th>PCP Appointment?</th>
<th>Associate with Entered Service</th>
<th>Worker(s) Who Made Appointment</th>
<th>PCP Appointment Information</th>
<th>Resources Needed</th>
<th>Appt. Disposition</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client has or had appointment scheduled with PCP:</td>
<td>Service Type:</td>
<td>1) ____________</td>
<td>Last Name:</td>
<td>□ Reminder call/message □ Transport – Car/Taxi/Van □ Transport – MetroCard □ Childcare – in field □ Childcare – service site □ Accompany from field □ Accompany at service site □ Appointment preparation □ Interpreting services □ Other (__________) □ N/A (none required)</td>
<td>□ Completed □ Rescheduled □ Client missed □ Client showed, but appnt incomplete □ Other (Specify: ____________)</td>
<td><strong>/</strong>/____</td>
</tr>
<tr>
<td>If Yes, date appt. made:</td>
<td>Service Date:</td>
<td>2) ____________</td>
<td>First Name:</td>
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<td>□ Completed □ Rescheduled □ Client missed □ Client showed, but appnt incomplete □ Other (Specify: ____________)</td>
<td><strong>/</strong>/____</td>
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Program Staff Completing Form: ________________________________
Name ________________________________ Signature ________________________________
Date: __/__/____ m / d / y y
# Referrals/Appointments Tracking Log

## P. 2: Referrals (External Primary Care or Other Services – Internal or External)

**Client Name:** ________________

**Client Record #:** ________________

<table>
<thead>
<tr>
<th>Referral for Services?</th>
<th>Associate with Entered Service</th>
<th>Worker(s) Who Made Referral</th>
<th>Other Service Referral and Appointment Information</th>
<th>Resources Needed</th>
<th>Appt. Disposition</th>
<th>Date Completed</th>
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<tbody>
<tr>
<td>Client has or had a referral for other services:</td>
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<tr>
<td>☐ Yes ☐ No</td>
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<td></td>
<td>Service Type: ________________</td>
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<tr>
<td>If Yes, date referral made:</td>
<td>Service Date: <strong>/</strong>/____</td>
<td></td>
<td>Agency: ________________</td>
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<tr>
<td>Client has or had appointment scheduled to receive other services:</td>
<td></td>
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<tr>
<td>☐ Yes ☐ No</td>
<td>Service Type: ________________</td>
<td></td>
<td>Service Type: ________________</td>
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<tr>
<td>If Yes, date referral made:</td>
<td>Service Date: <strong>/</strong>/____</td>
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<td>Agency: ________________</td>
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</tbody>
</table>

**Program Staff Completing Form:**

**Name:** ____________________

**Signature:** ____________________

**Date:** __/__/____

NYC eSHARE Forms

---

Revision Date: 09-28-11
APPENDIX AA – PCSM Update
I. Primary Care (Required for all service categories)

Do you currently have a Primary Care Physician (PCP) / HIV primary care provider?  
☐ Yes  ☐ No

PCP visits since last update: _____/_____/_______ (mm/dd/yyyy) OR ☐ N/A (no new primary care visit)
   _____/_____ (mm/dd/yyyy)  / / / (mm/dd/yyyy)  / / / (mm/dd/yyyy)

II. Clinical Information – Labs (Required for all service categories except ADV, LGL, HOA and TRN)

<table>
<thead>
<tr>
<th>CD4 tests since last update</th>
<th>If none are available, check box at right:</th>
<th>☐ No new CD4 count on record</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4 count</td>
<td>CD4 % (optional)</td>
<td>Date (mm/dd/yyyy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Viral Load tests since last update</th>
<th>If none are available, check box at right:</th>
<th>☐ No new VL on record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viral Load count</td>
<td>Viral Load Undetectable</td>
<td>Date (mm/dd/yyyy)</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Unknown</td>
</tr>
</tbody>
</table>

III. Antiretroviral Treatment (ART) Review (Required for all service categories except ADV, LGL, HOA and TRN)

Has client had any change in ART status or ART regimen (e.g., started or stopped any antiretroviral medication) since the last assessment?  
☐ Yes ☐ No If No, skip to Section IV.

If yes, is client currently prescribed ART?  
☐ Yes ☐ No

If client is not on ART, Why is the client not currently prescribed ART? (Check only one)
☐ Not medically indicated ☐ Not ready – by PCP determination ☐ Intolerance/side effects/toxicity
☐ Payment/insurance/cost issue ☐ Client refused ☐ Other reason ☐ Unknown

(Required for MCM and OMC only) If currently prescribed ART, please complete the table below:

<table>
<thead>
<tr>
<th>HIV medication names</th>
<th>Dosage</th>
<th># per Dose</th>
<th>Dose Unit (pills, ccs, mls)</th>
<th># Doses</th>
<th>Frequency</th>
<th>Date Started (mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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</tbody>
</table>

IV. HIV/AIDS Status Information (Required for all service categories)

Most Recent HIV Status: (Check only one)
☐ HIV+, Not AIDS ☐ HIV+, AIDS status unknown ☐ CDC-Defined AIDS

If AIDS, AIDS Diagnosis Date: _____/_____/_______ (mm/dd/yyyy) Optional for ADV, LGL, OHC, TRN
APPENDIX BB – Curriculum Coverage Log
Complete the Curriculum Coverage Log whenever a topic is discussed with the patient. Please use the Care Plan to guide curriculum activities. Write in the dates of the visits that included curriculum material, for each topic taught. When a topic is completed as expected in two visits, just write in the “Date Started” and “Date Completed.” However, if a topic is not completed in the second (or even third) teaching session on that topic, write in the date of that session under “Date Continued,” and then write in the final session date for “Date Completed.” At the right, note any areas that took or will take more time and practice, reasons for doing topics out of order, next steps, etc.

<table>
<thead>
<tr>
<th>TOPICS</th>
<th>DATE STARTED (mm/dd/yy)</th>
<th>DATE(S) CONTINUED (mm/dd/yy)</th>
<th>DATE COMPLETED (mm/dd/yy)</th>
<th>NOTES (challenges, needs, order changes, or next steps)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic 1: Introduction to Health Promotion (Core)</td>
<td>______________________</td>
<td>____________________________</td>
<td>_________________________</td>
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<tr>
<td>Topic 2: Me &amp; HIV (Core)</td>
<td>______________________</td>
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</tr>
<tr>
<td>Topic 3: Using a Pillbox (Core)</td>
<td>______________________</td>
<td>____________________________</td>
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</tr>
<tr>
<td>Topic 4: Handling Your ART Medications (Core)</td>
<td>______________________</td>
<td>____________________________</td>
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<tr>
<td>Topic 5: What is Adherence? (Core)</td>
<td>______________________</td>
<td>____________________________</td>
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<tr>
<td>Topic 6: Side Effects (discretionary)</td>
<td>______________________</td>
<td>____________________________</td>
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<tr>
<td>Topic 7: What is HIV and how does it affect my body? (Core)</td>
<td>______________________</td>
<td>____________________________</td>
<td>_________________________</td>
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</tr>
<tr>
<td>TOPICS</td>
<td>DATE STARTED (mm/dd/yy)</td>
<td>DATE(S) CONTINUED (mm/dd/yy)</td>
<td>DATE COMPLETED (mm/dd/yy)</td>
<td>NOTES (challenges, needs, order changes, or next steps)</td>
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<tr>
<td>Topic 8: Identifying and Building Social Support Networks (Core)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
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<tr>
<td>Topic 9: Adherence Strengths and Difficulties (Core)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
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<tr>
<td>Topic 10: Medical Appointments and Providers (Core)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
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<tr>
<td>Topic 11: Health Maintenance (discretionary)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
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</tr>
<tr>
<td>Topic 12: Harm Reduction: Sexual Behavior (discretionary)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
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<tr>
<td>Topic 13: Harm Reduction: Substance Use (discretionary)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
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<tr>
<td>Topic 14: Harm Reduction: Safety in Relationships (discretionary)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td></td>
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<tr>
<td>Topic 15: Healthy Living – Diet and Exercise (discretionary)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
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<tr>
<td>Topic 16: Wrap-up</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
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</tr>
</tbody>
</table>

Staff Member Completing Form: ________________________________  Date: ___ / ___ / ___
Name: ______________________________________________________ Signature: ____________________________

NYC Ryan White Part A Care Coordination Forms – Page 2 of 2 – Release Date: 01/15/10
APPENDIX CC – Pill Box Log (ART Only) – For Daily Regimens
# Pill Box Log (ART Only) - For Daily Regimens

**Client Name:**

**Client Record #:**

**Program Track:**
- B: Quarterly HP
- C1: Monthly HP
- C2: Weekly HP

---

**THIS FORM SHOULD ONLY BE COMPLETED FOR CLIENTS WHO ARE CURRENTLY ON ART BUT HAVE NOT BEEN RECEIVING DOT IN THIS REVIEW PERIOD.**

Program Staff: Add to the Monthly Pill Box Log at each weekly, monthly or quarterly visit. Include every pill box available for review since the previous review, going back at most 4 weeks. In the space below, identify the medications currently prescribed, the number of pills prescribed per day per medication, and the number of pills taken per day per medication. If a pillbox review cannot be completed, put an X in the spaces for “Sum of Total Pills Taken” and “Total Pills Prescribed.” After a weekly review, sum the number of pills taken per ARV in the first gray-shaded column and complete the weekly totals. A 4-week summary is on Page 2. If the regimen changes mid-week, start a new week on the first day of the new regimen.

<table>
<thead>
<tr>
<th>Week: <em><strong>/</strong></em>/___ to <em><strong>/</strong></em>/___</th>
<th>Number of Pills Taken</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication</strong></td>
<td><strong>List antiretrovirals (ARVs) and the # of prescribed pills/day for each</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong># pills/day</strong></td>
<td><strong>Day 1</strong></td>
<td><strong>Day 2</strong></td>
<td><strong>Day 3</strong></td>
<td><strong>Day 4</strong></td>
<td><strong>Day 5</strong></td>
<td><strong>Day 6</strong></td>
<td><strong>Day 7</strong></td>
</tr>
<tr>
<td><strong>Total Pills Taken per ARV</strong></td>
<td>b1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sum of Total Pills Taken (all ARVs)</strong></td>
<td>c1</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Pills Prescribed (a1 x days in period)</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>% Adherence</strong></td>
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</tr>
</tbody>
</table>
### Medication

*List antiretrovirals (ARVs) and the # of prescribed pills/day for each*

<table>
<thead>
<tr>
<th>Day</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Pills Taken per ARV</strong></td>
<td>b&lt;sub&gt;3&lt;/sub&gt;</td>
<td></td>
<td></td>
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<tr>
<td><strong>Total Pills Prescribed (a&lt;sub&gt;3&lt;/sub&gt; x days in period)</strong></td>
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</tr>
<tr>
<td><strong>% Adherence ([b&lt;sub&gt;3&lt;/sub&gt;/c&lt;sub&gt;3&lt;/sub&gt;) x 100]</strong></td>
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</tbody>
</table>

**Daily pills prescribed (across ARVs) =** a<sub>3</sub>

Week: __/__/____ to __/__/_____ | Number of Pills Taken | Weekly Totals

### Medication

*List antiretrovirals (ARVs) and the # of prescribed pills/day for each*

<table>
<thead>
<tr>
<th>Day</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Pills Taken per ARV</strong></td>
<td>b&lt;sub&gt;4&lt;/sub&gt;</td>
<td></td>
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<tr>
<td><strong>Total Pills Prescribed (a&lt;sub&gt;4&lt;/sub&gt; x days in period)</strong></td>
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<tr>
<td><strong>% Adherence ([b&lt;sub&gt;4&lt;/sub&gt;/c&lt;sub&gt;4&lt;/sub&gt;) x 100]</strong></td>
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</table>

**Daily pills prescribed (across ARVs) =** a<sub>4</sub>

### 4-week Adherence Summary:

\[
\left(\frac{b_1+b_2+b_3+b_4}{c_1+c_2+c_3+c_4}\right) \times 100 = \% \text{ Adherence by Pill Box count}
\]

**Date of Pill Box report:** __/__/____

**Staff Member Completing Form:**

Name: ____________________________

Signature: _________________________

Date: __/__/____

**Verified By:**

Name: ____________________________

Signature: _________________________

Date: __/__/____

NYC Ryan White Part A Forms – Page 2 of 2 – Revision Date: 9/23/11
APPENDIX DD – Pill Box Log (ART Only) – For Non-Daily Regimens
PILL BOX LOG (ART ONLY) - FOR NON-DAILY REGIMENS

Client Name: ____________________________  Client Record #: ____________________________

Program Track:  □ B: Quarterly HP  □ C1: Monthly HP  □ C2: Weekly HP

THIS FORM SHOULD ONLY BE COMPLETED FOR CLIENTS WHO ARE CURRENTLY ON ART BUT HAVE NOT BEEN RECEIVING DOT IN THIS REVIEW PERIOD. IN ADDITION, THIS VERSION IS INTENDED FOR CLIENTS WHO HAVE SOME ARVs PRESCRIBED FOR LESS-THAN-DAILY USE.

Program Staff: Add to the Monthly Pill Box Log at each weekly, monthly or quarterly visit. Include every pill box available for review since the previous review, going back at most 4 weeks. In the space below, identify the medications currently prescribed, the number of pills prescribed per day per medication, and the number of pills taken per day per medication. If a pillbox review cannot be completed, put an X in the spaces for “Sum of Total Pills Taken” and “Total Pills Prescribed.” After a weekly review, sum the number of pills taken per ARV in the first gray-shaded column and complete the weekly totals. A 4-week summary is on Page 2. If the regimen changes mid-week, start a new week on the first day of the new regimen.

<table>
<thead>
<tr>
<th>Week: <strong><strong><strong>/</strong></strong><em>/</em></strong>___ to <strong><strong><strong>/</strong></strong><em>/</em></strong>___</th>
<th>Number of Pills Taken</th>
<th>Weekly Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>Prescribed Pills and Frequency (# pills/day, # days/week)</td>
<td>Day 1</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

Pills prescribed (across ARVs) for each day: a1 = Total weekly pills prescribed (Rx’d)

<table>
<thead>
<tr>
<th>Week: <strong><strong><strong>/</strong></strong><em>/</em></strong>___ to <strong><strong><strong>/</strong></strong><em>/</em></strong>___</th>
<th>Number of Pills Taken</th>
<th>Weekly Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>Prescribed Pills and Frequency (# pills/day, # days/week)</td>
<td>Day 1</td>
</tr>
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</table>

Pills prescribed (across ARVs) for each day: a2 = Total weekly pills prescribed (Rx’d)

Cells shaded in gray may be calculated by the Adherence Form Assistance Tool.

NYC Ryan White Part A Forms – Page 1 of 2 – Revision Date: 9/23/11
<table>
<thead>
<tr>
<th>Medication</th>
<th>Prescribed Pills and Frequency</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
<th>Total Pills Taken per ARV</th>
<th>Sum of Total Pills Taken (all ARVs)</th>
<th>Total Pills Prescribed (a3)</th>
<th>% Adherence ([b3/a3] x 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>List antiretrovirals (ARVs)</td>
<td>(# pills/day, # days/week)</td>
<td></td>
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</tbody>
</table>

Pills prescribed (across ARVs) for each day: a3 = Total weekly pills prescribed (Rx’d)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Prescribed Pills and Frequency</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
<th>Total Pills Taken per ARV</th>
<th>Sum of Total Pills Taken (all ARVs)</th>
<th>Total Pills Prescribed (a4)</th>
<th>% Adherence ([b4/a4] x 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>List antiretrovirals (ARVs)</td>
<td>(# pills/day, # days/week)</td>
<td></td>
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</tbody>
</table>

Pills prescribed (across ARVs) for each day: a4 = Total weekly pills prescribed (Rx’d)

**Cells shaded in gray may be calculated by the Adherence Form Assistance Tool**

**Symptom review by self-report over 4 weeks:**
- Diarrhea
- Nausea
- Sleep disturbance
- Fatigue
- Muscle pain
- Nerve pain
- Abdominal pain
- Headache
- Dizziness or fainting
- Rash
- Other (Specify: ________________)

**4-week Adherence Summary:**

$$\frac{[b1+b2+b3+b4]}{(a1+a2+a3+a4)} \times 100 = \% \text{ Adherence by Pill Box}$$

<table>
<thead>
<tr>
<th>Total Taken</th>
<th>Total Prescribed</th>
<th>( \times 100 )</th>
<th>=</th>
</tr>
</thead>
</table>

**Staff Member Completing Form:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date: m m / d d / y y</th>
</tr>
</thead>
</table>

**Verified By:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date: m m / d d / y y</th>
</tr>
</thead>
</table>
APPENDIX EE – Monthly DOT Log (ART Only)
**MONTHLY DOT LOG (ART ONLY)**

**Month ________ Year ________**

**Client Name:**

**Client Record #:**

 DOT Specialist or Navigator: Document pills taken at each DOT visit in Section 1. The number at the top of each column refers to the day of the month. Please write the month of the review at the top of the form. For each medication, place the number of observed pills taken at the DOT visit above the dotted line, and place the number of unobserved pills taken below the dotted line, in the shaded area. NOTE: If regimen changes mid-month, create a new DOT log starting on the first day of the new regimen. (Example: if a new regimen starts on day 15, begin client a new DOT log leaving days 1-14 blank, with first entry on day 15.)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Pills Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>List ARVs, with #pills/day prescribed for each</td>
<td>#</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total pills Rx’d per day =**

**Monthly total pills taken (observed only) =**

**Monthly total pills taken (observed and unobserved) =**

**Pills Rx’d for each day**

Use this row only for ART regimens with varying pills Rx’d per day.

**Days without DOT**

At right, mark an ‘X’ for any day without any DOT (no dose(s) observed).

**Symptom Review by client self-report:**

- Diarrhea
- Fatigue
- Abdominal pain
- Rash
- Nausea
- Muscle pain
- Headache
- Other
- Sleep disturbance
- Nerve pain
- Dizziness or fainting
- Other

*(Specify: ___________________________)*

*In ‘d’ write Total pills Rx’d for the month (for a non-daily regimen)*

†Days in DOT month without an observation
Monthly DOT Log

Client Name: ____________________________ Client Record #: __________

Section 2: Monthly Adherence Summary – For program use only

At the end of the month, please complete boxes a, b, c, and d (if applicable) in Section 1, and the monthly summary in Section 2 for all pills prescribed and taken for the month. Include both an overall adherence measure and the strict adherence measure that counts observed pills only.

Date of DOT report: __________ / ________ / ________

ARV Medication (Transcribe from Section 1 on pg. 1)

<table>
<thead>
<tr>
<th>Item 1. Days in period</th>
<th>Item 2. TOTAL number of pills prescribed (Rx'd) in period (Multiply Total pills Rx'd per day by Days in period: a x e) OR (Insert Total pills Rx'd from box ‘d’ on page 1)</th>
<th>Item 3. TOTAL pills taken in period (c on p.1)</th>
<th>Item 4. TOTAL pills observed taken in period (b on p.1)</th>
<th>Item 5. Report of adherence by DOT count for a month (Item 3/Item 2) x 100 =</th>
<th>Item 6. Report of directly observed adherence by DOT for a month (Item 4/Item 2) x 100 =</th>
</tr>
</thead>
<tbody>
<tr>
<td>e</td>
<td></td>
<td>c</td>
<td>b</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Verified  ☐

Verified  ☐

Verified  ☐

Verified  ☐

☑ Directly observed adherence not available (N/A)

Notes:
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________

Staff Member Completing Form: ____________________________  Signature: ____________________________  Date: __________ / ________ / ________

Verified By: ____________________________  Signature: ____________________________  Date: __________ / ________ / ________
APPENDIX FF – Care Coordination Case Conference Form
CARE COORDINATION CASE CONFERENCE

Client Name: ___________________  Client Record #: ___________  Enroll Date: _____/_____/______

Navigator: ___________________  Last PCP Visit Date: _____/_____/______

Note: For clients in non-ART track (A), skip ART Regimen Review (bottom of P. 1) and Adherence Review (top of P. 2).
Care Coordinator or Navigator: Please discuss the client with the PCP and use this form to guide discussion at least once quarterly, throughout the client’s program enrollment.

Is this a formal/scheduled ongoing case review?  ❑ Yes  ❑ No  (If No, only field required for eSHARE is Date of Case Conference).

Date of Case Conference: _____/_____/______


Previous Conference (Date: _____/_____/______):

<table>
<thead>
<tr>
<th>#</th>
<th>Previous CD4:</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Previous VL:</th>
<th>Date</th>
</tr>
</thead>
</table>

Missed PCP appointments  ❑ N/A (no prior reported at last Conference: _______  Conference)

Current Conference From EMR and CC records

<table>
<thead>
<tr>
<th>#</th>
<th>Most Recent CD4:</th>
<th>Date(s)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Most Recent VL:</th>
<th>Date(s)</th>
</tr>
</thead>
</table>

Hospitalizations since last Case Conference:

ED visits since last Case Conference:

PCP appointments missed since last completed appointment: __________

Topics covered since last Conference:

Total # of topics covered to this point: ________

*Refer to intake, if this is first Conference.

Progress Notes (include progress with enrollment in services, topics covered, adherence barriers, risk behaviors, disclosure issues, social issues or services, and any other developments relevant to care plan):

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

ART Regimen Review  Currently prescribed ART:  ❑ Yes  ❑ No  (If No, skip to Notes on Page 2)

Check the appropriate option

❑ Regimen unchanged since last conference  ❑ Regimen changed since last conference

Reason for regimen change

❑ Treatment failure/ Viral resistance
❑ Intolerance/ Side effects (Specify: ____________)
❑ Change in guidance/regimen simplification
❑ Other (Specify: ____________)

Current ART Medications:  Pills/dose  Dose Frequency  Continued or New?  If New, Start Date:

<table>
<thead>
<tr>
<th>Pills/dose</th>
<th>Dose Frequency</th>
<th>Continued or New?</th>
<th>If New, Start Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>❑ Continuing  ❑ New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>❑ Continuing  ❑ New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>❑ Continuing  ❑ New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>❑ Continuing  ❑ New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>❑ Continuing  ❑ New</td>
<td></td>
</tr>
</tbody>
</table>

NYC Ryan White Part A Care Coordination Forms – Page 1 of 2 – Revision Date: 2/11/11
**Adherence Review** Complete only if client is prescribed ART. Leave left side blank if this is the first Conference.

<table>
<thead>
<tr>
<th>From previous conference:</th>
<th>For current conference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOT or Pillbox at <strong>PREVIOUS Conf.</strong></td>
<td><strong>SINCE LAST Conf.</strong></td>
</tr>
<tr>
<td>(Measure:______)</td>
<td>(Measure:______)</td>
</tr>
<tr>
<td>Value as % from 0-100</td>
<td>Value as % from 0-100</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
</tbody>
</table>

*Summary of up to 4 weekly pillbox checks or 1 month of DOT

**Record self-report adherence assessment**

<table>
<thead>
<tr>
<th>From previous conference:</th>
<th>For current conference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of last self-report Adherence Assessment at previous conf.</td>
<td>Date of most recent available self-report Adherence Assessment</td>
</tr>
<tr>
<td>4-day self-report adherence value</td>
<td>4-day self-report adherence value</td>
</tr>
<tr>
<td>Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 1, Box D</td>
<td>Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 1, Box D</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
</tbody>
</table>

**Notes on Current Needs:** Include adherence barriers, risk behaviors, disclosure issues, housing issues, social issues, and any other behavioral, clinical, or psychosocial concerns that need to be addressed

**Notes on Case Conference Discussion:**

**Client Disposition Summary**

Check the appropriate option

- [ ] Continue current Program/Track
- [ ] Change in Program/Track **(Update Client Status Change form)**
  - Change to:
  - [ ] A: Quarterly (No ART)  
  - [ ] B: Quarterly (ART)  
  - [ ] C1: Monthly  
  - [ ] C2: Weekly  
  - [ ] D: DOT
- [ ] Discharge from program **(Update Client Status Change form)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/PA/NP</td>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>Care Coordinator</td>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
</tbody>
</table>
APPENDIX GG – Reassessment Form
Program Staff: Re-assess clients at least every six months. When completing this interview/chart review, you should have the intake or previous assessment available for reference. Clients may need to be reminded of responses on the previous assessment, in order to report accurately on what has changed. For items collected via client interview, mention the date of the last assessment, and explain that, except where otherwise specified, you will be asking about any changes since that date.

Please note that this form is used for multiple service categories. Not all data elements contained in this form are expected for each service category. To identify which questions are required for your service category, please find the data element requirement codes in the grey section header bar or to the left of individual questions.

Data Element Requirement Codes:
[ ]= Required; [ ]= Optional

Service Category Codes:
ALL=All Categories; 1=MCM; 2=TCC; 3=PRS; 4=TSC

I. Clinical Information

### Hospitalizations and ED Visits since last assessment:

<table>
<thead>
<tr>
<th># of Events</th>
<th>Start Date (mm/dd/yyyy)</th>
<th>End Date (mm/dd/yyyy)</th>
<th>Reason/Discharge Dx</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Hospitalizations:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] If none, enter “0”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of ED Visits:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] if none, enter “0”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Has client received or newly reported any other medical conditions requiring treatment since last assessment?

[ ] Yes  [ ] No  [ ] Unknown

**ALL If Yes, What condition(s)? (Check all that apply)**

- [ ] Cancer
- [ ] Kidney disease
- [ ] Diabetes
- [ ] Hepatitis C
- [ ] Heart disease/hypertension
- [ ] Tuberculosis (TB)
- [ ] Liver disease
- [ ] Other (Specify: ___________________________)

### Has client received or newly reported a mental health diagnosis since last assessment?

[ ] Yes  [ ] No  [ ] Unknown

Legend:
[ ]= Required; [ ]= Optional

Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=PRS; 4=TSC
Client Name: ______________________________________

ALL If Yes, What diagnosis or diagnoses? (Check all that apply)

☑ Depression  ☑ Psychosis (Schizophrenia, etc.)
☑ Anxiety Disorder (Panic, GAD, etc.)  ☑ HIV-associated Dementia
☑ PTSD  ☑ Other (Specify: ___________________________)
☑ Bipolar Disorder

☑ 3 4 Pregnant: ☑ Yes ☑ No ☑ Unknown ☑ N/A (male) If No, Unknown or N/A, go to Section II.

☑ 3 4 If Yes, Date of report of client’s pregnancy to program: _______/_____/______ (mm/dd/yyyy)

☑ 3 4 Is client enrolled in prenatal care? ☑ Yes ☑ No ☑ Unknown

For the following questions, check “N/A” if client plans to terminate (and thus is not preparing for a live birth)

☐ 3 4 If Yes, When was client enrolled in prenatal care:

☑ First trimester ☑ Second trimester ☑ Third trimester

☑ At time of delivery ☑ N/A ☑ Unknown

☐ 3 4 Estimated Due Date: _______/_____/______

OR select one of the following: ☑ N/A ☑ Unknown

☐ 3 4 Is client prescribed ART to prevent maternal-to-child (vertical) transmission of HIV?

☑ Yes ☑ No ☑ N/A ☑ Unknown

II. Client Information

Has your employment status changed since the last assessment? ☑ Yes ☑ No

If Yes, please complete the following: If No, go to Section III.

Current employment status: (Check only one)

☑ Full-time ☑ Part-time ☑ Unemployed

☑ Unpaid volunteer/peer worker ☑ Out of workforce ☑ Other (Specify: _________________)

☑ Declined

III. Insurance Information

Has your insurance status changed since the last assessment? ☑ Yes ☑ No If No, go to Section IV.

If Yes, Insurance Status: ☑ Uninsured ☑ Insured

(If Insured, complete insurance details below. Otherwise, skip to Section IV.)

Check all that apply, and complete the related details/dates on each checked insurance type:

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Insurance details</th>
<th>Effective Date (mm/dd/yyyy)</th>
<th>End/Expiration Date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Private</td>
<td>(Check only one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☑ Employer plan</td>
<td></td>
<td>12/31/2020</td>
<td>12/31/2021</td>
</tr>
<tr>
<td>☑ Individual plan</td>
<td></td>
<td>12/31/2020</td>
<td>12/31/2021</td>
</tr>
<tr>
<td>☑ ADAP/ADAP+</td>
<td>(Check all that apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☑ ADAP (Rx Coverage)</td>
<td></td>
<td>12/31/2020</td>
<td>12/31/2021</td>
</tr>
<tr>
<td>☑ ADAP Plus</td>
<td></td>
<td>12/31/2020</td>
<td>12/31/2021</td>
</tr>
</tbody>
</table>

Legend:

☑= Required; 1= Optional

Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=PRS; 4=TSC

NYC Ryan White Part A Forms MCM/TCC/PRS/TSC – Page 2 of 9 – Revision Date: 1/16/14
<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Insurance details</th>
<th>Effective Date (mm/dd/yyyy)</th>
<th>End/Expiration Date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid or CHIP</td>
<td>(Choose only one plan type)</td>
<td></td>
<td>q Unknown q N/A</td>
</tr>
<tr>
<td></td>
<td>SNP (special needs plan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MCO (managed care organization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FFS (fee-for-service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not sure which type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
<td>q Unknown q N/A</td>
</tr>
<tr>
<td>Military, VA, HIS, TriCare</td>
<td></td>
<td></td>
<td>q Unknown q N/A</td>
</tr>
<tr>
<td>Other public insurance</td>
<td></td>
<td></td>
<td>q Unknown q N/A</td>
</tr>
</tbody>
</table>

IV. Financial Information [ALL]

What is your annual household income? $_________ per year

We will be asking you questions in the next two sections about substance use and sexual behaviors. Some of these questions may seem personal in nature, but we ask them of everyone in this program.
- Please answer honestly. You may refuse to answer a question; refusing will not affect your care.
- Please feel free to ask if you need any of the questions explained to you.
- If you do not want to answer a question now, please tell me and we will return to it another time.

V. Use of Prescriptions, Injectables and Other Substances [3-4]

Legend:
- Required: 1 = Optional

Service Category Codes: ALL = All Categories; 1 = MCM; 2 = TCC; 3 = PRS; 4 = TSC

NYC Ryan White Part A Forms MCM/TCC/PRS/TSC – Page 3 of 9 – Revision Date: 1/16/14
<table>
<thead>
<tr>
<th>Substance</th>
<th>Used in the past 3 months?</th>
<th>How often do you use?</th>
<th>How have you taken this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crystal Meth</td>
<td>Yes</td>
<td>___ times weekly</td>
<td>Orally</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>or</td>
<td>Smoked</td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>__ weekly</td>
<td>Inhaled/snorled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Declined</td>
<td>Injected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Cocaine/Crack</td>
<td>Yes</td>
<td>___ times weekly</td>
<td>Orally</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>or</td>
<td>Smoked</td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>__ weekly</td>
<td>Inhaled/snorled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Declined</td>
<td>Injected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Heroin</td>
<td>Yes</td>
<td>___ times weekly</td>
<td>Orally</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>or</td>
<td>Smoked</td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>__ weekly</td>
<td>Inhaled/snorled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Declined</td>
<td>Injected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Rx Pills to get high</td>
<td>Yes</td>
<td>___ times weekly</td>
<td>Orally</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>or</td>
<td>Patch</td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>__ weekly</td>
<td>Injected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Declined</td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Hormones/steroids</td>
<td>Yes</td>
<td>___ times weekly</td>
<td>Orally</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>or</td>
<td>Smoked</td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>__ weekly</td>
<td>Inhaled/snorled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Declined</td>
<td>Injected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Declined (no answer)</td>
</tr>
<tr>
<td>Anything else: _______</td>
<td>Yes</td>
<td>___ times weekly</td>
<td>Orally</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>or</td>
<td>Smoked</td>
</tr>
<tr>
<td></td>
<td>Declined</td>
<td>__ weekly</td>
<td>Inhaled/snorled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Declined</td>
<td>Injected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Declined (no answer)</td>
</tr>
</tbody>
</table>

**Legend:**

- **R** = Required; **1** = Optional
- **Service Category Codes:** ALL=All Categories; 1=MCM; 2=TCC; 3=PRS; 4=TSC

---

**Note:** If client has, at this interview, reported injecting any substance in the table above, select “Yes” to the question below and select “in the past 3 months” beneath that. Ask the client directly about sharing injection equipment.

**ALL** Have you ever injected any drug or substance? **If No, go to Section VI.**
- Yes
- No
- Declined (no answer)

**3 4 If Yes,** When was the last time you injected any substance?
- in the past 3 months
- between 3 and 12 months ago
- more than 12 months ago
- Declined

**3 4 If the client reported any injection behavior in the past 3 months, ask:**
Do you currently receive clean syringes from a syringe exchange program or pharmacy?
- Yes
- No
- Declined

**3 4 Have you ever shared needles or injection equipment with others?**
- Yes
- No
- Declined

**3 4 If Yes,** When was the last time you shared needles or injection equipment?
- in the past 3 months
- between 3 and 12 months ago
- more than 12 months ago
- Declined
### VI. Behavioral Risk Reduction

**Client Interview**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the past 12 months, did you have sex with anyone (oral, anal, or vaginal sex)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes to the above question, please ask the following questions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many sexual partners have you had in the last 12 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had vaginal sex with a male?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had vaginal sex with a female?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had vaginal sex with a transgender person?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes to any vaginal sex, then ask:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had vaginal sex without a condom?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had anal sex with a male?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had anal sex with a female?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had anal sex with a transgender person?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes to any anal sex, then ask:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had anal sex without a condom?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had oral sex with a male?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had oral sex with a female?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had oral sex with a transgender person?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes to any oral sex, then ask:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had oral sex without a condom, dental dam or other barrier?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*It is optional to ask this question if the client is biologically male.

*It is optional to ask this question if the client is biologically female.

### VII. Gender and Sexual Identity

**Client Interview**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since the last assessment, have you changed how you identify in terms of gender or sexual orientation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, please complete the below questions and update on Common Demographics form in eSHARE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is your current self-identified gender: (Check only one)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
<td>Transgender (M→F)</td>
<td>Transgender (F→M)</td>
</tr>
<tr>
<td>Read question without responses, and then verify answer: How would you identify your sexual orientation? (Check only one)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay/Lesbian/Homosexual</td>
<td>Straight/Heterosexual</td>
<td>Bisexual</td>
<td>Queer</td>
</tr>
<tr>
<td>Other (Specify: ____________________________)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Declined</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend:

- **R** = Required; **1** = Optional
- Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=PRS; 4=TSC
### VIII. General Health and Well-Being

#### 1. In general, would you say your health is:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

#### 2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

<table>
<thead>
<tr>
<th>a. Moderate activities, such as moving a table, pushing a vacuum cleaner, sweeping a floor or walking</th>
<th>❑</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Climbing several flights of stairs</td>
<td>❑</td>
</tr>
</tbody>
</table>

#### 3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Accomplished less than you would like</td>
<td>❑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Were limited in the kind of work or other activities</td>
<td>❑</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Accomplished less than you would like</td>
<td>❑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Did work or other activities less carefully than usual</td>
<td>❑</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 5. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, family visits, etc.)?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

#### 6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Have you felt calm and peaceful?</td>
<td>❑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Did you have a lot of energy?</td>
<td>❑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Have you felt downhearted and depressed?</td>
<td>❑</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, family visits, etc.)?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
</table>
IX. Disability Status

Are you deaf or do you have serious difficulty hearing?  
- Yes  
- No

Are you blind or do you have serious difficulty seeing, even when wearing glasses (or contact lenses)?  
- Yes  
- No

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?  
- Yes  
- No

OR  
- Client’s age is less than 5 years old (If checked, skip to Living Arrangement/Housing Information)

If the response to EITHER question 2a or 2b in Section VIII. General Health and Well-Being was “Yes, limited a lot” then select “Yes” for the next question; if the response to BOTH of those questions (2a and 2b) was “No, not limited at all” then select “No” for the next question. Under these two scenarios, the client does not need to be asked about difficulty walking or climbing stairs.

Do you have serious difficulty walking or climbing stairs?  
- Yes  
- No

Do you have difficulty dressing or bathing?  
- Yes  
- No

Because of a physical, mental, or emotional condition, do you have serious difficulty doing errands alone such as visiting a doctor’s office or shopping?  
- Yes  
- No

OR  
- Client’s age is less than 15 years old

X. Living Arrangement/Housing Information

Has your housing situation changed since last assessment?  
- Yes  
- No  

If No, go to P.8 Household Composition questions

If Yes, please complete the following questions:

- Are you currently enrolled in a housing assistance program?  
  - Yes  
  - No  
  - Declined

If Yes, Agency: __________________ OR  

- Unknown

What is your current living situation? (Check only one box at left)

- Homeless/Place not meant for human habitation (such as a vehicle, abandoned building, or outside)
- Emergency shelter (non-SRO hotel)
- Single Room Occupancy (SRO) hotel
- Other hotel or motel (paid for without emergency shelter voucher or rental subsidy)
- Supportive Housing Program If checked, complete the indented detail questions below:
  - Transitional Congregate
  - Transitional Scattered-Site
  - Permanent Congregate
  - Permanent Scattered-Site

- HIV housing program?  
  - Yes  
  - No

- Room, apartment, or house that you rent (not affiliated with a supportive housing program)
- Staying or living in someone else’s (family’s or friend’s) room, apartment, or house
- Hospital, institution, long-term care facility, or substance abuse treatment/detox center
- Jail, prison, or juvenile detention facility
- Foster care home or foster care group home
- Apartment or house that you own

Legend:

- Required; 1= Optional

Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC
Since what date (month and year) have you been living in your current situation? ____/_______ (mm/yyyy)

How long do you expect to be in your current living situation? If you do not know, what is your best guess? (Check only one)

- at least 1 year
- 6 months - <12 months
- 1 month - <6 months
- < 1 month

Have you been homeless any time since your last assessment?  

- Yes
- Declined

If Yes, When were you last homeless? ____/_______ (mm/yyyy)

Do not ask if client is homeless: What are your current housing issues? (Check all that apply)  

- Cost
- Eviction or pending eviction
- Conflict with others in household
- Doubled-up in the unit
- Expanding household (e.g. newborn)
- Release from institutional setting
- Health or safety concerns
- Space/configuration (e.g. too small)
- Other (Specify: ______________)

Has there been any change in who lives with you (any change in your household)?  

- Yes
- No

Total number in Household (including the client): ______

In the past 3 months, have you served any time in jail, prison, or juvenile detention (JD)?  

- Yes
- No
- Declined

If No, Have you served any time in the past 12 months?  

- Yes
- No
- Declined

Are you currently on parole/probation?  

- Yes
- No
- Declined

If client served any time in New York State, enter the NYSID [unique identifier assigned by the New York State Division of Criminal Justice Services (DCJS)]. This is an eight-digit number followed by one-character alpha (letter). Note: if the client has an old NYSID (with only 7 digits plus the letter at the end), insert a zero (0) at the start to reach 8 digits.

NYSID: __________________________ Entered on eSHARE Common Demographics form

Check current enrollments and any immediate referrals needed. Provide detail on referrals in Care Plan.

<table>
<thead>
<tr>
<th>Currently Enrolled?</th>
<th>Referral Needed?</th>
<th>Service Category:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>ADHC</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>SNP</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Medicaid Health Home</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Other Medicaid Case Management</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>HASA</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Outpatient Bridge Medical Care</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>No to all of the above</td>
</tr>
</tbody>
</table>

Legend:

@ = Required; 1= Optional

Service Category Codes: ALL=All Categories; 1=MCM; 2=TCC; 3=PRS; 4=TSC
APPENDIX HH – Status Change Information Form
(Track and Treatment Status)
# Status Change Information Form  
## (Track and Treatment Status)

### Client Name:  
______________________________  

### Client Record #:  
______________________________  

---

**Care Coordinator:** Please complete the below information for clients continuing active enrollment but with a change in program track or treatment status. If a client’s program enrollment is closed or their service activity is temporarily suspended or is resumed after a suspension, please complete the Status Change Form for Case Closure/Suspension.

---

1. **Date of update (mm/dd/yyyy):**  

2. **Last encounter date (mm/dd/yyyy):**

---

3. **Event prompting or indicating the change in client status** (What initiated this status change?):

   - Case conference Specify one type:  
     - Emergency/unscheduled conference
     - Formal/scheduled review
   - Separate notification by member of the care team
   - Notification by client’s friend/family member/acquaintance
   - Direct notification by client
   - Receipt of information through another agency
   - Other communication Specify:

4. **Indicate status change while continuing in program:** (Check all that apply, from bold checkbox options at left)

   - Change in track, to:  
     - A: Quarterly (no ART)
     - B: Quarterly
     - C1: Monthly
     - C2: Weekly
     - D: DOT

   **Reason:** (Check only one option)

   - Refusal to continue in higher-intensity track (despite need)
   - Reduced acuity of need (graduation to a lower-intensity track)
   - Agreement to try a track recommended previously
   - Difficulty keeping primary medical care appointments
   - First time on ART regimen or recent change in regimen
   - Recent non-adherence
   - Recent treatment failure
   - Other reason Specify:

   **Date new track started (mm/dd/yyyy):**  

   **Date prior track ended (mm/dd/yyyy):**

   - Change in treatment (ART) status:
     - Drug holiday or discontinued treatment
     - Started/resumed treatment
     - Regimen change

   - Change of residence or housing status within NYC

   - Any other change or correction to contact information

   - Change in household composition or disclosure status within household

   - Change in transportation needs

   - Other status change Specify:

---

**Notes:**

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

 ------------------------------------------------------------------------------------------------------------------------------------------

---

**Care Coordinator Completing Form:**  

| Name | Signature | Date:  

---|---|---

m m / d d / y y

---

NYC Ryan White Part A Care Coordination Forms  

--- Page 1 of 1 ---  

Revision Date: 9/28/11
APPENDIX II – Status Change Information Form  
(Case Closure/Suspension)
### Status Change Information Form

**CASE CLOSURE/SUSPENSION**

**Client Name:** __________________________

**Client Record #:** __________________________

**Program Staff:** Please complete the following information at the time of a client case closure, and enter into the enrollment details screen in eSHARE.

1. **Date of update (mm/dd/yyyy):**

2. **Last encounter date (mm/dd/yyyy):**

3. **Enrollment status**

   - [ ] Case Closed  *(Date of Closure (mm/dd/yyyy): ______/_____/_______)  (go to #5)*
   - [ ] Case Suspended  *(Date of Suspension (mm/dd/yyyy): ______/_____/_______)  (go to #4)*
   - [ ] Case Resumed after Suspension  *(Date Resumed (mm/dd/yyyy): ______/_____/_______)  (skip to end)*

4. **Please indicate the reason for client suspension from the program:**  *(Check only one bold option)*
   - [ ] Arrest with jail/prison time – not expected/known to be long-term
   - [ ] Hospital/institutional admission – not expected to be long-term
   - [ ] Other reason  *Specify reason:*

5. **Please indicate the reason for closing this client’s case:**  *(Check only one bold option)*
   - [ ] Completed program/graduated
   - [ ] Moved/relocated
   - [ ] Discharged due to a violation of program rules or requirements:  *(Check only one discharge reason)*
     - [ ] Refusal to continue (and no transfer to another program for comparable services)
     - [ ] Under-participation (participation below level needed to implement intervention according to model)
     - [ ] Ongoing active substance abuse  *(if this violates program rules or prevents constructive participation)*
     - [ ] Discontinuation/deferral of ART  *(if enrolled for ART Adherence services only)*
     - [ ] Inappropriate conduct
     - [ ] Concern for safety of field staff assigned to client
     - [ ] Ineligibility
     - [ ] Other  *Specify:*
   - [ ] Lost to follow-up
   - [ ] Transferred:  *(Check only one transfer detail)*
     - [ ] Incarcerated  *Specify facility:*
     - [ ] Hospitalized  *Specify facility:*
     - [ ] In residential treatment  *Specify facility:*
     - [ ] Otherwise institutionalized  *Specify facility:*
     - [ ] Receiving care elsewhere  *Specify facility:*
     - [ ] Other transfer situation  *Specify situation:*
   - [ ] Deceased  *(Date of Death (mm/dd/yyyy): ______/_____/_______)*
   - [ ] Program funding ended
   - [ ] Mistaken enrollment

**Notes:**

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

Program Staff:

**Completing Form:**

**Name:**

**Signature:**

**Date:**  ____/____/____

m m / d d / y y

NYC Ryan White Part A Forms – Page 1 of 1 – Revision Date: 9/27/11
APPENDIX JJ – Services Tracking Log
**SERVICES TRACKING LOG**  
(MCM/TCC)

Client Name: ______________________________

Client Record #: __________________________

Program Staff: Use this form to log services provided for an individual client, across days or weeks. Fill in the date of the service, start time, staff providing the service, location, service type, and service details. Not all services on this form are required for each client or at a certain interval. Start a new form when the space provided for an individual service type has been filled and you are ready to log another service of that type. **Note:** Travel time and End time (in grey shading) are **optional**. Except for Accompaniment, please keep Travel time out of service Start time and End time entries. Permissible service types are identified by the below service category codes.

**Service Category Codes:**  
ALL=All Categories, 1=MCM-NYC; 2=TCC; 3=MCM-W (Tri-County)

| Service Date  
(mm/dd/yyyy) | Service Start Time/End Time | Worker(s) | Site of service delivery  
(Select only one) | Service Type | Service Details |
|---------------|-----------------------------|-----------|------------------------|----------------|-----------------|
| __/__/____    | Start time: ___ : ___ am/pm | ❑ Program site  
(Specify: ____________) | ❑ Intake assessment  
ALL | (Select all that apply) | ❑ Re-Assessment (clinical, psychosocial, general health/well-being, housing, etc.) ❑ Adherence assessment - self-report ❑ Adherence assessment - pill count ❑ Adherence assessment - DOT ❑ Adherence assessment - other measure ❑ Logistical assessment or reassessment ❑ Health assessment ❑ Client risk assessment ❑ Mental health ❑ Harm reduction ❑ Case management ❑ Nutritional assessment ❑ 90 day follow up ❑ Other non-medical assessment/reassess (Specify: ____________) |
| Travel Time: ___ : ___  
(hours) (minutes) | End time: ___ : ___ am/pm | ❑ Client home ❑ Other field site  
(Specify: ____________) | ❑ Other assessment/reassessment  
ALL | ❑ Accompaniment  
(Select only one) | ❑ Client's home or other field (non-provider) location ❑ One provider to another - different street address ❑ One provider to another - same street address ❑ Jail/prison |
| ___/__/____    | Start time: ___ : ___ am/pm | ❑ Program site  
(Specify: ____________) | ❑ Care plan/service plan  
ALL | ❑ Development of initial plan with this enrollment ❑ Update to plan ❑ Start of new plan (replacing last care/service plan) ❑ Housing services plan ❑ Discharge plan ❑ Other (Specify: ____________) |
| Travel Time: ___ : ___  
(hours) (minutes) | End time: ___ : ___ am/pm | ❑ Client home ❑ Other field site  
(Specify: ____________) | ❑ Accompaniment  
ALL | ❑ Primary care ❑ Other healthcare service ❑ Social service | |
<table>
<thead>
<tr>
<th>Service Date (mm/dd/yyyy)</th>
<th>Service Start Time/End Time</th>
<th>Worker(s)</th>
<th>Site of service delivery (Select only one)</th>
<th>Service Type</th>
<th>Service Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2014</td>
<td>Start time: __ : ___ am/pm</td>
<td></td>
<td>❑ Program site (Specify: ________________)</td>
<td>Assistance with health care</td>
<td>ALL</td>
</tr>
<tr>
<td></td>
<td>Travel Time: ___ : ___ (hours) (minutes)</td>
<td></td>
<td>❑ Client home</td>
<td>❑ Other field site (Specify: ________________)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>End time: __ : ___ am/pm</td>
<td></td>
<td>Phone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 2/2/2014                 | Start time: __ : ___ am/pm |           | ❑ Program site (Specify: ________________)  | Assistance with entitlements and benefits | 1/2 |
|                          | Travel Time: ___ : ___ (hours) (minutes) |           | ❑ Client home | ❑ Other field site (Specify: ________________) |  |
|                          | End time: __ : ___ am/pm |           | Phone | | |

| 3/3/2014                 | Start time: __ : ___ am/pm |           | ❑ Program site (Specify: ________________)  | Assistance with social services | 1/2 |
|                          | Travel Time: ___ : ___ (hours) (minutes) |           | ❑ Client home | ❑ Other field site (Specify: ________________) |  |
|                          | End time: __ : ___ am/pm |           | Phone | | |

| 4/4/2014                 | Start time: __ : ___ am/pm |           | ❑ Program site (Specify: ________________)  | Assistance with housing | 1/2 |
|                          | Travel Time: ___ : ___ (hours) (minutes) |           | ❑ Client home | ❑ Other field site (Specify: ________________) |  |
|                          | End time: __ : ___ am/pm |           | Phone | | |

| 5/5/2014                 | Start time: __ : ___ am/pm |           | ❑ Program site (Specify: ________________)  | Outreach for patient re-engagement | ALL |
|                          | Travel Time: ___ : ___ (hours) (minutes) |           | ❑ Client home | ❑ Other field site (Specify: ________________) |  |
|                          | End time: __ : ___ am/pm |           | Phone | | |

**Required** for MCM-NYC (Select all that apply)  
- Help with filling out forms  
- Eligibility assessment  
- Reminder call/message  
- Referral/Appointment-making  
- Arrangement for transportation  
- Arrangement for childcare or eldercare  
- Arrangement for interpreting services  
- Appointment preparation  
- Court Advocacy  
- Other (Specify: __________________)
<table>
<thead>
<tr>
<th>Service Date (mm/dd/yyyy)</th>
<th>Service Start Time/End Time</th>
<th>Worker(s)</th>
<th>Site of service delivery (Select only one)</th>
<th>Service Type</th>
<th>Service Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Start time: __ __ : __ __ am/pm</td>
<td></td>
<td>Program site (Specify: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Client home (Specify: ____________)</td>
<td>Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other field site (Specify: ____________)</td>
<td>education/</td>
<td>promotion ALL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Phone</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>End time: __ __ : __ __ am/pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Travel Time: (hours) (minutes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Start time: __ __ : __ __ am/pm</td>
<td></td>
<td>Program site (Specify: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Client home (Specify: ____________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other field site (Specify: ____________)</td>
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</tbody>
</table>

Referral/Appointment Tracking form date: __/__/____ OR □ No Match

NYC Ryan White Part A Services Log for MCM/TCC – Page 3 of 4 – Revision Date: 04/17/14
<table>
<thead>
<tr>
<th>Program Staff Completing Form:</th>
<th>Date: Completed m m / d d / y y</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Signature</td>
</tr>
</tbody>
</table>
APPENDIX KK –Care Coordination eSHARE Mapping
# Mapping of Service Types and PMPD Thresholds
## Service Category: Care Coordination (MCM/MCC)

This mapping details all individual services recognized for Per Member Per Day (PMPD) Reimbursement Thresholds and is intended to guide data reporting in eSHARE. For details on payment rules and processing, please refer to the Guide to Requirements for Service Payability and Data Reporting In NYC DOHMH Performance-Based Contracts For HIV Care and Prevention Administered by Public Health Solutions, available on the PHS website.

### PMPD Thresholds | eSHARE Service Type | Information required in service details | eSHARE Service Site | Payment Point?
--- | --- | --- | --- | ---
1. **Ryan White Only Clients**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accompaniment</td>
<td></td>
<td>ANY service detail</td>
</tr>
<tr>
<td>Assistance with entitlements and benefits</td>
<td></td>
<td>ANY service detail</td>
</tr>
<tr>
<td>Assistance with health care</td>
<td></td>
<td>ANY service detail EXCEPT “Reminder call/message” or “Court Advocacy”</td>
</tr>
<tr>
<td>Assistance with housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistance with social services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case plan/service plan</td>
<td></td>
<td>ANY service detail EXCEPT “Housing services plan” or “Discharge plan”</td>
</tr>
<tr>
<td>Case conference</td>
<td></td>
<td>ANY service detail</td>
</tr>
<tr>
<td>Case finding</td>
<td></td>
<td>ANY service detail</td>
</tr>
<tr>
<td>Service type “Case finding” is meant to capture all case finding activity done PRIOR to enrollment and is entered no more than once per enrollment with a Service date equal to the enrollment date. All time spent on case finding activities for the client is aggregated and included in this one Service type entry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health education/promotion</td>
<td></td>
<td>ANY service detail EXCEPT “Non-Care Coordination health education conversations”</td>
</tr>
<tr>
<td>Intake Assessment</td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Medical assessment/reassessment</td>
<td></td>
<td>ANY service detail</td>
</tr>
<tr>
<td>Other assessment/reassessment</td>
<td></td>
<td>ANY service detail EXCEPT “Health assessment”, “Client risk assessment”, “Mental health”, “Harm reduction”, “Case management”, “Nutritional assessment”, or “90 day follow up”</td>
</tr>
<tr>
<td>Outreach for client re-engagement[^1]</td>
<td>To achieve seven (7) days of payability</td>
<td>Service detail must specify “Home Visit” or “Search in other Location”</td>
</tr>
<tr>
<td>Outreach for client re-engagement[^1]</td>
<td>To achieve three (3) days of payability</td>
<td>Service detail may specify “Letter”, “Phone call”, and/or “E-mail or text message”</td>
</tr>
</tbody>
</table>

[^1]: Outreach for client re-engagement is recognized for clients in Tracks C1, C2, or D only. Different combinations of service sites and service details are recognized to maintain clients in a payable status. Refer to the Guide to Requirements for Service Payability and Data Reporting In NYC DOHMH Performance-Based Contracts For HIV Care and Prevention Administered by Public Health Solutions.

2. **Ryan White - Health Home Dually Enrolled Clients**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case plan/service plan</td>
<td></td>
<td>ANY service detail EXCEPT “Housing services plan” or “Discharge plan”</td>
</tr>
<tr>
<td>Case conference</td>
<td></td>
<td>ANY service detail</td>
</tr>
<tr>
<td>Health education/promotion</td>
<td></td>
<td>ANY service detail EXCEPT “Non-Care Coordination health education conversations”</td>
</tr>
<tr>
<td>Intake Assessment</td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Medical assessment/reassessment</td>
<td></td>
<td>ANY service detail</td>
</tr>
<tr>
<td>Other assessment/reassessment</td>
<td></td>
<td>ANY service detail EXCEPT “Health assessment”, “Client risk assessment”, “Mental health”, “Harm reduction”, “Case management”, “Nutritional assessment”, or “90 day follow up”</td>
</tr>
</tbody>
</table>

3. **DOT Encounter (ART & Non-ART)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>DOT</td>
<td></td>
<td>ANY service detail</td>
</tr>
</tbody>
</table>

[^1]: Outreach for client re-engagement is recognized for clients in Tracks C1, C2, or D only. Different combinations of service sites and service details are recognized to maintain clients in a payable status. Refer to the Guide to Requirements for Service Payability and Data Reporting In NYC DOHMH Performance-Based Contracts For HIV Care and Prevention Administered by Public Health Solutions.
APPENDIX LL – Guide to Care Coordination Forms
Appendix LL: Guide to Care Coordination Forms

Important Points

- Use the most recently revised Care Coordination Program forms. Refer to the Resources list below.
- Review instructions in the grey section header bar of each form. The instructions provide helpful and necessary guidance on completing the forms.
- Items in double bolded boxes are required for entry into eSHARE.
- Forms are shared by non-Care Coordination service categories.
  - Care Coordination should complete items with the Service Category Code 1 (MCM) and Service Category Code ALL.
- To identify which questions are required for Care Coordination, find the data element requirement codes in the grey section header bar or to the left of individual questions.
  - Data Element Requirement Codes: 2= Required; 1= Optional

Key to Guide

<table>
<thead>
<tr>
<th>NAME OF FORM</th>
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<tbody>
<tr>
<td><strong>Usage</strong></td>
<td>• Describes whether the form is REQUIRED or OPTIONAL</td>
</tr>
<tr>
<td><strong>Key Points</strong></td>
<td>• Describes highlights and important points</td>
</tr>
<tr>
<td><strong>Definitions</strong></td>
<td>• Defines terms related to the form</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>• Describes when the form should be completed</td>
</tr>
<tr>
<td><strong>Staff Responsible</strong></td>
<td>• Describes which Care Coordination program staff is/are responsible for completing the form</td>
</tr>
<tr>
<td><strong>eSHARE Reporting</strong></td>
<td>• Describes the reporting requirements and how to enter the form/service into eSHARE</td>
</tr>
<tr>
<td><strong>Alternative Use</strong></td>
<td>• For the Adherence Forms only: Describes how the form may be used in other ways</td>
</tr>
<tr>
<td><strong>Payment Methodology</strong></td>
<td>• For the Services Tracking Log Form only: Describes which services count toward meeting the PMPD threshold</td>
</tr>
</tbody>
</table>

Resources

The current versions of the Care Coordination Forms can be downloaded from:

- eSHARE’s Resources section (PDF)
- Public Health Solutions, Contractor Resources website (EXCEL Adherence Assessment Forms Assistance Tool; WORD Services Tracking Log): [http://www.healthsolutions.org/hivcare/?event=page.resources](http://www.healthsolutions.org/hivcare/?event=page.resources)
## PRE-REFERRAL FORM

<table>
<thead>
<tr>
<th>Usage</th>
<th>This form is <strong>OPTIONAL</strong> and is not expected on every patient.</th>
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</thead>
<tbody>
<tr>
<td>Key Points</td>
<td>Use this form when the patient is referred to Care Coordination from a source other than the affiliated PCP.</td>
</tr>
<tr>
<td>Definitions</td>
<td>Referral sources other than the affiliated PC could include: Patient self-referral, HIV Testing program, social work department, in-patient and emergency departments, etc.</td>
</tr>
<tr>
<td>Frequency</td>
<td>One time, prior to the initial PCP visit, pre-enrollment into Care Coordination.</td>
</tr>
<tr>
<td>Staff Responsible</td>
<td>Any CC staff may complete the form.</td>
</tr>
</tbody>
</table>
| eSHARE Reporting | Form must be entered into eSHARE.  
  - Pre-Referral Form  
  - No service corresponds to this form. |

## PCP REFERRAL DISPOSITION FORM

<table>
<thead>
<tr>
<th>Usage</th>
<th>This form is <strong>REQUIRED</strong>.</th>
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</thead>
</table>
| Key Points | PCP uses this form to document referral reason(s) and recommended track.  
  - PCP completes this form *after*:  
    - Assessing the patient’s eligibility for enrollment in Care Coordination  
    - Obtaining verbal consent from the patient to enroll  
  - If the patient is referred to Care Coordination, then PCP hands-off this form and introduces the patient to CC staff (e.g. Care Coordinator or Medical Center Liaison). |
| Frequency | One time, during the initial PCP visit, pre-enrollment into Care Coordination. |
| Staff Responsible | PCP completes the form and hands-off to CC staff.  
  - CC staff receives and signs the form and documents the outcome of the referral. |
| eSHARE Reporting | Form must be entered into eSHARE.  
  - PCP Referral Disposition Form  
  - No service corresponds to this form. |
### RYAN WHITE PART A CARE COORDINATION PROGRAM AGREEMENT

<table>
<thead>
<tr>
<th>Usage</th>
<th>This form is <strong>REQUIRED</strong>.</th>
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</thead>
</table>
| Key Points    | Completion of this form with the patient’s signature is needed to begin providing services to the patient.  
                • Review the agreement verbally with the patient. |
| Frequency     | One time at referral and/or enrollment, or within five (5) business days of PCP referral and patient hand-off. |
| Staff Responsible | Patient signature required.  
                • Any CC staff may complete the form:  
                  o Primary: Care Coordinator or Medical Center Liaison  
                  o Secondary: Patient Navigator |
| eSHARE Reporting | Form must be entered into eSHARE.  
                • Enrollment details screen: check the box for Program Agreement and enter the date of the signed form.  
                • No service corresponds to this form. |

### HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND CONFIDENTIAL HIV RELATED INFORMATION FORM

<table>
<thead>
<tr>
<th>Usage</th>
<th>This form is <strong>REQUIRED</strong> for patients receiving services at multi-agency programs where the Care Coordination program is not part of the same agency as the medical provider.</th>
</tr>
</thead>
</table>
| Key Points    | Must be completed *prior* to receiving and/or providing medical information amongst programs that are not part of the same organization.  
                • Authorizes release of medical information including HIV-related information.  
                • Includes information that is specific to Care Coordination Programs. |
| Frequency     | Initial completion at time of referral and/or enrollment, or within five (5) business days of PCP referral and patient hand-off.  
                • Update when the time period expires. |
| Staff Responsible | Patient signature required.  
                • Any CC staff may complete the form:  
                  o Primary: Care Coordinator or Medical Center Liaison  
                  o Secondary: Patient Navigator |
| eSHARE Reporting | Form must be entered into eSHARE.  
                • Enrollment details screen: enter the start date and end date.  
                • No service corresponds to this form. |
### CONTACT INFORMATION FORM

**Usage**
- This form is **OPTIONAL**. You may document contact information using your agency’s form.

**Key Points**
- Ideally, collect contact information at the first meeting with the patient.
- Ask about “alternative contacts” and get as much information as possible. This will help your outreach efforts in case the patient does not return.
- Ask patient about whether you may disclose who you are or why you are calling to those listed as contacts.

**Frequency**
- One time at referral, enrollment or first meeting with CC staff.
- Update when contact information changes.

**Staff Responsible**
- Any CC staff may complete the form:
  - Primary: Care Coordinator or Medical Center Liaison
  - Secondary: Patient Navigator

**eSHARE Reporting**
- Form is not reported in eSHARE.
- No service corresponds to this form.

### LOGISTICS FOR NAVIGATOR FORM

**Usage**
- This form is **OPTIONAL**. You may document logistics using your agency’s form.

**Key Points**
- Ideally, collect contact information at the first meeting with the patient.
- Ask patient about their preferences in when and where to meet, medication storage, caregivers, confidentiality concerns, literacy level, etc.
- Aids in assigning a Patient Navigator to the patient.

**Frequency**
- One time at enrollment or first meeting with CC staff.
- Update when logistical information changes.

**Staff Responsible**
- Any CC staff may complete the form:
  - Primary: Care Coordinator
  - Secondary: Patient Navigator (except for the section on navigator assignment)

**eSHARE Reporting**
- Form is not reported in eSHARE.
- No service corresponds to this form.
### COMMON DEMOGRAPHICS FORM

**Usage**
- This form is **REQUIRED**.

**Key Points**
- Report the patient’s legal name in the bolded boxes.
- Report other names including preferred names in the “Alias” section.
- Demographics must be entered into eSHARE before you are able to add the Care Coordination program enrollment and all other forms and services.

**Frequency**
- One time within the first two (2) weeks of enrollment.
- Update when demographic information changes.

**Staff Responsible**
- Any CC staff may complete the form:
  - Primary: Care Coordinator
  - Secondary: Patient Navigator

**eSHARE Reporting**
- Form must be entered into eSHARE.
  - Demographic Data screen: add or edit demographics
  - No service corresponds to this form.

### INTAKE ASSESSMENT FORM

**Usage**
- This form is **REQUIRED**.

**Key Points**
- Required questions are preceded by Service Category code **ALL**
- The start date on the first page is the day you began the intake.
- The completed date on the last page is the day you completed all sections and signed the form.
- Complete the form using chart review and patient interview.
- PCP visit dates, CD4 and VL values that occurred BEFORE enrollment are reported on this form.
- **Questions in Section VIII “General Health and Well-Being” must be asked exactly as they are written.**
- To identify a patient dually enrolled in CC and COBRA or Health Homes, check the appropriate box in Section XI “Current Enrollments and Needed Referrals.”

**Frequency**
- One time within the first two (2) weeks of enrollment.

**Staff Responsible**
- Any CC staff may complete the form:
  - Primary: Care Coordinator
  - Secondary: Patient Navigator

**eSHARE Reporting**
- Form and Service must be entered into eSHARE.
  - Intake Assessment Form: After this is entered in eSHARE, you are able to enter back-dated Forms/Services that occurred between Enrollment and Intake.
  - Services Delivered Form
    - **Service Type**: “Intake Assessment”
    - **Service Detail**: None
    - **Service Site**: Should NOT be “Phone”
### COMPREHENSIVE CARE PLAN FORM

<table>
<thead>
<tr>
<th>Usage</th>
<th>• This form is <strong>OPTIONAL</strong>. You may document the care plan using your agency’s form.</th>
</tr>
</thead>
</table>
| Key Points | • Requires in-person participation from the patient and the PCP to create the initial and new care plans.  
• Records the patient’s goals (medical, social, other).  
• Update the outcome dates and dispositions for each goal.  
• UPDATE the Care Plan if there are minor changes/updates and if space remains on the form.  
• Create a NEW Care Plan if there are significant changes/updates to the goals. |
| Frequency | • One time within the first two (2) weeks of enrollment.  
• Ongoing, at least once every six (6) months. |
| Staff Responsible | • PCP and patient signatures are required.  
• Any CC staff may complete the form:  
  o Primary: Care Coordinator  
  o Secondary: Patient Navigator |
| eSHARE Reporting | • Form is not reported in eSHARE.  
• Service must be entered into eSHARE.  
  o Services Delivered Form  
    ▪ **Service Type:** “Care Plan/Service Plan”  
    ▪ **Service Detail:** “Development of initial plan with this enrollment” for the first care plan, OR “Update to plan” for updating an existing plan, OR “Start of new plan (replacing last care/service plan)” for replacing the last care plan.  
    ▪ **Service Site:** “Program site,” “Patient home,” “Other field site,” and “Phone.” |

### REFERRALS/APPOINTMENTS TRACKING LOG FORM

<table>
<thead>
<tr>
<th>Usage</th>
<th>• This form is <strong>OPTIONAL</strong>. You may document referrals using your agency’s form.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Points</td>
<td>• Used to track referrals or appointments to PCP or external services providers (e.g. social services, mental health, etc.)</td>
</tr>
<tr>
<td>Frequency</td>
<td>• As needed.</td>
</tr>
<tr>
<td>Staff Responsible</td>
<td>• Any CC staff may complete the form.</td>
</tr>
</tbody>
</table>
| eSHARE Reporting | • Form may be entered in eSHARE and may be linked with a Service.  
  o Referral/Appointment Tracking Form: enter the referral/appointment details.  
  ▪ To link the Form to a Service: Choose from a list of services entered in the last 6 months. A referral can only be associated with one service. |
### PCSM UPDATE FORM

**Usage**
- This form is **REQUIRED**.

**Key Points**
- Collects information on PCP visits, CD4, VL, ART status, HIV and AIDS status.
- This form must still be completed even if there are no new data to report.
- If there are no new lab values, PCP visits or status changes to report, then select “N/A” for each section.

**Frequency**
- Ongoing, at least once every 90 days. eSHARE Services Delivered lockout occurs after 120 days. Refer to August 23, 2011 communication from DOHMH on PCSM Reporting for Ryan White Part A Contracts.

**Staff Responsible**
- Any CC staff may complete the form.

**eSHARE Reporting**
- Form must be entered into eSHARE.
  - PCSM Form (located under PCSM Patient Search)
  - If you discuss PCSM updates with the patient, then a Service may be entered.
    - Services Delivered Form
      - **Service Type**: “Medical Assessment/Reassessment”
      - **Service Detail**: “Review of laboratory test values”
      - **Service Site**: “Program site,” “Patient home,” “Other field site,” or “Phone”

### CURRICULUM COVERAGE LOG FORM

**Usage**
- This form is **OPTIONAL**. You may track health promotion discussions using your agency’s form.

**Key Points**
- Tracks the status of health promotion curriculum topics that you have started, continued, or completed.

**Frequency**
- As needed.

**Staff Responsible**
- Any CC staff may complete the form:
  - Primary: Patient Navigator
  - Secondary: Care Coordinator

**eSHARE Reporting**
- Form is not reported in eSHARE.
- No service corresponds to this form.
## ADHERENCE ASSESSMENT FORM

### Usage
- This form is **REQUIRED** for patients currently on ART.
  - Tracks B, C1, C2, and D

### Key Points
- Documents patient’s **self-report** adherence assessments.
- ART includes pills, liquids, and injectable medications.
- Used in preparation for a formal case conference.
- Used in addition to the Pill Box Log or Monthly DOT Log.

### Frequency
- One time within the first two (2) weeks of enrollment.
- Ongoing, at least once every three (3) months.

### Staff Responsible
- Any CC staff may complete the form.

### eSHARE Reporting
- Form and Service must be entered into eSHARE.
  - Adherence Assessment Form (**ART only**)
  - Services Delivered Form (**ART only**)
    - **Service Type:** “Other assessment/reassessment”
    - **Service Detail:** “Adherence Assessment – self-report”
    - **Service Site:** “Program site,” “Patient home,” “Other field site,” or “Phone”

### Daily vs. Non-Daily
- Applies to all 3 adherence assessment forms:
  - Adherence Assessment Form
  - Pill Box Log Form
  - Monthly DOT Log Form
- Use only ONE form (daily or non-daily) per adherence assessment per patient.
- **ART Daily Regimens Only:** This form is used for patients who are prescribed the same number of ART pills each day of the week.
- **ART Non-Daily Regimens Only:** This form is used for patients who are prescribed a different number of ART pills on different days in the week.
  - **NOTE:** If the patient is taking at least one Non-Daily ART in their regimen, then **use the Non-Daily form to document the entire regimen of daily and non-daily ARTs**.

### Alternative Use (for non-Pill Box usage)
- May be used for patients in Tracks B, C1, and C2 who do not use a pill box.
- If used to replace the Pill Box Log, then the paper form and eSHARE entry must be completed at the frequency below:
  - **Track B:** At every Quarterly visit
  - **Track C1:** At every Monthly visit
  - **Track C2:** Once per month at one of the Weekly visits

### Alternative Use (for non-ART)
- To document non-ART (i.e. psychotropic and OI prophylactic medications) adherence assessments for patients in any Track, it is optional to use this **paper form**.
- In eSHARE: **DO NOT** enter the Form for adherence % results. The eSHARE Form is only for ART adherence.
# PILL BOX LOG FORM

## Usage
- This form is **REQUIRED** for patients on ART who are NOT receiving DOT.
  - Tracks B, C1, and C2

## Key Points
- Used to document pill box counts **conducted by CC staff**.
- **Do NOT** use to document patient self-reported adherence status.
- ART includes pills, liquids, and injectable medications.
- Records pill box counts going back no more than four (4) weeks regardless of patient track.
- Blister packs may be used to measure adherence on Pill Box Log.
  - Empty packs must be reviewed to verify number of pills taken each day against number of pill prescribed each day.

## Frequency
- **Track B**: At every Quarterly visit, review available pill boxes going back no more than four (4) weeks.
- **Track C1**: At every Monthly visit, review available pill boxes going back no more than four (4) weeks.
- **Track C2**: At every Weekly visit, review the pill box for the past week.
  - For Track C2, enter the adherence percentages calculated from the completed paper form into eSHARE only once per month.

## Staff Responsible
- Any CC staff may complete the form:
  - Primary: Patient Navigator
  - Secondary: Care Coordinator

## eSHARE Reporting
- Form and Service must be entered into eSHARE.
  - Pill Box Log Form (ART only)
  - Services Delivered Form (ART only)
    - **Service Type**: “Other assessment/reassessment”
    - **Service Detail**: “Adherence Assessment – pill count”
    - **Service Site** should NOT be “Phone”
    - **NOTE**: This service summarizes the last four (4) weeks of pill box counts. This is NOT meant to capture each Weekly pill box count.

## Daily vs. Non-Daily
- Refer to the ADHERENCE ASSESSMENT FORM section on “Daily vs. Non-Daily.”

## Alternative Use
- To document non-ART (i.e. psychotropic and OI prophylactic medications) pill counts for patients in any Track, it is optional to use this paper form.
- In eSHARE: **DO NOT** enter the Form for adherence % results. The eSHARE Form is only for ART adherence.
MONTHLY DOT LOG FORM

**Usage**
- This form is **REQUIRED** for patients on ART who are receiving modified Directly Observed Therapy (DOT).
  - Track D only

**Key Points**
- Used at **each DOT visit**.
- Documents direct or indirect observation by **CC staff** of pills taken.
- **Do NOT** use to document patient self-reported adherence status.

**Definitions**
- **Direct observation**: *CC staff visually observe* the patient take the medication dose.
- **Indirect observation**: *CC staff do NOT visually observe* the patient take the medication dose but DO visually observe that the medication dose was “gone” by conducting a pill count.
  - Indirect observation includes unobserved doses or days that occur when CC staff are not present (e.g. weekends).

**Frequency**
- Update the form at every DOT visit.
- Complete the calculations for both adherence percentages at the end of each calendar month.

**Staff Responsible**
- Any CC staff may complete the form:
  - Primary: Patient Navigator or DOT Specialist
  - Secondary: Care Coordinator

**eSHARE Reporting**
- **At every DOT visit**:  
  - Only if there is face-to-face contact with the patient.
    - Services Delivered Form  
      - **Service Type**: “DOT”  
      - **Service Detail**:  
        - Select ONE: “Yes” for directly observed doses OR “No” for indirectly observed doses  
        - Select All that Apply: “ART” for antiretroviral medications and/or “Psychotropic and/or Opportunistic Infection Medications”  
        - **Service Site** should NOT be “Phone”
- **Once per month**:  
  - Form and Service must be entered into eSHARE.
    - DOT Log Form **(ART only)**  
    - Services Delivered Form **(ART only)**  
      - **Service Type**: “Other assessment/reassessment”  
      - **Service Detail**: “Adherence Assessment – DOT”  
      - **Service Site** should NOT be “Phone”  
      - **NOTE**: This service summarizes the last 30-31 days of DOT sessions. This is NOT meant to capture each session.

**Daily vs. Non-Daily**
- Refer to the ADHERENCE ASSESSMENT FORM section on “Daily vs. Non-Daily.”

**Alternative Use**
- To document non-ART (i.e. psychotropic and OI prophylactic medications) DOT, it is optional to use this paper form.
- In eSHARE: **DO NOT enter the Form for adherence % results. The eSHARE Form is only for ART adherence.**
## CARE COORDINATION CASE CONFERENCE FORM

### Usage
- This form is **REQUIRED**.

### Key Points
- Used to document formal case conferences.
- CC staff prepares for case conference with PCP by gathering information from most recent adherence assessments, PCSM, and patient’s current issues.
- Case conferences may result in Track changes.
- Track changes should be discussed during case conferences with the PCP and CC staff.

### Definitions
- **Formal case conference** occurs when all elements included on the form are completed with the required attendees present, and does not need to be scheduled.
  - Required attendees include:
    - Program Staff (CC and/or PN and/or MCL)
    - Clinician (MD/DO/NP/PA)
  - Optional attendees include:
    - Patient

### Frequency
- Ongoing, at least once every three (3) months.

### Staff Responsible
- PCP signature is required.
- Any CC staff may complete the form:
  - Primary: Care Coordinator
  - Secondary: Patient Navigator

### eSHARE Reporting
- Form and Service must be entered into eSHARE.
  - Formal Case Conference Form
  - Services Delivered Form
    - **Service Type**: “Case Conference”
    - **Service Detail**: “Formal/scheduled ongoing case review”
    - **Service Site**: “Program site,” “Patient home,” “Other field site,” or “Phone”
# REASSESSMENT FORM

## Usage
- This form is **REQUIRED**.

## Key Points
- Required questions are preceded by Service Category Code [1] or **ALL**
- The start date on the first page is the day you began the intake.
- The completed date on the last page is the day you completed all sections and signed the form.
- Complete the form using chart review or patient interview.
- Questions in Section VIII “General Health and Well-Being” must be asked exactly as they are written.
- To identify a patient dually enrolled in CC *and* COBRA or Health Homes, check the appropriate box in Section XI “Current Enrollments and Needed Referrals.”

## Frequency
- Ongoing, at least once every six (6) months.
- OR, any time COBRA or Health Homes enrollment status changes.

## Staff Responsible
- Any CC staff may complete the form:
  - Primary: Care Coordinator
  - Secondary: Patient Navigator

## eSHARE Reporting
- Form *and* Service must be entered into eSHARE.
  - Re-Assessment Form
  - Services Delivered Form
    - **Service Type**: “Other assessment/reassessment”
    - **Service Detail**: “Re-Assessment (clinical, psychosocial, general health/well-being, housing, enrollments, etc.)”
    - **Service Site**: Should NOT be “Phone”
### STATUS CHANGE INFORMATION FORM

#### (TRACK AND TREATMENT STATUS)

**Usage**
- This form is **REQUIRED**.

**Key Points**
- Used for patients continuing active enrollment.
- Documents changes in program track, treatment status, housing status, contact information, household composition or disclosure status, transportation needs, and other.
- *Decisions that result in changes in track and treatment status MUST have supporting documentation in the patient chart.*
- “Date of update” is the date CC staff learns of the change.
- Change in Track:
  - Should occur *after* a formal Case Conference
  - Must select one reason for change
  - Consecutive dates must be used for “Date new track started” and “Date prior track ended”
    - If “Date prior track ended” is 3/1/2013, then the “Date new track started” is 3/2/2013, even though 3/2/2013 falls on a weekend.

**Frequency**
- As needed.

**Staff Responsible**
- Any CC staff may complete the form:
  - Primary: Care Coordinator
  - Secondary: Patient Navigator

**eSHARE Reporting**
- Form must be entered into eSHARE.
  - Patient Status Change Form
- No service corresponds to this form.
# STATUS CHANGE INFORMATION FORM
*(CASE CLOSURE/SUSPENSION)*

## Usage
- This form is **REQUIRED**.

## Key Points
- Used when you close a case, suspend a case, resume a suspended case.
- Must select one reason for closing or suspending a case.
- “Mistaken enrollment” is a case closure reason to identify patients who should not be counted in your enrollment list. When this reason is selected, the patient will no longer appear on any eSHARE reports for open or closed patients.
- “Enrollment Closed Date” should be set for one day *after* the last service was provided.

## Frequency
- As needed.

## Staff Responsible
- Any CC staff may complete the form:
  - Primary: Care Coordinator
  - Secondary: Patient Navigator

## eSHARE Reporting
- Form must be entered into eSHARE.
  - Enrollment Details screen: change Enrollment Status to “Closed” and add date of closure.
- No service corresponds to this form.
<table>
<thead>
<tr>
<th><strong>SERVICES TRACKING LOG FORM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Usage</strong></td>
</tr>
<tr>
<td><strong>Key Points</strong></td>
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</tbody>
</table>
**SERVICES TRACKING LOG FORM (continued)**

| Frequency | • Complete the form on each day a service occurs.  
|           | • This form should be entered into eSHARE at least once per month for patients in any Track. |
| Staff Responsible | • CC staff who conducted the service. |
| eSHARE Reporting | • Service must be entered into eSHARE.  
|                  |   o Services Delivered Form  
|                  |   ▪ Refer to the Service Type descriptions |
| Payment Methodology | • Refer to Public Health Solutions’ Guide to Requirements for Service Payability and Data Reporting (May 2013) and communications on November 3, 2011 and June 1, 2012 for full details.  
|                  | • For patients enrolled in **Ryan White only**, the following service types count as Face-to-Face as long as the Service Site is not “Phone,” and for the four “Assistance with...” services types, as long as the Service Detail is not “Reminder call/message”:  
|                  |   o Case Finding  
|                  |   o Intake Assessment  
|                  |   o Medical Assessment/Reassessment  
|                  |   o Other Assessment/Reassessment  
|                  |   o Care Plan/Service Plan  
|                  |   o Case Conference  
|                  |   o Accompaniment  
|                  |   o Assistance with Entitlements and Benefits  
|                  |   o Assistance with Health Care  
|                  |   o Assistance with Housing  
|                  |   o Assistance with Social Services  
|                  |   o Health Education/Promotion  
|                  | • For patients dually enrolled in **Ryan White and Health Homes**, the following service types count as Face-to-Face:  
|                  |   o Health Education/Promotion  
|                  |   o Intake Assessment  
|                  |   o Care Plan/Service Plan  
|                  |   o Case Conference  
|                  |   o Medical Assessment/Reassessment  
|                  |   o Other Assessment/Reassessment |
### SERVIES TRACKING LOG FORM (continued)

#### INTAKE ASSESSMENT SERVICE

| Definition | • Corresponds with completion of the Intake Assessment Form.  
|           | • Must be completed no more than 14 days after Enrollment Date. |
| Service Date | • Service Date = Intake Form Completed Date. |
| Site of Service Delivery | • Should NOT be “Phone”. |
| Service Details | • None. |

#### OTHER ASSESSMENT/REASSESSMENT SERVICE

| Definition | • This Service corresponds to the completion of the appropriate Form specified in the Service Details section. |
| Service Date | • Service Date = Form Completed Date. |
| Site of Service Delivery | • Should NOT be “Phone”. |
| Service Details | • Select all that apply from the service details available to CC:  
|           |   o “Re-Assessment (clinical, psychosocial, general health/well-being, housing, enrollments, etc.)” corresponds to the Reassessment Form.  
|           |   o “Adherence assessment - self-report” corresponds to the Adherence Assessment Form.  
|           |   o “Adherence assessment - pill count” corresponds to the Pill Box Log Form.  
|           |   o “Adherence assessment - DOT” corresponds to the Monthly DOT Log Form.  
|           |   o “Adherence assessment - other measure” does not correspond to a Form, but may be used for other types of adherence assessments.  
|           |   o “Logistical assessment or reassessment” corresponds to the Logistics for Navigator Form.  
|           |   o “Other non-medical assessment/reassessment” does not correspond to a Form, but may be used for other types of assessments. |

#### CARE PLAN/SERVICE PLAN SERVICE

| Definition | • This Service corresponds to the completion of the Comprehensive Care Plan Form. |
| Service Date | • Service Date = Form Completed Date on updated plan or new plan. |
| Site of Service Delivery | • “Program site,” “Patient home,” “Other field site,” or “Phone.” |
| Service Details | • Select only ONE from the following service details available to CC:  
|           |   o “Development of initial plan with this enrollment” corresponds with the Care Plan Form developed during the first two weeks of enrollment.  
|           |   o “Update to plan” corresponds to updating an existing Care Plan Form.  
|           |   o “Start of new plan (replacing last care/service plan)” corresponds to a new Care Plan Form that replaces the last Form. |
## SERVICES TRACKING LOG FORM (continued)

### ACCOMPANIMENT SERVICE

<table>
<thead>
<tr>
<th>Definition</th>
<th>• Escort (travel with patient at least one way) AND/OR Accompany (stay with patient during appointment).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Date</td>
<td>• Service Date = Date that accompaniment activity occurred.</td>
</tr>
</tbody>
</table>
| Site of Service Delivery | • Site = Location where you START the service.  
• Should NOT be “Phone.” |
| Service Details | • First, select only ONE from the *Accompaniment TO* service details:  
  o “Primary care”  
  o “Other healthcare”  
  o “Social service”  
• Second, select only ONE from the *Accompaniment FROM* service details:  
  o “Patient’s home or other field (non-provider) location”  
  o “One provider to another - different street address”  
  o “One provider to another - same address”  
  o “Jail/prison” |

### ASSISTANCE WITH HEALTH CARE SERVICE

| Definition | • Examples include PCP visits, other medical appointments, mental health care.  
• DO NOT USE for escorts to or accompaniments during a medical visit.  
• USE when you assist a patient *before or after* a medical visit.  
• These activities may involve encounters with the patient or with other service providers on behalf of the patient. |
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</thead>
<tbody>
<tr>
<td>Service Date</td>
<td>• Service Date = Date that assistance activity occurred.</td>
</tr>
<tr>
<td>Site of Service Delivery</td>
<td>• “Program site,” “Patient home,” “Other field site,” or “Phone.”</td>
</tr>
</tbody>
</table>
| Service Details | • Select all that apply EXCEPT for “Court Advocacy” from the following service details:  
  o “Help with filling out forms”  
  o “Eligibility assessment”  
  o “Reminder call/message”  
  o “Referral/Appointment-making”  
  o “Arrangement for transportation”  
  o “Arrangement for childcare or eldercare”  
  o “Arrangement for interpreting services”  
  o “Appointment preparation”  
  o “Other (Specify:)” |
### SERVICES TRACKING LOG FORM (continued)

#### ASSISTANCE WITH ENTITLEMENTS AND BENEFITS SERVICE

**Definition**
- Examples include SSI, SSDI, food stamps, public assistance, health insurance or coverage (i.e. ADAP, Medicaid).
- These activities may involve encounters with the patient or with other service providers on behalf of the patient.

**Service Date**
- Service Date = Date that assistance activity occurred.

**Site of Service Delivery**
- “Program site,” “Patient home,” “Other field site,” or “Phone.”

**Service Details**
- Select all that apply EXCEPT for “Court Advocacy” from the following service details:
  - “Help with filling out forms”
  - “Eligibility assessment”
  - “Reminder call/message”
  - “Referral/Appointment-making”
  - “Arrangement for transportation”
  - “Arrangement for childcare or eldercare”
  - “Arrangement for interpreting services”
  - “Appointment preparation”
  - “Other (Specify: )”

### ASSISTANCE WITH SOCIAL SERVICES SERVICE

**Definition**
- Examples include social work, case management, food and nutrition services, legal services, other supportive services.
- These activities may involve encounters with the patient or with other service providers on behalf of the patient.

**Service Date**
- Service Date = Date that assistance activity occurred.

**Site of Service Delivery**
- “Program site,” “Patient home,” “Other field site,” or “Phone.”

**Service Details**
- Select all that apply EXCEPT for “Court Advocacy” from the following service details:
  - “Help with filling out forms”
  - “Eligibility assessment”
  - “Reminder call/message”
  - “Referral/Appointment-making”
  - “Arrangement for transportation”
  - “Arrangement for childcare or eldercare”
  - “Arrangement for interpreting services”
  - “Appointment preparation”
  - “Other (Specify: )”
### SERVICES TRACKING LOG FORM (continued)

#### ASSISTANCE WITH HOUSING SERVICE

<table>
<thead>
<tr>
<th>Definition</th>
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</table>
| - Examples include HASA, housing placement, rental assistance.  
  - These activities may involve encounters with the patient or with other service providers on behalf of the patient. |

<table>
<thead>
<tr>
<th>Service Date</th>
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<tbody>
<tr>
<td>- Service Date = Date that assistance activity occurred.</td>
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</tbody>
</table>

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<tr>
<th>Site of Service Delivery</th>
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<tbody>
<tr>
<td>- “Program site,” “Patient home,” “Other field site,” or “Phone.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Details</th>
</tr>
</thead>
</table>
| - Select all that apply \textit{EXCEPT for “Court Advocacy”} from the following service details:  
  - “Help with filling out forms”  
  - “Eligibility assessment”  
  - “Reminder call/message”  
  - “Referral/Appointment-making”  
  - “Arrangement for transportation”  
  - “Arrangement for childcare or eldercare”  
  - “Arrangement for interpreting services”  
  - “Appointment preparation”  
  - “Other (Specify: )” |

### OUTREACH FOR PATIENT RE-ENGAGEMENT SERVICE

<table>
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<tr>
<th>Definition</th>
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</table>
| - Used for “Missed Appointment” procedure outreach activities.  
  - Document all outreach activities once an enrolled patient misses an appointment (e.g. scheduled home visit, medical visit, etc.)  
  - May use for outreach activities that resulted in either making or not making contact with patient. |

<table>
<thead>
<tr>
<th>Service Date</th>
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<tbody>
<tr>
<td>- Service Date = Date that outreach activity occurred.</td>
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</table>

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<tr>
<th>Site of Service Delivery</th>
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</table>
| - “Program Site:” CC Staff is conducting outreach activities at the CC office or the PCP office.  
  - “Client Home:” CC Staff is searching for the patient at the patient’s home (e.g. knocking on door, speaking to roommate, calling patient while standing outside house, etc.).  
  - “Other Field Site:” CC Staff is searching for the patient at a field site (e.g. park, café, patient’s work location, methadone clinic, calling patient while in field location, etc.).  
  - “Phone:” CC Staff is at the \textbf{Program Site} and is calling the patient. |

<table>
<thead>
<tr>
<th>Service Details</th>
</tr>
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</table>
| - Select all that apply.  
  - If “Made contact with patient” is selected, then you should report a second service type that matches what you discussed with the patient. For example, if an outreach activity resulted in having a health promotion discussion with the patient, then report a second service type of “Health education/promotion.” |
### HEALTH EDUCATION/PROMOTION SERVICE

**Definition**
- **Topic #**
  - Use only CC HIV curriculum topic numbers (1-16).
  - For discussions that do not follow the curriculum guide, use the topic number that most closely represents your discussion.
  - For other topics not captured in 1-16, use “Other topic (please specify).”
  - DO NOT USE Non-Care Coordination Conversation #.
- **Started, Continued, Completed**
  - You may cover a topic as many times as needed.
  - You may start and stop a topic as needed, i.e. take more than one encounter to complete one topic.
  - After a topic is completed, you may start or continue as many times as needed.

**Service Date**
- Service Date = Date that health promotion activity occurred.

**Site of Service Delivery**
- “Program site,” “Patient home,” “Other field site,” or “Phone.”

**Service Details**
- **First**, select the “Topic #” which may be 1-16, or select “Other topic (please specify).”
- **Second**, select only ONE of the following service details.
  - “Started topic, but did not complete”
  - “Continued topic, but did not complete”
  - “Completed topic”

### MEDICAL ASSESSMENT/REASSESSMENT SERVICE

**Definition**
- You may choose to use “medical assessment/reassessment” alone OR combine with “health education/promotion.”

**Service Date**
- Service Date = Date that medical assessment occurred.

**Site of Service Delivery**
- “Program site,” “Patient home,” “Other field site,” or “Phone.”

**Service Details**
- Select all that apply:
  - “Review of laboratory test values” documents the “service” for PCSM Update form only if there are new laboratory values (CD4, VL) to report, AND/OR supplements Health Promotion discussions with review of laboratory values.
  - “Review of symptoms and/or side effects” supplements Health Promotion discussions on ART adherence with review of symptoms and side effects.
  - “Risk behavior (PWP) assessment/discussion” supplements Health Promotion conversations with review of risk behaviors.
  - “Other Review/discussion” for other medical assessment/reassessment activity.
### CASE FINDING SERVICE

**Definition**
- Case Finding = “Return to Care” activities
  - Re-engage those who meet the definition of “out of care” (i.e. patient was seen at the agency within 2 years but not during the last 9 months) AND are not enrolled in CC.
  - Used to document the pre-enrollment case finding activities after the patient is enrolled.
  - Used once to sum the total amount of time spent on pre-enrollment case finding activities.

**Service Date**
- Service Date = Enrollment Date.

**Site of Service Delivery**
- “Program site”

**Service Details**
- Select all that apply.
- Sum the total amount of time spent on case finding.

### CASE CONFERENCE SERVICE

**Definition**
- **Initial case conference** is a brief face-to-face meeting between the PCP and CC staff that occurs during the initial hand-off of the patient at the time of PCP referral.
  - Required attendees include:
    - Program Staff (CC/PN or MCL)
    - Clinician (MD/DO/NP/PA)
    - Patient

- **Informal case conference** occurs as frequently as needed - scheduled or unscheduled - and does not require completion of the Case Conference Form, and may be a stand-alone Service.
  - Required attendees include:
    - Program Staff (CC and/or PN and/or MCL)
    - Non-Program Staff (Clinician, Social Worker, Mental Health Provider, Nutritionist, etc.)
  - Optional attendees include:
    - Patient

- **Formal case conference** occurs when all elements included on the Case Conference Form are completed with the required attendees present, and may be scheduled or unscheduled.
  - Required attendees include:
    - Program Staff (CC and/or PN and/or MCL)
    - Clinician (MD/DO/NP/PA)
  - Optional attendees include:
    - Patient
### SERVICES TRACKING LOG FORM (continued)

#### CASE CONFERENCE SERVICE (continued)

**Service Date**
- Service Date of **Initial case conference** = Date of patient “hand-off” from PCP. If this occurs before the patient is enrolled, then Service Date = Enrollment Date.
- Service Date of **Informal case conference** = Date that informal case conference occurred.
- Service Date of **Formal case conference** = Case Conference Form Completed Date.

**Site of Service Delivery**
- **Initial case conference**: should NOT be “Phone.”
- **Informal case conference**: “Program site,” “Patient home,” “Other field site,” or “Phone.”
- **Formal case conference**: should NOT be “Phone.”

**Service Details**
- Select only ONE of the following service details:
  - “Initial case conference (at or before enrollment)” corresponds to the definition of **Initial case conference**.
  - Informal/unscheduled ongoing conference” corresponds to the definition of **Informal case conference**.
  - “Formal/scheduled ongoing case review” corresponds to the definition of **Formal case conference** AND to the Date of Completed Case Conference Form.

### DOT SERVICE

**Definition**
- Only for patients enrolled in Track D, on ART.
- Only if there is Face-to-Face contact with the patient.
  - If not, then log only on the Monthly DOT Log Form.
- CC DOT is a modified type of DOT, which is typically scheduled for one dose per business day (i.e. five days per week).
- **Field-based DOT** occurs at the patient’s home or another field-based location of the patient’s choosing.
  - Patients are responsible for the storage of their medications.
  - DOT may be conducted by non-clinical Program Staff (e.g. DOT Specialist, Patient Navigator, etc.)
- **Clinic-based DOT** occurs at the Program location and/or the primary medical care site:
  - Medication dispensed on site – Programs must have proper medication storage facilities and licensed clinical staff to dispense medications.
  - Medication not dispensed on site – Programs do not store or dispense medications. Patients may bring their medications to the site for DOT, which may be conducted by clinical or non-clinical Program Staff (e.g. DOT Specialist, Patient Navigator, etc.).
### SERVICES TRACKING LOG FORM (continued)

#### DOT SERVICE (continued)

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<tr>
<th>Service Date</th>
<th>• Service Date = Date of face-to-face DOT encounter.</th>
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</table>
| Site of Service Delivery | • “Program site” indicates clinic-based DOT.  
• “Patient home” or “Other field site” indicate field-based DOT.  
• Should NOT be “Phone.” |
| Service Details (1) | • Select only ONE answer to **Dose Directly Observed?**  
  o “YES,” directly observed dose; CC staff observes the patient take the dose.  
  o “NO,” indirectly observed dose; CC staff does not observe the patient take the dose but uses pill box or other means to verify that the patient took the dose. |
| Service Details (2) | • Select ONE or BOTH for type of medication observed.  
  o “ART” for antiretroviral medications  
  o “Psychotropic and/or Opportunistic Infection Medications” for these types of non-ART medications |
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<th>STATUS</th>
<th>REVISION DATE</th>
<th>PAGE NO.</th>
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**NOTE:** Appendix V [SF-12v2™ General Health and Wellbeing Survey (Spanish)] may be used to supplement Spanish transmissions of the Intake Assessment Form and the Reassessment Form.