| Riverside/San Bernardino, CA TGA<br>Policy and Procedure<br>Policy #4<br>Forms and Tools:<br>Required and Recommended | Effective.....March 1, 2010<br>Revised.....February 2011<br>Revised.....March 1, 2012<br>APPROVED<br>Scott Rigsby<br>Scott Rigsby, Public Health Program Coordinator |
|---|---|

**PURPOSE** This policy is intended to clarify which tools and forms are required by the Ryan White Program (RWP) of the Riverside/San Bernardino, CA Transitional Grant Area (TGA).

**POLICY** RW-funded agencies are required to utilize the relevant forms and tools listed in Tables 1 and 2 below in the provision of RW-funded services to RW-eligible clients. Failure to do so will result in monitoring findings and/or delay in reimbursement. The forms and tools listed in Table 3 are not required, but recommended.

**SCOPE** This applies to all contracted agencies providing Ryan White Program funded services to eligible clients in the TGA.

**PROCEDURE**

**A.** **Tables 1 and 2** below contain a list of required TGA Ryan White Program forms and tools. Table 1 applies to all agencies, regardless of service provision. Table 2 applies to only agencies that deliver the specific service. If your agency is not contracted by the RWP to provide the service, your agency is not required to utilize the tool/form in Table 2 related to that service.

**Table 1: General Required Forms and Tools**

| TOOL/FORM TITLE | Attachment | FREQUENCY |
|---|---|---|
| **General (All Service Categories)** | | |
| Document Transmittal | Attachment 1 | With all submissions to RWP |
| Budget Template | Attachment 2 | Annually and when updates required |
| Scope of Work Template | Attachment 3 | Annually and when updates required |
| Monitoring CAP Response Format | Attachment 4 | Annually and revisions |
| ARIES Digital Certificate Request | Attachment 5 and www.projectaries.org | As new employees require access |
| ARIES Laptop Certificate Request | Attachment 6 | When use of laptop is necessary |
| ARIES Consent | Attachment 7 | Every 3 years and new clients |
| Cultural and Linguistic Competence Organizational Self Assessment Tool | Attachment 8 | As necessary to assess agency progress |
| Client Satisfaction Survey *(format/method may change)* | Attachment 9 | Biannually |
| Ryan White Services Report (RSR) | http://www.careacttarget.org/rsr.asp | Annually |

The following general forms/tools are **required**, but do not have a standardized, required format. Each agency can use/create its own form:

- ❑ Invoice Template (recommendation in Table 3)
- ❑ HIPAA Acknowledgment Form (recommendation in Table 3)
- ❑ Staff Confidentiality Statement
- ❑ Staff Training Log
- ❑ Grievance Form (recommendation in Table 3)
- ❑ Grievance Log (recommendation in Table 3)
- ❑ EIS/Outreach Consent Form (recommendation in Table 3)

**Table 2: Service-Specific Required Forms and Tools**

| TOOL/FORM TITLE | Attachment | FREQUENCY |
|---|---|---|
| **Case Management (non-Medical)** | | |
| Client Acuity Score Sheet | Attachment 10 | At intake and necessary updates |
| **Early Intervention Services (EIS)** | | |
| Enrollment Form | Attachment 11 | For all new/referred EIS clients |
| Progress Form | Attachment 12 | As necessary to document activity |
| **Medical Case Management** | | |
| Client Acuity Score Sheet | Attachment 10 | Annually and necessary updates |

The following service-specific forms/tools are required, but do not have a standardized, required format. Each agency can use/create its own form/tool:

- ❑ Medical Case Management Care Plan (recommendation in Table 3)
- ❑ Medical Case Management Case Conference Doc. (recommendation in Table 3)
- ❑ Case Management (non-Medical) Statement of Need
- ❑ Oral Health Treatment Plan
- ❑ Mental Health Treatment Plan
- ❑ Mental Health Outcomes Tracking Sheet (recommendation in Table 3)
- ❑ Substance Abuse Treatment Plan
- ❑ Substance Abuse Outcomes Tracking Sheet (recommendation in Table 3)
- ❑ Pharmacy Log
- ❑ Food Distribution Log
- ❑ Transportation Log
- ❑ EIS/Outreach Log (for encounters that cannot be entered in ARIES) (recommendation in Table 3)

**B. Table 3** below contains a list of forms and tools by service category with formatting that is recommended by the RWP. The specific formatting is not required. Some of these are "best-practices" that are currently being utilized by one or more RW-funded providers in the TGA.

**Table 3: Recommended Forms and Tools (Format Not Required)**

| TOOL/FORM TITLE | Attachment | FREQUENCY |
|---|---|---|
| **General (All Service Categories)** | | |
| Invoice Template | Attachment 13 | Monthly and as needed |
| HIPAA Acknowledgment Form | Attachment 14 | All clients at intake |
| Grievance Form | Attachment 15 | Readily available to all clients |
| Grievance Log | Attachment 16 | Updated as necessary |
| Behavior Contract | Attachment 17 | All clients at intake or as necessary |
| EIS/Outreach Consent Form | Attachment 18 | New clients |
| Referral/Emergency Assist Form | Attachment 19 | Utilized as necessary |
| **Medical Case Management** | | |
| ISP / Care Plan | Attachment 20 | Annually and as necessary |
| Case Conferencing Documentation | Attachment 21 | Annually and as necessary |
| Acuity Tracking and MCWP/CMP Documentation Form | Attachment 22 | At intake and as necessary |
| **Case Management (non-Medical)** | | |
| Acuity Tracking and MCWP/CMP Documentation Form | Attachment 22 | At intake and as necessary |
| **Outreach** | | |
| EIS/Outreach Tracking Log | Attachment 23 | As necessary to document service provision outside of ARIES (minimum = must include all elements) |
| **Mental Health** (could be adapted for **Substance Abuse** as well) | | |
| Client Outcomes Tracking Form | Attachment 24 (Riv Co form) | Annually and as necessary |

C. **Compliance:** Providers are encouraged to request assistance from the RWP if necessary. RWP staff will monitor compliance with this policy on a regular basis and during provider site visits. Violation of this policy will result in a monitoring finding and may result in delay or denial of payment.

# Ryan White Program

## Document Transmittal Form

**IMPORTANT:** This Document Transmittal form must be attached to all correspondence and invoice supporting documentation. Any item received without this form will be returned to the Provider and may result in delayed payment.

Ryan White Program Office
San Bernardino County Public Health Department
120 Carousel Mall
San Bernardino, CA 92415-0475
Main Line: (909) 388-0400
FAX: (909) 388-0401

| | |
|---|---|
| **Provider Name:** | |
| **Date Documents Sent:** | |
| **Date Received by Ryan White Program Office:** | |
| | Date Stamp<br>(To be completed by Ryan White Program Office) |

| REPORT | ENCLOSED |
|---|---|
| Invoice | |
| Letter (Any Type) | |
| Other: _____<br>(Please Describe) | |

| **Notes to Ryan White Program staff:** |
|---|
| Attention: |
| |

### CHANGE IN PROVIDER INFORMATION

| Type of Change | N/A | Effective date, reason for change, estimated date to fill, etc |
|---|---|---|
| Change in Administrative & Board personnel (Director, Finance, Chair, etc) | | |
| Number of line staff vacancies | | |
| Change in Point of Contact | | |
| Change in service delivery | | |
| Change in contact info (new phone #'s, new address, etc) | | |
| Change in service hours | | |
| Change in locations (New site, closed down site, etc) | | |

**Provider Name**
**Contract Name/Number**
**Riverside/San Bernardino, California TGA**

**Attachment 2**

**Budget**

Budget Period

| Budget Category | Budget Amount |
|---|---|
| ***Personnel*** | |
| **Title: (Salary x FTE)** | |
| **Title: (Salary x FTE)** | |
| **Title: (Salary x FTE)** | |
| **Title: (Salary x FTE)** | |
| **Fringe Benefits:** | |
| **TOTAL PERSONNEL** | **$ -** |
| ***Other*** | |
| ***Equipment:*** | |
| **Travel:** | |
| **Supplies:** | |
| **Rent:** | |
| **Utilities:** | |
| **Telephone:** | |
| **Insurance:** | |
| **Printing/Postage:** | |
| **TOTAL OTHER** | **$ -** |
| **SUBTOTAL (Personnel and Other)** | **$ -** |
| **Indirect Costs** (Not to exceed 10% of the Total Budget) | |
| **TOTAL BUDGET** | **$ -** |

# RYAN WHITE PROGRAM
## SCOPE OF WORK

| RYAN WHITE PROGRAM PART A: MAR 1, 2011 - FEB 29, 2012 | |
|---|---|
| **CONTRACT NUMBER:** | Leave Blank |
| **CONTRACTOR:** | Contractor name here |
| **SERVICE CATEGORY:** | Name of service here |
| **SERVICE GOAL:** | Enter goal here per service definitions |
| **SERVICE HEALTH OUTCOME(S):** | Enter health outcome(s) per service definitions |

| Planned Services to Clients by service area of residence: | 1 Riv W | | 2 Riv C | | 3 Riv E | | 4 SB WV | | 5 SB E V | | 6 SB D | | Total | Newly Diagnosed | HIV Unaware | Aware/ Not in Care |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current | New | Current | New | Current | New | Current | New | Current | New | Current | New | | | | |
| Total # Undup Clients to be Served | | | | | | | | | | | | | | | | |
| Caucasian/White | | | | | | | | | | | | | | | | |
| African American | | | | | | | | | | | | | | | | |
| Latino/a | | | | | | | | | | | | | | | | |
| Women | | | | | | | | | | | | | | | | |
| Infants | | | | | | | | | | | | | | | | |
| Children | | | | | | | | | | | | | | | | |
| Youth | | | | | | | | | | | | | | | | |

| Planned Client Utilization by service area of residence : | 1 Riv W | | 2 Riv C | | 3 Riv E | | 4 SB WV | | 5 SB E V | | 6 SB D | | Total | Newly Diagnosed | HIV Unaware | Aware/ Not in Care |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current | New | Current | New | Current | New | Current | New | Current | New | Current | New | | | | |
| Total # of Service UNITS to be delivered | | | | | | | | | | | | | | | | |
| Caucasian/White | | | | | | | | | | | | | | | | |
| African American | | | | | | | | | | | | | | | | |
| Latino/a | | | | | | | | | | | | | | | | |
| Women | | | | | | | | | | | | | | | | |
| Infants | | | | | | | | | | | | | | | | |
| Children | | | | | | | | | | | | | | | | |
| Youth | | | | | | | | | | | | | | | | |

**RYAN WHITE PROGRAM**
**SCOPE OF WORK**

| Planned Client Visits by service area of residence : | 1 Riv W | | 2 Riv C | | 3 Riv E | | 4 SB WV | | 5 SB E V | | 6 SB D | | Total | Newly Diagnosed | HIV Unaware | Aware/ Not in Care |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Current | New | Current | New | Current | New | Current | New | Current | New | Current | New | | | | |
| Total # of Service UNITS to be delivered | | | | | | | | | | | | | | | | |
| Caucasian/White | | | | | | | | | | | | | | | | |
| African American | | | | | | | | | | | | | | | | |
| Latino/a | | | | | | | | | | | | | | | | |
| Women | | | | | | | | | | | | | | | | |
| Infants | | | | | | | | | | | | | | | | |
| Children | | | | | | | | | | | | | | | | |
| Youth | | | | | | | | | | | | | | | | |

**RYAN WHITE PROGRAM**
**SCOPE OF WORK**

| PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES: | SERVICE AREA | TIMELINE | PROCESS OUTCOMES |
|---|---|---|---|
| **Service Delivery Element #1:**<br><br>**Implementation Activity #2-1:**<br><br>**Implementation Activity #2-2:** | Indicate "All" or identify each individual service area proposed for service delivery | 3/1/11-2/29/12 | **Indicated process outcome measures specific to the Service Delivery element.**<br><br>Process Outcome = Documented evidence of service delivery. |
| **Service Delivery Element #2:**<br><br>**Implementation Activity #2-1:**<br><br>**Implementation Activity #2-2:** | Indicate "All" or identify each individual service area proposed for service delivery | 3/1/11-2/29/12 | **Indicated process outcome measures specific to the Service Delivery element.**<br><br>Process Outcome = Documented evidence of service delivery. |

**RYAN WHITE PROGRAM**
**SCOPE OF WORK**

| Group Name and Brief Description | Service Area of Service Delivery Site | Targeted Population | Open/ Closed | Expected Average Attendance Per Session | Session Length (Hours) | Sessions per Week | Group Duration | Outcome Measures |
|---|---|---|---|---|---|---|---|---|
| **Group Name #1**<br>• Briefly describe group purpose / subject matter.<br>• Include DSM diagnoses of clients that are expected to benefit from the group. | Indicate # of the Service Area where the group meets | Examples: Women, MSM, Youth, Monolingual, etc | Indicate whether the group is Open or Closed | Indicate how many clients, on average, will attend each group meeting. | Indicate how long each session will last (e.g. one hour) | Indicate how many sessions will be held each week | Examples: Ongoing, 6 months, 12 months, etc. | Example:<br>"80% of clients being treated for anxiety will demonstrate a decreased level of anxiety as measured by the Behavior Assessment Inventory (BAI) by the end of the 6 month period." |
| **Group Name #2** | | | | | | | | |
| **Group Name #3** | | | | | | | | |

# Program Monitoring, 20XX
# Corrective Action Plan

| **Name of Agency** | **Name & Title of person writing the CAP** |
|---|---|

| # | **CAP Item** | **Proposed Response** | **Responsible Party** | **Timeline** |
|---|---|---|---|---|
| 1 | *As it is written in monitoring report* | *Activities to improve/correct the deficiency* | *Who will carry out corrective action* | *When will improvement/ correction be in place* |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |

State of California - Health and Human Services Agency

Print Form

California Department of Public Health
Office of AIDS

# ARIES User Registration Form

**Contractor Information:**

Agency/Provider Name: _____

Site (if applicable): _____

Address: _____

City: _____, CA Zipcode: _____

By signing this form as an authorized agency representative, I am certifying that the user identified below is an employee of the agency and their job requires the level of access to ARIES I have indicated below.

Authorized by (please print clearly): _____

_____ _____

*Signature* *Date*

**User Information (please print clearly):**

First Name: _____ Last Name: _____

Email: Phone: _____

Job Title: _____

Number of computers this staff person will use to access ARIES: _____

**ARIES Application Name (please check all that apply):**

☐ ARIES Client, If checked, User Group Role. _____

☐ ARIES Report/Export ☐ ARIES Import

By signing this form as an employee of the above Agency/Provider, I am certifying that I am aware of the confidentiality requirements for Protected Health Information (PHI) and that I will follow the Agency's/Provider's guidelines pertaining to patient confidentiality and the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____

*Employee Signature* *Date*

**EMA Approval (if applicable):**

Printed Name:_____ Signature:_____ Date:_____

**OA Use Only:**

Date Received:_____ Received by:_____
User ID Assigned:_____ Date Assigned:_____
Certificate Issued:_____ Cert Issued by:_____
Date Issued:_____ Date Installed:_____

**Revocation Information:**

Application Deactivated:_____ Deactivated by:_____ Date Deactivated:_____
Date Certificate(s) Revoked:_____ Revoked by:_____

**Attachment 6**

**Riverside/San Bernardino, CA TGA**
**Ryan White Program (RWP)**
**Laptop ARIES Digital Certificate Request Form**

Date: _____ Agency Requesting Laptop Certificate: _____

Address(*es*) of ALL locations where the laptop may/will be used: _____

_____

_____

Laptop Serial # (ITTP Address)_____

Laptop User:_____
Print First Name Print Last Name Title/Job/Position

I understand and agree to adhere to all requirements including:

1. Adhering to all CA State Office of AIDS ARIES Policy Notices (Note: Policies No. A1 and No. B4 specifically address Digital Certificates and Laptop use).
2. Ensuring the laptop will not be used in or near any internet public access areas (WiFi zones) such as a Starbuck's, etc.;
3. Ensuring that the laptop will not be taken home or to any other place of residence;
4. Ensuring that the laptop will not be left unattended in any vehicle;
5. Ensuring the following if the laptop is lost, misplaced, or stolen:
    a. Immediate filing of report w/ the police agency of the area in which the incident occurred,
    b. Immediate notification, by telephone & Email, to the Ryan White Program (RWP) Office of the incident, preferably speaking with the Program Manager or the Program Coordinator,
    c. Provision of a copy of the police report to the RWP as soon as it is available,
    d. Follow up with the RWP Office ensuring immediate cancellation of the ARIES certificate;
    e. Full cooperation with the County of San Bernardino's Public Health Department's HIPAA Compliance Officer's investigation as well as with any investigation conducted by the RWP staff.

***In addition, a written justification must be submitted with this form.**

I have read and understand the above requirements including the CA State Office of AIDS ARIES Policy Notices No. A1 and No. B4. I understand that any violation of the laptop policy and requirements listed on this form may constitute the immediate revocation of the applicable ARIES certificate *(this may be done without notification to the user in the interest of protecting confidential client information).*

Laptop User: _____ _____ Date:_____
Print Name Signature

Agency Executive Director:_____ _____ Date:_____
Print Name Signature

Public Health Ryan
Program Coordinator:_____ _____ Date:_____
Print Name Signature

Revised: March 1, 2011

# ARIES Client Consent Form

## for the San Bernardino/Riverside Transitional Grant Area

I, _____ *(print full name)*, wish to register with the AIDS Regional Information and Evaluation System (ARIES) in order to receive services provided by the San Bernardino County Public Health Department and/or its service providers. During registration, I will be asked to provide information about myself, including my name, race, gender, birth date, income, and other demographic data. Depending upon the agency or program I am registering with, I may also be asked questions about my CD4 cell count, viral load, use of HIV medications, general physical and medical condition, and medical history.

In addition to providing information, I may be asked to provide an original letter of diagnosis signed and dated by my doctor or have a blood test that shows that I am HIV-positive.

**SHARE:** By signing below, I choose to share my information with all other agencies I receive services from that are part of ARIES. The purposes for sharing my information in ARIES are to determine my need and eligibility for services, enroll in appropriate programs, and receive coordinated care and treatment including appropriate referrals for other services. By stating that I am willing to share my information, I will usually not need to re-register (in ARIES) or provide a letter of diagnosis when I receive services from another agency providing services funded by the Ryan White HIV/AIDS Program or the California Department of Public Health (CDPH), Office of AIDS. Only authorized personnel at an agency will have access to my information on a need-to-know basis. The information shared may include information about services received or my treatment at a particular agency. Mental health, alcohol/substance use, and legal information will not be shared.

As a condition of receiving services, I consent that my ARIES information may be made available to my local health department, to fiscal agents who fund the services I receive, and to the CDPH/Office of AIDS for mandated care and treatment reporting, program monitoring, statistical analysis, and research activities. This data includes, but is not limited to, demographic, financial, medical, service, mental health, alcohol/substance use, and legal information.

Additionally, as a condition of receiving services, I consent that my local health department may disclose to my health care providers the minimum necessary of my ARIES information to assist them in complying with HIV reporting laws and regulations. Mental health, alcohol/substance use, and legal information will not be disclosed for this purpose.

My registration in ARIES does not guarantee services from any other agency. Wait lists or other eligibility requirements may exclude me from services at other ARIES agencies.

By signing this form, I acknowledge that I have talked about and understand my rights to confidentiality with respect to ARIES with the staff person indicated below. I understand that this form will be stored in my paper file. This Consent remains in effect for three (3) years from the date I sign this form.

| Signature of Client or Parent/Guardian of Minor Child | Date |
|---|---|

**For Local Agency Use Only**

| Administered By (Staff Name) | Agency Name |
|---|---|
| Signature | Date |

If applicable, this client is a **NON-SHARE** client because (check all that apply):

☐ Unable to give consent ☐ Related/Affected Client ☐ HIV-Negative

Condado de San Bernardino | Departamento de Salud Pública

## Formulario de Consentimiento Para Área de Transición de San Bernardino/Riverside Cliente ARIES

Yo, _____ *(nombre completo con letra de molde)*, deseo inscribirme con El Sistema Regional de Información y Evaluación del SIDA (ARIES), para recibir servicios suministrados por el Departamento de Salud Pública del Condado de San Bernardino y/o sus proveedores de servicios medicos. En mi inscripción se me pedirá que proporcione información personal, incluyendo mi nombre, raza, género, fecha de nacimiento, ingresos, y otros datos demográficos. De acuerdo con la agencia o el programa con el cual me registro, es posible que se me hagan más preguntas sobre mi recuentro de células CD4, carga viral, uso de medicamentos para el VIH, comportamientos de riesgo, general de condición física y médica, y historia médica.

Además de proporcionar información, se me puede pedir una carta original del diagnóstico firmado y fechado por mi médico o un examen de sangre que muestra que soy VIH positive.

**COMPARTIR:** Al firmar a continuación, acepto compartir información sobre mi inscripción con todas las agencias que me proporcionen servicios que forman parte de ARIES. Los objetivos para compartir mi información en ARIES son para determinar mi necesidad y elegibilidad para los servicios, para inscribirme en los programas adecuados, y recibir atención médica, apropiadamente coordinada y tratamiento, incluyendo referencias apropiadas para otros servicios. Al declarar mi disposición de compartir mi información, generalmente no tendré que reinscribirme (en ARIES) ni proporcionar carta de diagnóstico cuando reciba servicios de una agencia que opere con fondos del Ryan White VIH/SIDA Programa o de CDPH/Oficina del SIDA. Los datos compartidos podrán incluir los servicios o tratamientos recibidos de determinada agencia. La información relacionada a mi salud mental, alcohol y consumo de sustancias, y las cuestiones jurídicas no será compartida.

Como condición para recibir los servicios, consiento que mi información ARIES puede ponerse a disposición de mi departamento de salud local, a los agentes fiscales que proporcionan los fondos que pagan por los servicios que recibo, y al CDPH / Oficina del SIDA para el cuidado de mandato y presentación de informes de tratamiento, seguimiento de los programas, el análisis estadístico, y las actividades de investigación. Estos datos incluyen, pero no se limita a, demográficos, financieros, médicos, servicios, salud mental, alcohol y consumo de sustancias, y la información jurídica.

Asimismo, como condición para recibir los servicios, consiento que mi departamento de salud local puede revelar a mis proveedores de atención medica y salud la informacion minima de ARIES necesaria para ayudarlos a cumplir con las correspondientes leyes de VIH y otros reglamentos. La información relacionada a mi salud mental, alcohol y consumo de sustancias, y las cuestiones jurídicas no sera compartida.

Mi inscripción en ARIES no garantiza servicios de ninguna otra agencia. Las listas de espera u otros requisitos de participación podrían excluirme de servicios de otras agencias ARIES.

Al firmar este documento, reconozco que he hablado con la persona de la agencia señalada abajo sobre derechos de confidencialidad con respecto a ARIES. Entiendo que este documento será guardado en mi archivo de documentos. Este consentimiento es válido por tres (3) años a partir de la fecha en que firme este formulario.

Firma de Cliente o Padre/Tutor de Menor _____ Fecha _____

**Para Uso de la Agencia Únicamente (For Local Agency Use Only)**

| | |
|---|---|
| Administrado Por (Administered By) | Nombre de la Agencia (Agency Name) |
| Firma (Signature) | Fecha (Date) |

Este paciente no desea compartir su información porque (seleccione las opciones que sean necesarias):
(This client is a **NON-SHARE** client because [check all that apply]):

☐ No puedo dar consentimiento (Unable to give consent)
☐ Paciente familiar/afectado (Related/Affected Client)
☐ VIH negative (HIV-Negative)

# Cultural and Linguistic Competence Organizational Self Assessment
## Ryan White Program (RWP) Riverside/San Bernardino TGA

This tool was developed with community input from the Nubian AIDS Coalition-Inland Empire (NAC-IE), Ryan White Program Staff, and San Bernardino County Public Health Department Statistical Analyst Staff. Its purpose is to provide contractors with a method to establish capacity, develop a Cultural and Linguistic Plan, and measure progress in responding to the TGA's Cultural and Linguistic Competency Standards*. It will also respond to Inland Empire HIV Planning Council service directives and to RWP Contract requirements.

Questions designated to assist providers with establishing capacity will be identified with (CA).

** The standards were adapted from the Office of Minority Health; National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care.*

*Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Based on Cross, Bazron, Dennis, & Issacs, 1989)*

The completed tool will be submitted to the RW Program office upon request as a condition of the RW contract. Some questions are designed to assist with evaluating capacity and for the purposes of creating the initial Cultural and Linguistic Services Plan. These questions are identified with "EC". If you have any questions, please contact the Ryan White Program Office at 909-387-4290.

## Organization Information

**1. Date this assessment is being completed:** _____

**2. Please provide the following information about your organization.**

Company: _____

Address: _____

Address 2: _____

City/Town: _____ State: _____ Zip/Postal Code: _____

Email Address: _____ Phone Number: _____

**3. Please provide the name and title of the person completing this instrument (Note that this person must be a member of the organization's management team or lead staff if services are provided in a satellite office)**

Name: _____ Title: _____

**4. Please check the category that best describes your organization**

☐ Community based organization ☐ Faith-based organization ☐ Private Medical Clinic
☐ County Health Department ☐ Public (Government)
☐ Other – Explain _____

## I. Agency Infrastructure – Staff and Racial/Ethnic Representation

**5. What is the total number of individuals on your board of directors? _____**

**6. Provide the total number of individuals that comprise the following:**

Board of Directors: _____

Leaders/Management: _____
Full-Time Staff: _____
Part-Time Staff:_____
TOTAL Staff: _____

**7. Provide the demographic proportions (%) of your Board of Directors, Leaders/ Management, Full-Time Staff, and Part-Time Staff in the table below. For comparison, also include the demographic proportions of your agency's Riverside/San Bernardino TGA Service Areas' HIV/AIDS Prevalence.** Ideally, your agency's board member and staff proportions should be similar to the Service Areas' proportions.

*Note: If you are a County Health Department or other Public (Government) organization, you do not have to provide the proportions for Board Members.*

**Comparison of Demographic Proportions**

| • **Input Proportions (%)**<br>• **If unknown, leave blank** | **Service Areas' HIV/AIDS Prevalence** | **Board Members** | **Leaders/ Mgmt** | **Full-Time** | **Part-Time** | **TOTAL Staff** |
|---|---|---|---|---|---|---|
| **RACE/ETHNICITY** | | | | | | |
| White | | | | | | |
| African American | | | | | | |
| Hispanic | | | | | | |
| Asian/Pacific Islander | | | | | | |
| American Indian/Native Alaskan | | | | | | |
| 2 or More | | | | | | |
| Other | | | | | | |
| TOTAL | | | | | | |
| **GENDER** | | | | | | |
| Male | | | | | | |
| Female | | | | | | |
| Transgender | | | | | | |
| Other | | | | | | |
| TOTAL | | | | | | |
| **SEXUAL ORIENTATION** | | | | | | |
| Heterosexual | | | | | | |
| Questioning | | | | | | |
| Gay | | | | | | |
| Lesbian | | | | | | |
| Bisexual | | | | | | |
| Queer | | | | | | |
| Transsexual | | | | | | |
| Other | | | | | | |
| TOTAL | | | | | | |

## II. Staff Development

**8. (EC) How frequently does your organization provide education and/or training to staff regarding the following:**

| | Never | Weekly | Monthly | Quarterly | Bi-Annually | Annually |
|---|---|---|---|---|---|---|
| **Culturally** appropriate service delivery to **African-Americans** | | | | | | |
| **Culturally** appropriate service delivery to **Hispanic/Latino-Americans** | | | | | | |
| **Linguistically** appropriate service delivery to **African-Americans** | | | | | | |
| **Linguistically** appropriate service delivery to **Hispanic/Latino-Americans** | | | | | | |

**9. Which education and training methods are used by your agency to provide staff with information relative to:**

| CHECK ALL THAT APPLY | Workshops | Written Materials | Conferences | Guest Speakers | In-Service | Other (specify) |
|---|---|---|---|---|---|---|
| **Culturally** appropriate service delivery to **African-Americans** | | | | | | |
| **Culturally** appropriate service delivery to **Hispanic/Latino-Americans** | | | | | | |
| **Linguistically** appropriate service delivery to **African-Americans** | | | | | | |
| **Linguistically** appropriate service delivery to **Hispanic/Latino-Americans** | | | | | | |

**Written Materials = books, pamphlets, fact sheets, etc.**

## III. Agency Infrastructure: Client Satisfaction

**10. (EC) How frequently does the organization provide the following:**

| | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| **Culturally** appropriate service delivery to **African-Americans** | | | | | |
| **Culturally** appropriate service delivery to **Hispanic/Latino-Americans** | | | | | |
| **Linguistically** appropriate service delivery to **African-Americans** | | | | | |
| **Linguistically** appropriate service delivery to **Hispanic/Latino-Americans** | | | | | |

**11. (EC) How frequently does your organization conduct client satisfaction surveys in addition to the RW Program contractually required annual survey?**

☐Never ☐Rarely (1-2 per year) ☐Sometimes (3-4 per year)

☐Often (5+ per year)

**12. (EC) How frequently does your organization conduct client satisfaction surveys that include measurement of <u>culturally</u> appropriate service delivery?**

☐Never ☐Rarely (1-2 per year) ☐Sometimes (3-4 per year)

☐Often (5+ per year)

**13. (EC) How frequently does your organization conduct client satisfaction surveys that include measurement of <u>linguistically</u> appropriate service delivery?**

☐Never ☐Rarely (1-2 per year) ☐Sometimes (3-4 per year)

☐Often (5+ per year)

## IV. Agency Infrastructure: Plan Development and Training

**14. (EC) Has your organization developed and implemented a <u>written plan</u> to ensure delivery of:**

| | Yes | No* |
|---|---|---|
| **Culturally** appropriate services to **African-Americans**? | | |
| **Culturally** appropriate services to **Hispanic/Latino-Americans**? | | |
| **Linguistically** appropriate services to **African-Americans**? | | |
| **Linguistically** appropriate services to **Hispanic/Latino-Americans**? | | |

***If no, include this in your implementation plan.**

**15. (EC) Check the areas listed below that are included in your plan to ensure <u>culturally</u> appropriate services to African-American and Latino/Hispanic-Americans.**
***Note: This is to be used as a tool to review y our plan once it is completed.***

☐Clearly defined goals

☐Clearly written policies

☐Staff training of the plan

☐Strategies for recruiting racially diverse staff

☐Strategies for promoting racially diverse staff

☐Staff feedback of the plan is included in annual staff evaluation

☐A process is outlined to conduct organizational cultural competency assessment

☐A process is outlined to conduct organizational linguistic competency assessment

☐Service area demographics are considered and addressed

☐Staff training (Cultural competency)

☐Staff training (Linguistic competency)

☐Annual assessment of racially diverse representation by staff

## V. Agency Infrastructure: Organizational Cultural Competency Self Assessment

**16. (EC) Briefly describe your agency's plan to address deficiencies discovered by the Organizational Cultural Competency Self Assessment (Baseline Survey only) in the space below.**

**17. Describe the plan to address deficiencies discovered by the Organizational Cultural Competency Self Assessment (Survey 2 and 3 only).**

## VI. Agency Infrastructure: Data Collection and Use (ARIES)

**18. Describe how your agency uses demographic data to guide agency management and policy in the area below. ****If your agency currently does not use demographic data, please include this in your plan.***

## VII. Communication: Client Satisfaction &Language Strategy

**19. Indicate the number of clients who receive services at your agency who have been identified with limited English proficiency. _____**

**20. Indicate the number of clients who receive services at your agency who have been identified as deaf. _____**

**21. How often does your agency provide interpreter services at no cost to clients who have been identified as having <u>limited English proficiency</u> at all points of contact?**

☐Never ☐Sometimes ☐Often ☐Always ☐Not Applicable

**22. How often does your agency provide interpreter services at no cost to clients who have been identified as being <u>deaf</u> at all points of contact?**

☐Never* ☐Sometimes ☐Often ☐Always ☐Not Applicable
*If never, skip to question #40

**23. How often is sign language provided to hearing impaired individuals in the dialect understood by the individual (ex. ASL and exotic sign languages- non ASL)?**

☐Never ☐Sometimes ☐Often ☐Always ☐Not Applicable

**24. How often are friends or family used as interpreters for clients who have been identified as having limited English proficiency?**

☐Never ☐Sometimes ☐Often ☐Always ☐Not Applicable

**25. How often are friends or family used as interpreters for clients who have been identified as being deaf?**

☐Never ☐Sometimes ☐Often ☐Always ☐Not Applicable

**26. Check the reason(s) listed below that might prohibit your agency from providing interpreter services to customers at no cost in a timely manner at all points of contact.**

☐Unable to locate interpreters - Exotic language
☐Cost
☐Coordination
☐Unknown need
☐Clients routinely bring friends and family – Client's choice (comfort/support)
☐Other – Specify:_____

**27. What percentage of line staff (staff that has direct contact with clients) speaks the languages listed below?**

| Language | Percentage of Line Staff |
|---|---|
| Spanish | |
| American Sign Language | |
| Vietnamese | |
| Other (please list language) | |

******If not already doing so, include in your agency's plan how your agency will provide bilingual/staff interpreter services to clients with limited English proficiency.***

******If not already doing so, please describe in your agency's plan how your agency will provide bilingual/staff interpreter services to clients who are deaf (in the language understood by client).***

**28. (EC) How often does your agency conduct client satisfaction surveys to measure appropriate language service delivery in the area of providing interpreters?**

☐Never ☐Sometimes (1-2 per year) ☐Often (3-4 per year) ☐Frequently (5+ per year)

## VIII. Communication: Written Materials

**29. Describe how data is collected by your agency to identify languages other than English that are spoken in your target service area. Check all that apply.**

☐Census information ☐Client Survey ☐Other* Explain _____

**30. List the languages other than English that have been identified as being spoken in your target service area in the space below.**

**31. How often does your agency provide written materials to clients in their native language at no additional cost to clients who have been identified as having limited English proficiency at all points of contact?**

☐Never ☐Sometimes ☐Often ☐Always ☐Not Applicable

**32. How often are signs and notices posted in languages other than English?**

☐Never ☐Sometimes ☐Often ☐Always ☐Not Applicable

**33. How often does your agency conduct client satisfaction surveys to measure appropriate <u>language</u> service delivery in the preferred language of the customers in your target service area?**

☐Never ☐Sometimes (1-2 per year) ☐Often (3-4 per year) ☐Frequently (5+ per year)

**34. Describe any obstacles that currently exist that prevent your agency from providing written materials (including client satisfaction surveys) in the client-appropriate <u>languages</u> for your target service area. Check all that apply.**

☐Cost ☐Availability ☐Coordination ☐Other* Explain _____

# Encuesta de Satisfacción 2011 ✉

**Agencia:**

**Fecha:** 13 de Febrero 2012 **De:** Condado de San Bernardino Programa RW
**Para:** Clientes del Programa de Ryan White **Objetivo:** Satisfacción de Servicios

El Departamento de Salud Pública del Condado de San Bernardino quiere saber qué tan satisfechos están los clientes con los servicios proveídos por la agencia mencionada en la parte superior derecha de esta página. **Usted puede ayudar al Condado completando y regresando esta encuesta en el sobre adjunto (no necesita estampilla) no más tardar el 16 de Marzo, 2012.**

**Antes de llenar esta encuesta, tenga en mente**:

- La encuesta es totalmente *anónima*.
  - Esto significa que toda la información que usted provea permanecerá confidencial y la agencia no sabrá quien contesto.
  - Usted no esta obligado a poner su nombre en ninguna parte de esta encuesta y usted no será identificado por llenar esta encuesta.
- La encuesta es *opcional*.
  - Esto significa que usted no esta obligado a tomar la encuesta y sus servicios no serán afectados, aunque usted no complete la encuesta.
- Esta encuesta es una manera de *explicarnos que es lo que piensa de estos servicios*. Sus respuestas serán agrupadas con otras respuestas que han sido contestadas acerca de esta agencia para mejorar los servicios.

**Mientras** usted llena la encuesta toma en cuenta:

- Las respuestas deben ser acerca *de la agencia mencionada en la parte superior derecha de esta hoja*.
- Sea claro y especifico lo mejor posible. Esto ayudará al Condado a entender sus respuestas. Si necesita más espacio, por favor adjunte más hojas de papel.
- Recuerde que el Condado usará esta información para mejorar los servicios. Usted puede compartir sugerencias de cómo mejorar estos servicios.

1. Raza/Grupo Étnico:
   ☐ Blanco ☐ Hispano ☐ Africano-Americano ☐ Asiático-Isleño del Pacifico
   ☐ Indio- Americano/Nativo de Alaska ☐ Multirracial ☐ Otro: _____
2. Sexo:
   ☐ Masculino ☐ Femenino ☐ Transgénero ☐ Otro: _____
3. Ciudad de Residencia: _____
4. Código Postal: _____
5. Edad:
   ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65+
6. Seguro de Salud Principal:
   ☐ Medi-Cal ☐ Medicare ☐ Medi-Medi ☐ Privada ☐ MISP/CMSP ☐ VA
   ☐ Ninguno ☐ Otro: _____
7. Sobretodo, ¿que tan satisfecho esta usted con los servicios de esta agencia?
   ☐ Muy Satisfecho ☐ Algo Satisfecho ☐ Ni Satisfecho o insatisfecho
   ☐ Algo insatisfecho ☐ Muy insatisfecho
8. ¿Recomendaría usted esta agencia ha otras personas? ☐ Si ☐ No ☐ Sin Opinión

# Encuesta de Satisfacción 2011 ✉

***Agencia:***

9. ¿En el último ano, ha recibido todos los servicios que usted ha necesitado? ☐ Si ☐ No
   Si no, por favor explique: _____

   _____

10. ¿En el último año, esta agencia me ha preguntado si deseo ayuda para decirle a mis amigos acerca de mi estado de salud? ☐ Si ☐ No
11. ¿El ano en que fue primer diagnosticado: _____
12. ¿Esta satisfecho con el <u>numero</u> y <u>tipo</u> de referencias que ha recibido?

    **A.** Numero ☐ Si ☐ No **B.** Tipo ☐ Si ☐ No

    Si no, por favor explique _____

    _____

| *Por favor de marcar una respuesta por pregunta:* | Muy de Acuerdo | De Acuerdo | Des-acuerdo | Mucho des-acuerdo | Sin Opinión | No Aplica |
|---|---|---|---|---|---|---|
| 13. Me siento muy **bienvenido** en **esta agencia**. | | | | | | |
| 14. El **tiempo** de espera que usualmente **espero** para recibir servicios es razonable | | | | | | |
| 15. **El personal** de la agencia **me trata con respeto** | | | | | | |
| 16. El personal de **la agencia responde** a mis preocupaciones y/o quejas. | | | | | | |
| 17. Los **servicios** que recibo de esta agencia toma en consideración mi **cultura/antecedentes**. | | | | | | |
| 18. El personal de la agencia habla conmigo en el **lenguaje** que puedo entender. | | | | | | |
| 19. El **Material escrito** que recibo esta en un lenguaje que puedo entender. | | | | | | |
| 20. Las referencias que recibo para otras agencias toman en consideración mi **cultura/antecedentes**. | | | | | | |
| 21. Creo que mi **salud ha mejorado** como resultado de los servicios que he recibido de esta agencia. | | | | | | |
| 22. Cuando tengo una **queja o preocupación** acerca de un servicio en la agencia, **ya sé qué hacer** para que la agencia escuche mi queja y preocupación. | | | | | | |

23. Por favor de compartir cualquier comentario adicional que usted tenga sobre esta agencia (adjunte más hojas de papel si necesario) _____

    _____

24. ¿Le gustaría participar en un grupo de discusión dirigido por el condado (grupo de enfoque) con respecto a servicios? ☐ Si, me gustaría participar en el grupo de enfoque ☐ No

25. ¿Le gustaría ser contactado acerca algo de esta encuesta?
    ☐ Si, por favor de llamarme ☐ No

    Si contesto Si a pregunta 24 o 25, por favor de incluir su nombre, numero de teléfono y su correo electrónico abajo.

Nombre: _____ Teléfono:_____ correo electrónico:_____

# Client Satisfaction Survey 2011 ✉

**Agency:**

**Date:** February 13, 2012 **From:** County of San Bernardino RW Program
**To:** Ryan White Services Clients **Subject:** Satisfaction with Ryan White Services

The San Bernardino County Department of Public Health wants to learn how satisfied clients are with the services being provided by the agency identified at the top right hand of this page. **You can help the County do this by completing this survey and returning it in the enclosed envelope (no stamp required) before March 16, 2012.**

**Before you complete the survey, keep in mind that**:

- This survey is completely *anonymous*.
  - This means that all information you provide will be kept confidential and your agency will not know how you answered the questions.
  - You are not required to put your name on any part of the survey and you will not be identified by taking this survey.
- This survey is *optional*.
  - This means that you are not required to take this survey and your care or services will not be affected, *whether or not you complete this survey*.
- This survey is *a way for you to tell us what you think about services*. Your responses will be grouped with others who respond about this agency and be used to improve services.

**While you complete the survey, keep in mind that**:

- Your responses should be about the *agency named in the upper right corner of this page*.
- Be as *clear and specific* as you can. This will help the County understand your answers. If you need more space, feel free to attach additional sheets of paper.
- Remember that the County will use this *information to improve services*. You may want to include suggestions about how you think services can be improved.

---

**1.** Race/Ethnicity:

☐ White ☐ Hispanic ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Native Alaskan ☐ Multi Racial
☐ Other: _____

**2.** Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____

**3.** City you live in: _____

**4.** Zip Code: _____

**5.** Age: ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65+

**6.** Primary Health Insurance:

☐ Medi-Cal ☐ Medicare ☐ Medi-Medi ☐ None
☐ Private ☐ MISP/CMSP ☐ VA ☐ Other: _____

---

**7.** Overall, how satisfied are you with the services you get at this agency?

☐ Very Satisfied ☐ Somewhat Satisfied ☐ Neither Satisfied nor Dissatisfied
☐ Somewhat Dissatisfied ☐ Very Dissatisfied

**8.** Would you recommend this agency to others?

☐ Yes ☐ No ☐ No Opinion

# Client Satisfaction Survey 2011 ✉

**Agency:**

**9.** In the past year, have you been able to receive all of the service(s) you need?
☐ Yes ☐No: If *No*, please explain: _____

_____

**10.** In the past year, I have been asked by this agency if I would like help in telling my friends about my health status.
☐ Yes ☐No

**11.** The year you were first diagnosed:
Year: _____

**12.** Are you satisfied with the number and type of referrals you receive?
**A.** Number: ☐ Yes ☐ No **B.** Type: ☐ Yes ☐ No
If *No* for either of these, please explain:_____

_____

| *Please mark only ONE RESPONSE per question.* | Strongly Agree | Agree | Disagree | Strongly Disagree | No Opinion | Not Applicable |
|---|---|---|---|---|---|---|
| 13. I feel **welcome** at **this agency**. | | | | | | |
| 14. The amount of **time** that I usually **wait** before receiving services is reasonable. | | | | | | |
| 15. The staff at **this agency treats me with respect**. | | | | | | |
| 16. The staff at **this agency responds** to my concerns and/or complaints. | | | | | | |
| 17. The **services** I receive from this agency take into consideration my **culture / background**. | | | | | | |
| 18. The staff speaks to me using **language** that I understand. | | | | | | |
| 19. The **written materials** provided to me use language that I understand. | | | | | | |
| 20. The **referrals** I receive to other agencies take into consideration my **culture / background**. | | | | | | |
| 21. I believe that my **health has improved** as a result of the services I have received at this agency. | | | | | | |
| 22. When I have a **complaint or concern** about a service at the agency, **I know what to do** to have the agency listen to my complaint/concern. | | | | | | |

**23.** Please share any additional comments you have about this agency (attach additional sheets if needed):

_____

_____

_____

_____

**24.** Would you like to participate in a county-led group discussion (focus group) regarding client services?
☐ Yes - I would like to participate in a focus group. ☐No

**25.** Would you like to be contacted regarding something on this survey?
☐ Yes – Please contact me. ☐No

If you answered **YES to number 24 or 25**, please include your name, phone number, and email below.

NAME: _____ Phone Number: 1 (_____) _____ Email:_____

# Riverside/San Bernardino, CA TGA: Ryan White Program
# CLIENT ACUITY SCORE SHEET

**The following <u>are required</u> for all Case Managed (medical and non-medical) clients to ensure acuity levels are comparable across the TGA:**

1. **Ryan White-funded agencies <u>must use the standard parameters</u> below to determine acuity levels.**
2. **The resulting acuity scores <u>must be recorded in ARIES</u> and updated <u>annually</u> in ARIES, at a minimum.**

- **The Life Areas indicated below are those that may justify a particular score. All examples need not apply *[i.e. some Life Areas may receive zero (0) points].***

*Use any space available for client-specific notes:*

| Life Area Score | Stage 1 (1 point) | Stage 2 (2 points) | Stage 3 (3 points) |
|---|---|---|---|
| **Basic Need:** | Able to meet housing, utilities, and food needs | Primary needs occasionally not met; needs assistance with accessing services/benefits | Primary needs not met consistently |
| **HIV Disease Progression:** | Asymptomatic | One or more significant symptoms which impair normal functioning | Advanced HIV disease; significant symptoms which impair normal functioning |
| **Other Medical Needs:** | Stable health | Sporadic need for treatment/medication for non-HIV related medical condition(s) | Significant/ongoing non-HIV related medical need(s) |
| **Medication:** | Understands compliance of medication regimen; little or no side effects or not on HIV medications | Occasional side effects of HIV medications/occasional non-compliance of medication. Needs medication education | Severe side effects of HIV medications/complex medication regimen; non-compliant with medication regimen |
| **Activities of Daily Living:** | Fully independent with activities of daily living | Needs occasional assistance with activities of daily living | Dependent on assistance to meet activities of daily living |
| **Transmission Prevention Practices:** | Consistent use of transmission prevention practices | Occasional lapse in transmission prevention practices; needs occasional education/reinforcement | Inconsistent or unsafe transmission prevention practices; has maximum education needs |
| **Support System:** | Consistent, healthy support system | Inconsistent support network; unhealthy support system | Lacks support system |
| **Living Situation:** | Stable/adequate; clean housing | Needs occasional short-term rental assistance/ mortgage/utilities to maintain stable housing | Frequent changes in living arrangements/homeless. Imminent eviction. Safety hazards in the home. |
| **Mental Health:** | No mental health issues; no need for counseling referrals | Identified mental health issue under treatment or stable | Has mental health issues which require ongoing mental health intervention (treatment) |

# Riverside/San Bernardino, CA TGA: Ryan White Program
# CLIENT ACUITY SCORE SHEET

| Life Area Score | Stage 1 (1 point) | Stage 2 (2 points) | Stage 3 (3 points) |
|---|---|---|---|
| **Substance Abuse:** | No current challenges with alcohol or drug use | Occasional problems with drugs and/or alcohol; immediate family/social network has substance abuse problems impacting client sobriety | Impairment due to alcohol/substance abuse; has need for treatment |
| **Financial Benefits:** | Adequate/steady source of income which is not in jeopardy; able to meet monthly financial obligations | Inconsistent/insufficient income to meet primary needs | No income; is in current financial crisis |
| **Transportation:** | Has consistent, available means of transportation; can drive self; can afford and is able to use private or public transportation | Occasional need for assistance with transportation and or training/education related to transportation use | Consistent barriers to accessing transportation (remote area, unreliable/no vehicle); unable to negotiate transportation systems |
| **Legal:** | No recent or current legal problems; all pertinent legal documents completed | Wants assistance completing standard legal documents; possible recent or current minor legal problems | Standard legal documents not completed; involvement in civil or criminal matters; recently incarcerated |
| **Culture/Language:** | Understands how to negotiate service system; culture/language is not a barrier to accessing other services | Needs interpretation of services/help in understanding service system; family needs education; some cultural/language barriers | Lack of understanding of service system creates state of fear/anxiety and distrust in client/family and becomes a barrier to care |

**TOTAL SCORE:**

| Point Value | Stage | Please Check ↓ |
|---|---|---|
| **0-20** | **1** | ❑ |
| **21-34** | **2** | ❑ |
| **35-42** | **3** | ❑ |

Additional Supporting Information:

# ENROLLMENT FORM: Ryan White EIS

Ryan White Program: Riverside/San Bernardino, CA TGA

**Attachment 11**

**Client Information** (*If current/former RW client, all info in this box is REQUIRED. Otherwise, provide as much as possible.*)

**First Name:**_____ **Middle Initial:**_____ **Last Name:**_____

**Date of Birth (*MM/DD/YYYY*):** ___/___/____ **Mother's Maiden Name:** _____

**Gender:** ☐Male ☐Female ☐Transgender **ARIES URN:** _____

**Additional Client Information**

**Race/Ethnicity:** _____ **Phone Number(s):** _____

**Address (+ zip):** _____ **Last Date of Contact**___/___/___

**Permission to contact:** ☐**Yes** ☐**No**

**If "Yes" → Phone Msg OK?** ☐**Yes** ☐**No** **Mail OK?** ☐**Yes** ☐**No** **Home Visit OK?** ☐**Yes** ☐**No**

**Risk Factors/Exposure (*check all that apply*):**

☐ Sex with men ☐ Sex with women ☐ Injection Drug Use ☐ Sharing Needles

☐ Transfusion ☐ Other(s): _____

**Individual:**
- ☐ needs to be tested for HIV (possibly HIV+ unaware)
- ☐ is HIV+ and has never received HIV medical care from any source (RW, Kaiser, the ER, etc).
- ☐ has received HIV medical care at some time but has never received RW-funded services.
- ☐ is a current or former RW client who stopped receiving services / fell out of care ("unmet need").

**Referral Information (if applicable)**

**Referral From (*Agency/Program*):** _____ **Date:** _____

**Referral To (*Agency/Program*):** _____

**Missed Appointments with (*Agency/Program*):** _____ **# Missed Appts:** ____

**Brief description of Need for RW EIS Services and any other useful information:**

_____

_____

_____

_____

**Person Completing This Form**

**Print Name:** _____ **Signature:** _____

**Phone Number:** _____ **Date:** _____

# PROGRESS FORM: Ryan White EIS

Ryan White Program: Riverside/San Bernardino, CA TGA

**Attachment 12**

1. **Client Name:** _____
2. **Original EIS Enrollment Date:** _____

*See original EIS Enrollment Form for detailed client and service "need" information.*

3. **EIS Services Provided (contacts, encounters, etc)**

| Date | Activity | Next Step |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

4. **Referrals:**

| Date | Service | Agency | Referral Status* | Link Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

* Optional Codes: IP=In Progress; D=Deferred; CP=Complete; U=Unattainable; O=Other

5. **Discharge: Client Discharged from EIS?** ☐ Yes ☐ No

**If "Yes", why is the client being discharged from EIS (*check one*)?**

- ☐ Client has been successfully linked / re-linked to care (transferred to MCM or CM)
- ☐ Client cannot be found
- ☐ Client has moved outside the TGA
- ☐ Client is incarcerated
- ☐ Client refuses service
- ☐ Client is deceased
- ☐ Other: _____

**If "Yes", justification for discharge agreed upon by:**

*If referred to EIS due to missed appointments, discharge from EIS must be agreed upon by all parties involved. A minimum of two disciplines must "sign off" on the discharge (e.g. EIS worker and Medical/Non Medical Case Manager). Ideally would also include Physician and/or Medical/Non Medical Case Manager in case conference.*

**1.** _____

**2.** _____

**3.** _____

6. **EIS Staff Member Name:** _____ **Date:** _____

7. **Copies of form sent to (**agency/name**):** _____

_____

_____

# INVOICE

**Attachment 13**

**Ryan White Program, Part A**

**Riverside/San Bernardino, CA TGA**

**Contract Period:**_____ **Invoice #:**_____

Agency: _____ Billing Period: _____

Contract #: _____ Service Category: _____

| Line Items | Total Budget | Expended This Period | Expended Contract-to-Date | Unexpended Budget | Check # | Invoice # | Allocation Spreadsheet (Y or N) |
|---|---|---|---|---|---|---|---|
| Personnel | | | | | | | |
| 1. *(Position & Incumbent)* | $ | $ | $ | $ | | | |
| 2. | $ | $ | $ | $ | | | |
| etc. | | | | | | | |
| ***Total Personnel*** | $ | $ | $ | $ | | | |
| 1. Travel | $ | $ | $ | $ | | | |
| 2. Supplies | $ | $ | $ | $ | | | |
| 3. Equipment | $ | $ | $ | $ | | | |
| 4. Contractual | $ | $ | $ | $ | | | |
| 5. *(Nature of Service/Vendor)* | $ | $ | $ | $ | | | |
| 6 . | $ | $ | $ | $ | | | |
| etc. | | | | | | | |
| ***Total Contractual*** | $ | $ | $ | $ | | | |
| Other | | | | | | | |
| 1. *(Specify Nature of Cost)* | $ | $ | $ | $ | | | |
| 2. | $ | $ | $ | $ | | | |
| 3. | $ | $ | $ | $ | | | |
| etc. | | | | | | | |
| ***Total Other*** | $ | $ | $ | $ | | | |
| **Indirect** (*Admin. Only*) | | | | | | | |
| Totals | $ | $ | $ | $ | | | |

I certify that the information provided herein and all costs being claimed are true, correct and in accordance with the contract provisions; that funds were expended or obligated during the contract period; and that the amount claimed has not been previously presented for payment to the County or another third party payor(s).

_____ _____

*Authorized Signature* *Date*

# NOTICE OF PRIVACY PRACTICES

**ENGLISH**

**ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge receipt of the Notice of Privacy Practices information, which explains my rights and limits on ways in which this agency may use or disclose my medical information, (also known as "protected health information" or "PHI").

| Client Name (print) | Client Signature | Date |
|---|---|---|

| Client's Representative (print) | Client's Representative Signature | Date |
|---|---|---|

If signed by other than client, indicate relationship and legal capacity.

| Relationship to client | Authority to act for client |
|---|---|

**ESPAÑOL**

**RECONOCIMIENTO DE HABER RECIBIDO LA DECLARACIÓN DE LAS PRACTICAS DE PRIVACIDAD**

Yo confirmo que he recibido la Declaración de las Prácticas de Privacidad, que explica mis derechos y limitaciones por las cuales el Condado puede usar o revelar mi información médica, (también conocida como "Información de Salud Protegida" o "PHI").

| Nombre del Cliente (Impreso) | Firma del Cliente | Fecha |
|---|---|---|

| Nombre del Representante del Cliente (Impreso) | Firma del Representante del Cliente | Fecha |
|---|---|---|

Si firmado por alguien que no es el cliente, indique parentesco y autoridad legal.

| Parentesco al cliente | Autoridad para representar al cliente |
|---|---|

# CONSUMER COMPLAINT FORM

**Attachment 15**

*For Grievances Against Service Provider*

**Reason(s) for complaint (check all that apply):**

☐ Denial of Service (See back for explanation)
☐ Substandard Service (See back for explanation)

Service/s in question: _____

_____

Is the service funded by the Ryan White Program?
☐ Yes ☐ No ☐ Don't know

**Consumer Information:**

Consumer's Full Name: _____ Today's Date: _____
Street Address: _____ City: _____ Zip Code: _____
Home or Message Telephone Number: (Day) _____ (Night)_____
Agency(s) Involved: _____
How long have you received services from this agency (years/months) ?_____
Date of Incident: _____ Time of Incident (if applicable):_____
Names of all people involved: _____

**Description of Incident and Suggested Solution:**

Please describe what happened. *(Be as specific as possible. Attach additional sheets of paper if necessary.)*

Please indicate what action/s you believe would best address the issue. (**This section <u>MUST</u> be completed.**)

**Permission for agency staff and/or Ryan White Program staff to contact consumer:**

I have answered the above to the best of my knowledge and ability. I understand that the contact information provided above may be used by the agency staff and/or Ryan White Program staff to contact me.
Signed_____ Date: _____
Consumer/Client Signature

**Assistance in preparing this form?**

If you received assistance in preparing this form please include the name of the person who helped you prepare this form and their relationship to you.
Name of Person: _____ Relationship:_____

*Form Revised: February 2011*

# CONSUMER COMPLAINT FORM

Attachment 15

*For Grievances Against Service Provider*

Instructions for completing the front of this form.

Please completely fill out all areas of the form to the best of your ability and knowledge. Complaints by Consumers against Agencies may be filed for the following reasons only:

**Grounds for Complaint**

- **Denial of Service:** This means that even though the service is available and you are eligible to receive the service, the agency has told you that you cannot receive the service. This does not include times when an agency reduces services due to financial cutbacks.
- **Substandard Service:** This means that the agency is providing services that you believe do not meet the Standards set forth by the Inland Empire HIV Planning Council (IEHPC). (For a copy of these, please go to www.IEHPC.org .)

**Service Information:**

**Service/s in question:** Please indicate the service for which you are filing a complaint. For example - Medical Care, Food Services, Housing, Medical Case Management, Case Management (non-Medical), Pharmacy, Mental Health Services, Dental, Substance Abuse Treatment, Transportation, Home Health, etc.

**Ryan White funded Service:** Indicate, to the best of your knowledge, whether Ryan White funds are used to pay for the service/s in question. You may also request this information from the agency.

**Consumer Information:**

Please complete this section entirely. Incomplete information may delay the process.

**Description of Incident and Suggested Solution:**

**Incident:** To the best of your ability, please completely describe what happened. Include a description of the service you were asking for/receiving, why you have a complaint about the service, which and how many of the agency's staff were involved, and any other information that is related to what happened. You may attach a separate piece of paper if you need more space.

**Action/s:** Please describe what you want to see happen or what you would like the Agency to do concerning your complaint. **This section MUST be completed**. The Complaint Form will be returned to you for completion if this section has not been completed. This will delay the process.

**Permission for Ryan White Grantee Staff to contact consumer:**

Please sign and date this section to give the Ryan White Program staff, the Agency, and any other party essential to the Complaint Process, access to your contact information and permission to use the information solely for the purposes of contacting you regarding resolution of the complaint described in this form.

**Assistance in Preparation:**

If you received assistance from anyone in completing this form, please provide that person's information.

**Submit Complaint Form:**

- Mail the completed complaint form to the agency against which you are filing a complaint. The agency is required to respond to you with an outcome/resolution within **30 days** of receipt of this completed form.
- If you are not satisfied with the agency's response, you may submit your complaint along with the agency's response to the Ryan White Program office within **10 days** of receipt of the agency's response.
  Ryan White Program: 120 Carousel Mall, San Bernardino CA, 92415-0475.

# FORMA DE QUEJA PARA EL CONSUMIDOR/CLIENTE

*Para quejas contra el proveedor/agencia*

**Motivos de queja (marque todas las que apliquen):**

☐ Negación de servicio
(Vea la próxima página para una explicación)

☐ Servicios deficientes (vea la próxima página para una explicación)

Servicio/s en cuestión: _____

_____

¿Es el servicio financiado por el programa de Ryan White?
□ Si □ No □ No Se

## Información del consumidor/cliente:

Nombre Completo: _____ Fecha de hoy: _____
Dirección: _____ Ciudad: _____ Código postal: _____
Número de teléfono de casa o para mensaje: (Día) _____ (Noche) _____
Agencia (s) implicada: _____
¿Por cuánto tiempo ha recibido servicios de esta Agencia (años/meses)? _____
Fecha de incidente: _____ Tiempo de incidente (si es aplicable):_____
Los nombres de todas las personas involucradas: _____

## Describa el incidente y la solución sugerida:

Por favor, describa lo que sucedió. *(Sea lo más específico posible. Adjunte hojas adicionales si es necesario.)*

_____
_____
_____
_____
_____

Por favor indique qué acción(es) usted sugiere para mejorar el incidente. (**Esta sección <u>debe</u> completarse.**)

_____
_____
_____
_____
_____

## Permiso para que el personal de la agencia y/o del programa de Ryan White para comunicarse con el consumidor:

He respondido a lo anterior a lo mejor de mi conocimiento y capacidad. Entiendo que la información de contacto proporcionada anteriormente puede utilizarse por el personal de la Agencia y/o el personal de la programa de Ryan White para ponerse en contacto conmigo.

Firma: _____ Fecha: _____
Firma del consumidor/cliente

## ¿Ayuda al completar esta forma?

Si ha recibido asistencia en la preparación de esta forma, por favor incluya el nombre de la persona que le ayudó a preparar esta forma y la relación con usted.

Nombre de la persona: _____ Relación: _____

# FORMA DE QUEJA PARA EL CONSUMIDOR/CLIENTE

*Para quejas contra el proveedor/agencia*

Instrucciones para completar el frente de esta forma.

Conteste todas las áreas de la forma completamente a lo mejor de su capacidad y conocimientos. Las quejas de los consumidores contra las agencias pueden ser presentadas por las siguientes razones solamente:

**Motivos de queja**

- **Servicios Fueron Negados:** Esto significa que a pesar de que el servicio está disponible y usted es elegible para recibir el servicio, la Agencia le ha dicho que usted no puede recibir el servicio. Esto no incluye incidentes cuando una agencia reduce los servicios debido a recortes financieros.
- **Servicios deficientes:** Esto significa que usted cree que la Agencia que está proporcionando servicios no cumple con las normas establecidas por el Inland Empire HIV Planning Council (IEHPC). (Para una copia de estas normas, vaya a www.IEHPC.org.)

**Información de servicio/s:**

**Servicio/s en cuestión:** Indique el servicio por el cual está presentando una queja. Por ejemplo - atención médica, servicios de alimentación, vivienda, administración de casos médicos, administración de caso (no médicos), farmacia, servicios de salud mental, servicios de dentista, tratamiento de abuso de sustancias, transporte, etc..

**Servicio/s financiados por Ryan White:** Indique, a lo mejor de su conocimiento, si se utilizan fondos de Ryan White para pagar el servicio/s en cuestión. También puede solicitar esta información de la Agencia.

**Información del consumidor:**

Por favor, complete esta sección por completo. La información incompleta puede demorar el proceso.

**Descripción de la solución de incidente y sugerida:**

**Incidente:** A lo mejor de su capacidad, por favor describa lo que ocurrió. Incluya una descripción del servicio que se solicito / recibio, y el porque tiene una queja sobre el servicio, cual/es personal de la Agencia se involucraron, y cualquier otra información que esté relacionado con lo que sucedió. Si necesita más espacio, puede adjuntar otro pedazo de papel.

**Acción/es:** Por favor, describa lo que desea suceder o lo que desea que la Agencia tome en cuenta a su queja. **Esta sección debe completarse**. Esta forma de queja será devuelto a usted si esta sección no está completó. Esto retrasará el proceso.

**Permiso para el personal de Ryan White de comunicarse con los consumidores/clientes:**

Por favor, firme y ponga la fecha en esta sección para permitir que el personal del programa de Ryan White, la Agencia y cualquier otra parte esencial en el proceso de queja tenga acceso a su información de contacto y el permiso para utilizar la información únicamente para los propósitos de comunicarse con usted con respecto a la resolución de la queja que se describe en esta forma.

**Asistencia en preparación:**

Si ha recibido asistencia en la preparación de esta forma, por favor incluya el nombre de la persona que le ayudó a preparar esta forma y la relación con usted.

**Sométase la forma de queja:**

- Envíe la forma a la agencia contra que usted declara su queja. La agencia es requerida a responderle con un resultado/resolución dentro de 30 días de recibo de esta forma.
- Si usted no es satisfecho con la respuesta de la agencia, usted puede someterse su queja junto con la respuesta de la agencia a la oficina del programa de Ryan White dentro de 10 días de la respuesta de la agencia:
  Ryan White Program: 120 Carousel Mall, San Bernardino CA, 92415-0475.

# GRIEVANCE/COMPLAINT ACTIVITY LOG

***See supporting, backup documentation for more information.***

| Grievance Number | Date Received | Client Name (Last, First) | Status Tracking | | | | | | Resolve Date |
|---|---|---|---|---|---|---|---|---|---|
| *Example 1* | *1/1/2009* | *Doe, John* | *Gathering Info* | *CM Contacted* | *Ct Contacted* | *Letter Sent to Ct* | *Resolved* | | *1/23/2009* |
| *Example 2* | *8/26/2009* | *Doe, Jane* | *MH Counselor Contacted* | *Ct Contacted* | *Sched Meeting w Ct* | | | | |
| *Example 3* | *9/29/2009* | *Mouse, Mickey* | *Gathering Info* | | | | | | |
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Attachment 16

# Contrato de Comportamiento del Cliente

## (Agency Name)

Se espera que los clientes asuman responsabilidades específicas para asegurar que las acciones del cliente no atenten contra los derechos y la seguridad de otros clientes o el personal de [Agency Name].

Firmando este contrato, yo, _____, entiendo que, como un cliente de esta agencia, tengo responsabilidades de comportamiento específicos que incluyen, pero no se limitan, a los siguientes (inicial cada uno de los siguientes):

_____ Debo conseguir citas con el personal adecuado antes de tiempo para todo el servicio que requiero. Si las citas no se pueden mantener o se deben cambiarse, yo debo notificar al menos 24 horas antes de la cancelación de personal de la agencia. Además, yo entiendo que las citas serán disponibles según la disponibilidad del personal de la agencia.

_____ Exhibirá un comportamiento adecuado durante cualquier tipo de contacto con personal de la agencia o de otros clientes. Esto incluye cualquier y todos los contactos en persona y en conversaciones telefónicas. Seré respetuoso y cortés al personal de la agencia y a otros clientes de la agencia todo el tiempo. Me abstendré de insultos, amenazas verbales de violencia física, violencia real y el comportamiento acosos, o de otra forma abusivo hacia a los clientes y al personal y voluntarios de la agencia. Entiendo que si no cumplo, puedo ser des matriculado de los servicios y la agencia.

_____ No estaré en propiedad de la agencia bajo la influencia de drogas o alcohol. Entiendo que los clientes bajo la influencia se les pedirá a salir de las instalaciones y que ofensas repetidas pueden resultar en des matriculación de servicios.

_____ Entiendo que si siento que los servicios no se prestan servicios de una manera que no cumplan con mis necesidades, tengo la responsabilidad de llevar estas preocupaciones a mi administrador de casos médico o a mi administrador de casos (no medico) o puedo pedir referencias a otras agencias de servicios.

He leído y entendido mis comportamientos responsabilidades como un cliente de [Agency Name]. Entiendo que la agencia reserva el derecho de terminar o suspender los servicios si no cumplo con mis responsabilidades de comportamientos mencionados.

_____ _____
Firma del cliente (padre o guarda si es menor de 18 años de edad) fecha

_____ _____
Firma del Medical Case Manager /Case Manager (non-Medical) fecha

_____ _____
Firma del Director/Proveedor fecha

# CLIENT BEHAVIOR CONTRACT

**[Agency]**

Clients are expected to assume specific responsibilities to ensure that the client's actions do not infringe upon the rights and safety of other clients and/or [agency] staff.

In signing this contract, I, _____, understand that, as a client of this agency, I have specific behavior responsibilities which include but are not limited to the following *(initial each of the following)*:

_____ I must schedule appointments with the appropriate staff ahead of time for all service needs. If appointments cannot be kept or need to be rescheduled, I must notify agency staff at least 24 hours before the cancellation. In addition, I understand that the scheduling of appointments depends on the availability of agency staff.

_____ I will exhibit appropriate behavior during any type of contact with agency staff or other clients. This includes any and all face to face contacts and telephone conversations. I will, at all times, be respectful and courteous to agency staff and other agency clients. I will refrain from verbal abuse, verbal threats of physical violence, actual violence, and otherwise abusive or harassing behavior towards staff, volunteers, and clients. I understand that if I do not comply, I may be dis-enrolled from services.

_____ I will not be on [agency] property while under the influence of drugs and/or alcohol. I understand that clients under the influence will be asked to leave the premises and that repeated offenses may result in dis-enrollment.

_____ I understand that if I feel services are not being provided in a manner that meets my needs, I will bring these concerns to my assigned medical or non-medical case manager and/or ask for appropriate referrals to other service agencies.

I have read and understand my behavioral responsibilities as a client of [agency]. I understand that [agency] reserves the right to terminate or suspend services if I do not fulfill my above mentioned behavioral responsibilities as a client.

_____ _____
Client's Signature (parent or guardian if under 18 yrs…note) Date

_____ _____
Medical Case Manager /Case Manager (non-Medical) Date

_____ _____
Director/Provider Signature Date

# Riverside/San Bernardino, CA TGA
# Ryan White Program
# Outreach / EIS / Bridge Consent Form

I, _____, authorize a Riverside/San Bernardino TGA Outreach/EIS/Bridge Worker (Worker) to contact me regarding my care and treatment. I understand that a Worker will contact me by telephone or in person if I miss two (2) or more consecutive scheduled appointments. This contact will be to discuss adherence and assist me in returning to care and treatment.

I also understand that the Worker may contact other Outreach/EIS/Bridge workers in either Riverside or San Bernardino County Public Health Departments to determine if I am being cared for by other organizations. The Worker may also share my HIV status with those same organizations.

I further understand that the purpose of the Outreach/EIS/Bridge program is to provide informational counseling, advocacy, and assistance with linkage to vital services. The Worker will ensure my awareness of services and take the necessary steps to assure my continued participation in HIV care and treatment.

_____ _____

Client Signature Date

_____ _____

Witness Date

**Attachment 19**

**Referral/Emergency Assistance Request Form**
**Ryan White Program**

Request Date: _____ Requesting Agency/Program:_____

***ARIES CLIENT IDENTIFIERS***
***To enable agencies to locate this client in ARIES, you must provide ALL of the following elements and they must MATCH your agency's records exactly. These can be verified on the Demographic Detail tab in ARIES.***

***Name:*** _____ _____ _____ ***Date of Birth:*** _____/_____/_____
*(Last)* *(First)* *(Middle Initial)*

***Mother's Maiden Name:*** _____ ***Gender:*** ____Male ____Female ____Transgdr MTF ____Transgdr FTM

***SSN:*** _____ ***Race/Ethnicity:*** ___White ___Black ___Hispanic/Latino(a) ___Asian ___Pacific Islander

___Am. Indian/Nat. Alaskan ___Multiple Races ___Other ___Unk/Unreported

*Is client registered in ARIES?* ___Yes ___No ***If YES, SKIP following the section and go directly to REFERRAL section.***

*Client's Current Residential Address or New Address (if moving):*

Address: _____ City:_____, CA Zip Code: _____

*Living Situation*: ____Permanent Housing ___Temporary Housing ___Homeless ___Other/Unknown

*Household Monthly Income:* _____ *Source of Income:* _____

*# of adults living in household:* _____ *# of dependants living in household:* _____

*Federal Poverty Level:* ___<100% ___101%-150% ___151%-200% ___201%-300% ___>301%

*Insurance Type:* ___Medicare ___Medi-Cal ___Medi-Medi ___Other Public
___Private ___Veterans ___None ___Other/Unknown:_____

*Diagnosis:* ___Symptomatic ___Asymptomatic ___AIDS

*Primary HIV Exposure:*
(*check all that apply*) ___MSM ___Bisexual ___Heterosexual ___IDU ___Pediatric/Perinatal ___Other/Unknown

REFFERAL:

*Service(s) Needed:*_____

*Justification for Service Need(s):*_____

_____

*Receiving Agency:* _____

**Case Manager's signature below certifies that applicant is eligible for Ryan White services, the required docs (letter of diagnosis, proof of income, etc.) are on file with the agency and all other resources and methods of payment for applicant have been exhausted so that Ryan White Program is payer of last resort.**

_____ _____ _____ _____
*Case Manager's Signature* *Printed Name* *Phone Number* *Date*

_____ _____
*Reviewed by* *Date*

Revised: 1/31/11

# Ryan White Care Plan

*For use with clients who are receiving Case Management Non-Medical **and/or** Medical Case Management*

**Client Name:** **Date:** **Agency:**

---

**Problem / Issue:** **Service Need:**

| **Goal:** | | |
|---|---|---|
| **Action** | **Responsible Party** | **Date/Timeframe** |
| | | |

---

**Problem / Issue:** **Service Need:**

| **Goal:** | | |
|---|---|---|
| **Action** | **Responsible Party** | **Date/Timeframe** |
| | | |

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**Problem / Issue:** **Service Need:**

| **Goal:** | | |
|---|---|---|
| **Action** | **Responsible Party** | **Date/Timeframe** |
| | | |

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**Problem / Issue:** **Service Need:**

| **Goal:** | | |
|---|---|---|
| **Action** | **Responsible Party** | **Date/Timeframe** |
| | | |

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## Signatures

| Signature / Print Name | Date | Client or Agency Name |
|---|---|---|
| | | |
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## Notes

# Ryan White Care Plan Case Conferencing Summary

*For Medical Case Management clients*

Client Name:_____

Use this form to document case conferencing with other service providers as required by the Care Coordination Policy.

| Participant Name | Agency Name (if applicable) | Date |
|---|---|---|
| | | |
| Notes: | | |

| Participant Name | Agency Name (if applicable) | Date |
|---|---|---|
| | | |
| Notes: | | |

| Participant Name | Agency Name (if applicable) | Date |
|---|---|---|
| | | |
| Notes: | | |

| Participant Name | Agency Name (if applicable) | Date |
|---|---|---|
| | | |
| Notes: | | |

# ACUITY TRACKING AND MCWP/CMP DOCUMENTATION

Riverside/San Bernardino, CA TGA – Ryan White Program

_____

Client Last Name First Name Middle Initial

_____

Agency Name Case Manager

Acuity Assessment Tracking:

| Assessment: | Original Acuity | Acuity Reassessment | Acuity Reassessment | Acuity Reassessment | Acuity Reassessment |
|---|---|---|---|---|---|
| **Date:** | | | | | |
| **Score:** | | | | | |

MCWP/CMP Qualification Assessment:

☐ Not Eligible for MCWP/CMP ☐ Eligible for MCWP/CMP → ☐ Enrolled in MCWP/CMP
☐ Placed on MCWP/CMP Waiting List
☐ Declined Enrollment in MCWP/CMP

Summarize MCWP/CMP eligibility and referral documentation or MCWP/CMP ineligibility documentation below. Attach supporting documentation and/or indicate where supporting documents are filed.

MCWP/CMP Referral: Complete the following if the client was referred to another agency.

Referred to (agency): _____ Method: _____ Date: _____

If discharged/disenrolled, reason: _____

By signing below, I acknowledge that the Acuity Assessment Process, including the Client Acuity Score Sheet, has been explained to me and I understand my case management options:

_____ _____

Client Signature Date Case Manager Signature Date

**Office Use Only:**

☐ *Check here, if this process has been explained and agreed to as part of the agency's standard consent process. Consumer signature not required.*

# EIS / OUTREACH LOG

This log is for those for which there is not enough information to enter record in ARIES. Transfer data to ARIES when there IS enough information and record ARIES URN on this log.

*Format Revised (3/1/12)*

| Last Name, First Name, MI | Service Date | E/T | Service Units | Service Details | Status | | | | Initial Entry (X) | Chart Number | Unaware or Not in Care | Part A or MAI | Gender (M/F) | Race (abbr) | Date of Birth | Residence Zip Code | Transfered to ARIES ARIES URN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | IP | LFU | REF | LNK | | | | | | | | | |
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# EXAMPLE: EIS / OUTREACH LOG - PORTIONS TO BE SUBMITTED WITH INVOICE

**DO NOT SUMBIT ANY IDENTIFYING INFORMATION WITH THE INVOICE.**

**SUBMIT ONLY DATA COLUMNS SUCH AS DATES, UNITS, AND SERVICE DELIVERY DETAILS.....SEE EXAMPLE BELOW**

**IF THE INDIVIDUAL'S INFORMATION WAS SUBSEQUENTLY TRANSFERRED TO ARIES, THE ARIES URN MUST BE ENTERED ON THE LOG.**

| Last Name, First Name, MI | Service Date | E/T | Service Units | Service Details | Status | | | | Initial Entry (X) | Chart Number | Unaware or Not in Care | Part A or MAI | Gender (M/F) | Race (abbr) | Date of Birth | Residence Zip Code | Transfered to ARIES ARIES URN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | IP | LFU | REF | LNK | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
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The data submitted with invoices must be backed up with the full log at your agency. The Ryan White Program office will verify these logs during annual monitoring visits.
Your log may look different from this log. This is an example that shows the MINIMUM variables that must be collected.

# Mental Health Services
# Outcome Measurement Form

**Name of Client:**_____ **ARIES ID:**_____

**Global Assessment of Functioning (GAF) for *Individual* Mental Health Services:**

| Initial Assessment DATE: | 6-Month Assessment DATE: | 6-Month Assessment DATE: | 6-Month Assessment DATE: |
|---|---|---|---|
| **GAF Score** | **GAF Score** | **GAF Score** | **GAF Score** |

Comments:_____

The **Global Assessment of Functioning (GAF)** is a numeric scale (0 through 100) used by mental health clinicians and doctors that measures the overall level of social, occupational and psychological functioning of adults. This information is useful in planning treatment and measuring its impact, and in predicting outcome. The higher the score is the higher the functioning of adults.

**Current Affect Scale for *Group* Mental Health Services:**

| Initial Assessment DATE: | 6-Month Assessment DATE: | 6-Month Assessment DATE: | 6-Month Assessment DATE: |
|---|---|---|---|
| **Total Score** | **Total Score** | **Total Score** | **Total Score** |

Comments:_____

The **Current Affect Scale** is a scale used by mental health clinicians to measure the client's functioning in the areas of individual, relational and social. In ongoing sessions, comparisons between the scores show the progress of therapy. If positive changes occur in these three areas, it is widely considered to be a valid indicator of successful treatment outcome (Lambert, 1996).

** All GAF and Current Affect Scale scores are recorded in ARIES.*

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**Mental Health Clinician**