CARE COORDINATION PROTOCOL
FOR HIV-INFECTED PERSONS

Issued by:
New York City Department of Health and Mental Hygiene
Bureau of HIV/AIDS Prevention and Control
Care, Treatment, and Housing Program
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CARE COORDINATION PROTOCOL FOR HIV-INFECTED PERSONS

ORIGINAL EFFECTIVE DATE: August 2009
REVISION DATE: October 2011

POLICIES

• All HIV-infected persons, also referred to as persons living with HIV/AIDS (PLWHA), in NYC should have access to ¹:
  - 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 can expect that critical health information is available to providers when they need it, and that adequate security measures are in place to safeguard its confidentiality.

BACKGROUND

In the United States, over half a million people are known to be living with HIV or AIDS.² New York City (NYC) continues to be at the epicenter of the U.S. epidemic, with 107,177 New Yorkers reported with HIV/AIDS as of June 30, 2009.³ 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 being from a racial/ethnic minority, being an injection drug user, having a mental illness, and being of a lower socioeconomic status.⁴,⁵,⁶,⁷ Many of these factors coexist among persons

¹ Refer to the Definitions section (Page 3) for definitions referenced throughout the protocol.
² CDC, HIV/AIDS Surveillance Report, 2006 (HIV reporting data are from 33 states).
belonging to racial/ethnic minority groups in NYC and accordingly these groups are more likely to be out of care and access care later. 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. 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. 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. Golin et al. documented a mean ART adherence of 71% in a prospective study, demonstrating the critical need for ART adherence support.

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 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

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11 Bangsberg DR. Less than 95% adherence to non-nucleoside reverse-transcriptase inhibitor therapy can lead to viral Suppression. *Clin Infect Dis* 2006;43:1 Oct:939-941.
12 Ibid.
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 will experience a decrease in viral load (VL), an increase in CD4 counts, and advances in disease stage will 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 protocol 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.

**OBJECTIVES OF HIV CARE COORDINATION**

- Ensure that patients maintain a stable health status.
- Ensure that PLWHA are linked to care in a timely and coordinated manner and maintain medical stability and suppressed viral load.
- Maintain patients in care via navigation, coordination of medical and social services and provision of support and coaching.
- Teach and support treatment (medications) adherence.
- Support and coach patients to become self-sufficient so that they are able to manage their medical and social needs autonomously.

**DEFINITIONS**

Definitions referenced throughout the protocol are listed below:

**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 or her home or work). Meeting a patient at a location near the medical provider (i.e. within a few blocks) is not allowable. Accompaniment is intended for high-risk PLWHA who struggle with conventional treatment regimens, and the intent is that even in circumstances where the patient is ambivalent about following through with the appointment, the patient navigator can reasonably find him or her. 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.\textsuperscript{15}

**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.\textsuperscript{16} 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.\textsuperscript{17}

**Case Management:** A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes, as defined by the Case Management Society of America.\textsuperscript{18}

**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:** A formal, scheduled interdisciplinary meeting during which all Care Coordination team members involved in providing care to the patient (e.g., clinician, Program Director, Care Coordinator, 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 formal case conference may also be an interdisciplinary meeting (scheduled or unscheduled) held directly following a medical

\textsuperscript{15} Behforouz HL, Farmer PE, Mukherjee JS.  From directly observed therapy to accompagnateurs: enhancing AIDS treatment outcomes in Haiti and Boston.  *Clinical Infectious Disease* 2004;38:S429-36.


\textsuperscript{17} Haggerty JL et al. cited in Bodhenheimer T.  Coordinating Care—A Perilous Journey through the Health Care System.  *NEJM.* 358;10, March 6, 2008.  p.1064.

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.19

**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.

**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 will 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 can accommodate language, values, beliefs, and behavioral differences of the individuals they serve in a cross-cultural setting.20

**Directly Observed Therapy (DOT):** A trained health community health worker (CHW) observes the patients as they take their prescribed medication every day. DOT provides 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.”21

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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 health education. The level of health promotion interventions will 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 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.

Medical Case Management: The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) defines medical case management as “a range of client-centered services that link clients 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 clients' 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

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24 The Ryan White HIV/AIDS Treatment Modernization Act (HATMA) of 2006 changed to include medical case management as a core service.
services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes all types of case management, including face-to-face meetings, phone contact, and any other forms of communication.”

**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.25

**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 navigator 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. 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. Various theory-based methods can be used to assist the patient to achieve set goals, such as strengths-based model or trans-theoretical approach, while the focus remains on navigating the system to obtain needed services and coaching for self-sufficiency.

**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 provider (physician, nurse practitioner, physician assistant) responsible for the patient’s comprehensive treatment plan with respect to HIV.

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

ELEMENTS OF THE PROTOCOL

1.0 Practice Standards

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

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

1.3 Address urgent needs and schedule follow-up medical care during intake.

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

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

1.6 Provide education/health 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 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.

1.11 Develop monitoring protocols and quality management activities.

1.12 Ensure all services are documented and reported appropriately.

1.12.1 Agencies must keep any paper forms used by the Care Coordination Program until May 31, 2011 (or a later date if notified by DOHMH).

1.12.2 After May 31, 2011 (or a later date if notified by DOHMH), agencies will no longer be required to keep paper forms for monitoring purposes. However, eSHARE is not an electronic medical record system or a client charting system; therefore, the system currently in place for charting client services must be maintained.

1.12.3 An agency may maintain paper forms in client charts if they choose.

1.12.4 Exceptions: The Ryan White Part A Care Coordination Program Agreement (Appendix K) and the HIPAA Compliant Authorization for Release of Medical Information (Appendix M if applicable) must continue to be maintained in client charts and be available for monitoring purposes. Also, the General Health and Well-Being section (also known as the SF-12) on page seven (7) of both the Intake Assessment Form (Appendix
R) and the Reassessment Form (Appendix CC) must currently be completed and maintained on a paper form.

1.12.5 Throughout this protocol, references to the paper Care Coordination forms are made, and these forms are included as Appendices; however, agencies are welcome to move to a near paperless environment utilizing a combination of eSHARE and the agency’s electronic medical record.

### 2.0 Components of Care Coordination

#### 2.1 Care Navigation

2.1.1 Care Navigation will be implemented to ensure that every patient knows where, when, and how to access all health and related services and must ensure the adequacy of resources available to the patient to do so.

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/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 fashion:

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 will 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 will 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* will receive at least two reminders by phone 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 V).

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 U) 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 section 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).

2.1.5 The Program will assist the patient in scheduling and rescheduling appointments, when necessary.

2.1.6 The Program will ensure translation services are available if not accessible on site by the PCP.

• Minor children (<18) are not allowed to be used as translators.

2.1.7 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 A.

• A 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 cannot 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.

2.1.8 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.
• Refer to the Childcare information presented in Appendix B.
• Payment for childcare in the patient’s home when circumstances do not allow bringing the child to the care center.
• HRSA\(^{26}\) prohibits payment to individual patients and therefore, Programs must develop a system to reimburse childcare providers.

2.1.9 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.

2.1.10 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.

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

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

2.2 Health Promotion (Education, Coaching and Medication Adherence)
2.2.1 The Program will ensure optimal health literacy for all enrollees 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 will provide a standard health promotion curriculum.

\(^{26}\) For more information, refer to [http://hab.hrsa.gov/](http://hab.hrsa.gov/)
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 client’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. These topics are outlined in more detail in Appendix G.

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

2.2.3 The Program will ensure that all service staff that provide health promotion and all direct or indirect supervisory staff receive regular trainings on the curriculum. The NYC DOHMH will train key staff who in turn will train the rest of the Program staff.

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

2.2.5 All patients with low intensity (refer to section 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

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 will 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 D 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 can 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 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).

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

2.2.5.7.4 Ideally, each patient will 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 will 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 can be covered over more than one session over the course of a calendar year.
### 2.2.6 All patients with **high intensity** (refer to section 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 G. |
| 2.2.6.2 | Each health promotion session is accompanied by some manner of 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 can transition to a less frequent intervention level (refer to Appendix F) 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 40-60 minutes. |
| 2.2.6.7.1 | It may take more than one session (encounter) to complete a topic, and at times different conversations can 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 will cycle through the curriculum once prior to graduation. |

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

### 2.2.8 For patients taking ART, pill counting 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 41 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 will occur within two weeks of enrollment into the Program.

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

2.3.4 Patients already receiving services from HASA at the time of enrollment need a more limited assessment (refer to section 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 will be evaluated for eligibility in a housing program. Programs can use AccessNYC for eligibility screening (refer to Appendix C).\(^{27}\)

2.3.5.3 Housing program application:

- Patients found to be eligible for one or more housing or housing assistance programs will be assisted in

completing all the forms and gathering the requisite support documentation that constitute application for the program.

- The Program will 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.28
- 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 can be accomplished by guiding the patient through the eligibility and referral services of AccessNYC.29 Programs currently covered are listed in Appendix C. Patients not already receiving benefits from the HIV/AIDS Services Administration (HASA) should also be assisted with an application.30

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

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

28 Housing Opportunities for Persons with AIDS (HOPWA). Contact phone (347) 396-7454.
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 assessment.

2.3.7.3 Perform a simplified assessment of housing needs, regardless of a current housing assessment, using the Reassessment Form (Appendix CC).

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

2.4 Directly Observed Therapy (DOT)

2.4.1 DOT will be provided to serve patients in the setting that is most likely to yield clinical success; for some this is a health center, for others the home or another field-based location of their choosing.
DOT will be performed for patients in need of high intensity services. Patients receiving DOT must be enrolled in Track D.

2.4.2 DOT is a resource for those persons who have had difficulty adhere to an anti-retroviral regimen independently or with the support of intensive health promotion but are willing to take ART. A written or verbal agreement to participate in DOT is required to be documented in the patient record.

2.4.2.1 DOT is generally offered or encouraged when other interventions fail aren’t 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 F).

2.4.2.2 Patients receiving DOT also receive weekly health promotion in conjunction (refer to Section 2.2 – Health Promotion). After a sustained period of clinical (CD4 counts and VL) and behavioral improvement the patient may graduate from DOT and continue receiving weekly health promotion visits.

2.4.2.3 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.

2.4.2.4 When ingestion of medications cannot be observed directly by Program personnel 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 can 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.
2.4.2.5 In some primary care settings, regulation or policy may require that a RN or LPN administer the medications delivered for DOT.

2.4.2.6 Services should include: Observation of patient pill consumption as well as any side effects reported or observed.

2.4.3 Any observation by a DOT Specialist 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.

2.4.4 It is preferable for the DOT Specialist 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.

2.4.5 The Program documents ART medication adherence by means of completing a Monthly DOT Log (Appendix AA). This form is limited to ART and should not be used to document adherence to other medications.

2.5 Other social support

2.5.1 There are certain factors that would help care coordination. The Program will ensure that enrollees can have maximal access to support from their community peers, the Program should maintain a formal relationship with a community services agency that provides in its center(s) such as:

- Access to a communal space where PLWHA can 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 In different Programs, the responsibilities described below may be bundled differently and staff titles may vary. 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 might 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 H) 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.

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 When relevant to Program needs, these services may be provided by a Patient Navigator.
3.3.1.2 Verifies eligibility and conducts duplication checks.
3.3.1.3 Performs the Intake Assessment including the initial social services, logistical and benefits assessment.
3.3.1.3.1 When relevant to Program needs, these services may be provided by a Patient Navigator.
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 When relevant to Program needs, these services may be provided by a Patient Navigator.
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 of Patient Navigators is 3-5 (60-75 patients maximum).

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 section 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 and discuss with the PCP even when co-location is not possible.

3.3.3.3 The Care Coordinator will 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 cannot 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 section 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 section 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 An MCL can handle a caseload in excess of 200. Only the largest medical centers should need more than one MCL.

3.4.2 If the Care Coordinator is based onsite at the PCP, it is unnecessary to also have a Medical Center Liaison.

### 3.5 Patient Navigator

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

3.5.2 Accompanies patients to routine primary care appointments and to other health care and social service 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 When relevant to Program needs, these services may be provided by another staff member. Some responsibilities may be handled by the MCL, 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 can be incorporated
3.5.4.3 It is important to deliver this information in a way that is suitable to meet your client’s education, developmental, language, gender, sexual and cultural needs.

3.5 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. Information should help inform 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 An appropriate caseload for each is 14-20 patients.

3.6 DOT Specialist – Field

3.6.1 Observes and records patient self-administration of ART.

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

3.6.3 An appropriate caseload for each is seven (7).

3.7 DOT Specialist – Health Center

3.7.1 Observes and records patient taking his/her medication at the clinic.

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

3.7.3 This role is listed separately because clinic policy often requires a Registered Nurse (RN) or a Licensed Practice Nurse (LPN) for this role. This allows for the dose to be administered, as well as observed, by the staff as indicated above.

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

3.7.4 An appropriate caseload for each is 14 - 20.

3.8 Clinical Supervision

3.8.1 The nature of care coordination work and the close relationship that can develop between direct-service staff members (Care Coordinators, Patient Navigators, DOT Specialists) and their patients along with the challenging nature of their patients, creates a need for staff to talk about their emotional reactions to their work.

3.8.2 Clinical supervisor provides clinical or mental health guidance and the opportunity to review mental health and substance use issues as they relate to particular patients.

3.8.3 All staff providing services directly to clients (i.e. 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, psychiatrist, psychologist) for 30-40 minutes, at least once every two weeks, individually or in a group.  
3.8.4.1 Ideally, clinical supervision will alternate between bi-weekly group and individual sessions.  
3.8.5 It is strongly recommended that clinical supervision should not be provided to a staff person by his/her non-clinical supervisor(s). 
3.8.5.1 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.

3.9 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, can 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 J), 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 case conferences with Care Coordination staff. 
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 Incorporates within the medical charting system a clearly identifiable medical treatment plan that constitutes the basis of the Program’s Care Coordination efforts.
3.10 **NYC DOHMH**

3.10.1 Funds the Care Coordination Program via Ryan White funds.
3.10.2 Provides programmatic technical assistance.
3.10.3 Provides training/education of Program staff.
3.10.4 Monitors program implementation.
3.10.5 Evaluates program performance and clinical outcomes.

3.11 **Public Health Solutions (PHS)**

3.11.1 NYC DOHMH’s Master Contractor, managing Ryan White-funded contracts for the Department.
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 Eligible clients must meet one of the following criteria in order to enroll in the DOHMH Care Coordination Program. Criteria can be general or biological.

4.1.2 **General Criteria**

   PLWHA who:

   4.1.2.1 Are newly diagnosed with HIV;
   4.1.2.2 Are at least 18 years of age;
   4.1.2.3 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;
   4.1.2.4 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 will have the best sense of appointment keeping behavior.

4.1.2.5 Have difficulty adhering to ART.

4.1.3 **Biological Criteria**

   PLWHA who:

   4.1.3.1 Are ART naive and starting treatment AND have one or more of the following associated factors:  

• 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.

4.1.3.2 Are 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.

4.1.3.3 Are on ART and experience recurrent virologic rebound after successful suppression.
• One definition of virologic failure is having two sequential viral load measures of HIV-1 RNA >1,000 copies/mL.

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 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 Section 9.0).

4.2.2.8 An agency that provides HIV testing services.

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 J) 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 M).

4.3.2.3 The PCP and Care Coordinator or 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 section 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 J) 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 client 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 I). This form should then be given to the Program-affiliated PCP that the patient has chosen so that the new PCP can evaluate the patient and complete the PCP Referral Disposition Form (Appendix J). The Program should check primary care appointment status and schedule as needed. At this point, the referral process should proceed as described in section 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 I) 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 client has a scheduled medical appointment prior to the client 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 client has been engaged in medical care, the Care Coordination Program will share the required documentation of linkage with the referring agency. This documentation includes the date the appointment was kept by the referred client, along with proof of the kept appointment (refer to section 4.3.3.1.3.1). At this point, the referral process should proceed as described in section 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 client was referred
- Viral load order, and/or result, from the agency to which the client was referred
- Copy of a medical note with the word 'HIV' or 'AIDS' in the context of the client’s diagnosed condition, from the agency to which the client was referred
- Orders and/or a prescription for any ARV, from the agency to which the client was referred
- Letter or note from staff at the treating agency to which the client 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 J) 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 J) documenting the reason for not referring the patient.

4.3.3.6 The accepting Program will track all referrals with regard to the disposition, e.g. enrolled, declined, lost to follow-up prior to enrollment.
4.4 Referral Sources

4.4.1 Referrals received from the Emergency Department (ED) and similar programs that conduct HIV screening or may identify at risk HIV+ persons during non-business hours.

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

4.4.1.2 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 can reasonably find him or her the following business day. Collect the name and contact information of one individual who will always know where the patient is, if possible.

4.4.2 Direct referral – via outreach, care coordination provider, other service provider, self-referral or other Ryan White affiliated medical providers.

4.4.2.1 Referral from another source implies that the patient will 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.

4.4.2.2 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.

4.4.2.3 The accepting Program or PCP will then meet with the patient and complete either a Pre-Referral to CC Program Form (Appendix I) or a PCP Referral Disposition Form (Appendix J).

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

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

4.4.2.4.2 The Program is only obligated to ensure that the patient attend the initial PCP visit so that the PCP may determine if the patient is eligible for the Program.

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.).
4.5  **Program outreach prior to PCP referral ("Return to Care")**

4.5.1  Search commences at the beginning of program implementation to find patients lost to follow-up.

4.5.2  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.

4.5.3  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.

4.5.3.1 Contact information is verified.

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

4.5.5  Programs should use the Return to Care Tracking Tool developed in Microsoft Excel by DOHMH to maintain a log of Lost to Care outreach activities and disposition. Contact your DOHMH Project Officer to receive this tracking tool electronically.

4.6  **Intake**

4.6.1  At intake, Program staff must check for enrollment in four large NYC-funded and/or NYS-funded programs:

- Comprehensive Medicaid Case Management Program including, but not limited to, the Community Follow-up Program (COBRA);
- Identical Ryan White funded program;
- HIV Special Needs Plan (SNPs);
- AIDS Adult Day Health Care (ADHC) program.

4.6.1.1 Based on PLWHA enrollment and eligibility for Medicaid or funded programs, the Program will follow payment procedures to ensure correct allocation of the cost of particular services.

4.6.1.2 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 recipient which agency best suits his or her needs.

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

4.6.2.1 Orientation will begin at the PCP’s health facility.

4.6.2.2 The purpose of the orientation is to:

- Explain the purpose and structure of the Program.
- 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 will deliver most of the care coordination services. Also provide contact information for the Care Coordinator.
- Ensure appropriate and complete contact information is on record (including a contact number at which the patient can be reached during business hours, cell phone, home number, etc.) and a friend or relative that will know the patient’s whereabouts and can be contacted in the event that communication with the patient is unsuccessful. The Contact Information Form (Appendix O) and the Common Demographics Form (Appendix Q) 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.
- Explain the importance of notifying the Program and PCP in the event of a hospitalization or travel.
- Address urgent needs such as need for housing, domestic violence, etc.
- Ensure medical treatment follow-up is in place.
- Ensure all the requisite elements for comprehensive assessment—including a benefits assessment—and plan are scheduled.
- Check childcare and transportation needs with regard to care access up to and including the next scheduled encounter.

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

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

4.6.2.3.2 Obtain appropriate releases of information and document on the HIPAA Compliant Authorization for Release of Medical Information (Appendix M) if needed.
4.6.2.3.3 Record detailed contact information and document on the Contact Information Form (Appendix O).

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

4.6.2.3.5 This is accomplished immediately after the referral and hand off. 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 K) and the HIPAA Compliant Authorization for Release of Medical Information (Appendix M) are completed to allow Program to follow-up with patient.

4.6.2.4 During the first two weeks of enrollment, baseline assessments of clinical and psychosocial status (Intake Assessment Form), the completion of the 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.

4.6.2.5 Primary care appointments

4.6.2.5.1 Patients referred through a source other than the affiliated medical provider (refer to section 4.2.2) should have a primary care appointment scheduled as soon as possible so that the affiliated PCP can evaluate the patient for the Care Coordination Program.

4.6.2.6 The Care Coordinator or the Medical Center Liaison at the clinical site (refer to section 3.3) is primarily responsible for the orientation to Care Coordination (section 4.6.2), the Intake Assessment, the initial Adherence Assessment, and the Comprehensive Care Plan.

4.6.2.7 In addition to forms mentioned above in section 4.6.2.3, essential items will be documented on the Intake Assessment Form (Appendix R), the Comprehensive Care Plan (Appendix U) and the Adherence Assessment Form (Appendix S or T).
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 so as 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 service 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 documentation of other programs’/departments’ assessments.

5.1.2.3 The outcome of all relevant information gathered during the comprehensive assessment process is the Comprehensive Care Plan (Appendix U).

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 counts 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 S or T).

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 service (e.g., case manager) personnel have conducted such a review. See section 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 R), 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 Childcare responsibilities impacting daily routine.
- 5.4.1.3 Patient’s preferred language.
- 5.4.1.4 Outstanding criminal justice issues (parole, etc.).
- 5.4.1.5 General or health literacy impediments.
- 5.4.1.6 Social barriers to delivering services in the home such as the risk of family violence.

5.4.1.7 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.

5.4.1.8 Elements of the logistical assessment are documented on the following forms: Logistics for Navigator Form (Appendix P), Intake Assessment Form (Appendix R), Common Demographics Form (Appendix Q), and the Contact Information Form (Appendix O).

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 Section 5.0. The Comprehensive Care Plan generates a prospective calendar of care navigation activities and goals that
cover the period until the next regularly scheduled primary care visit.

6.1.2 The plan must be documented in writing with each part clearly specified as per the provided Comprehensive Care Plan Form (Appendix U). This Plan, as well as the Intake Assessment Form (Appendix R), identifies the ongoing intensity and frequency of care coordination and the level of health promotion services the patient will receive.

6.1.3 The full plan must have the signature of the Program staff completing it (typically, the Care Coordinator), and every item of the plan needs a prospective date attached to it and anticipated resources required.

6.1.4 The plan incorporates behavioral health, nursing, and other specialist and allied health professional plans as indicated. The interdisciplinary Comprehensive 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

6.2 Time Requirement: The Comprehensive Care Plan is completed within two weeks of enrollment to the Program and could/should 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 (including social services needs, clinical status, behavioral health details such as current drug use, both patient’s and PCP’s perspectives of the barriers to care and treatment) 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, the Care Coordinator or 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 were not assigned to the patient prior to the hand-off, the Program Director does so as soon as possible afterward.

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 protocol is
followed, all necessary steps are taken, and to explore the quality of care, e.g. what has been missed, how else can the patient be assisted?

6.3.2.1.2 These can 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 will meet with Navigator staff no less than once per week for the purpose of reviewing cases.

6.3.2.1.5 Navigators will select all cases with significant activity during the prior week for report at Care Coordinator reviews. All cases should be reviewed by the Care Coordinator at least once per quarter.

6.3.2.1.6 The Program Director will meet 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 will also review all cases in the portfolio once per quarter. This is discussed in section 12.0 (Quality Management) in detail.

6.3.3 Case conference

6.3.3.1 A case conference occurs any time a clinical evaluation – for example, a physician visit – generates new information that could impact the client’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 or client has active behavioral health problems, and the input of a mental health provider is required.

6.3.3.4.2 The patient or client 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 Care Coordination Case Conference Form (Appendix BB).

6.3.3.6 A formal case conference includes any case conference where all elements included on the Care Coordination Case Conference Form (Appendix BB) 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 Operational guidance

6.3.3.7.1 Ideally, case conferences are a structured, interdisciplinary meeting involving all parties providing direct service to the patient. Many clinical programs currently hold interdisciplinary team meetings once per week in order to ensure that all important patient care conversations can occur in timely fashion. Programs with network partners that are not co-located can 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.

6.3.3.7.2 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.

6.3.3.7.2.1 When there are no Care Coordination staff members on the premises, the PCP instead contacts the Care Coordinator at the conclusion of the visit to update him/her. This should occur rarely.
6.3.3.7.2.2. When a status change occurs outside the context of PCP evaluation, the Care Coordinator and/or the Navigator contact the PCP as soon as possible after they become aware of the status change. This should occur rarely.

6.3.3.7.2.3. If the medical provider already has a mechanism for interdisciplinary case conferences in place, the conversation may be deferred until the next meeting.

6.3.3.7.3 Each patient should be discussed at a case conference at least once per quarter.

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 can 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. Refer to Table 2 on page 41 for a description of intensity levels and Appendix F for criteria for transition. It is anticipated that the majority of patients will continue receiving weekly health promotion visits until s/he demonstrates clinical and behavioral improvements.

7.1.2 Intervention Types (refer to Tables 1 and 2 and Criteria for Transition in Appendix F)

- 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 While this is the ideal schedule, prior program experience has shown that some patients may need some additional time after enrollment to actually 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 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.

7.2.3 Patients prescribed ART are guided as per the curriculum in transferring their pills to a pill box as early as possible.

7.2.4 Care Navigation Activities
7.2.4.1 Patients in the Induction phase will receive health promotion interventions by a Patient Navigator at least once per week.

7.2.4.2 Patients in the Induction phase will be 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 assuring 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 Coordinator should tailor his or her approach according to patient successes and challenges.

7.2.5 Health Promotion
7.2.5.1 Health promotion activities are described in 2.2

7.2.5.2 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. The patient and Patient Navigator may decide together to prioritize conversations differently as well as postpone conversations to a later date.

7.2.5.3 ART pill counting is documented weekly on a suitable form that reflects expected, taken, and missed doses for each medication.
Table 1: Health Promotion in the *Induction* phase of Care Coordination

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

7.2.6 DOT

7.2.6.1 See section 2.4 for details.

7.3 Ongoing Care Coordination

7.3.1 Following the induction phase of the Care Coordination program, the patient will be served with respect to his or her level of need - high versus low intensity. 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

7.3.3.1 Ongoing care coordination services are administered until the case is closed (patient graduation).

7.3.4 Components

7.3.4.1 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 will be accompanied from their homes (or an alternative mutually-agreed upon location in the community) to all medical appointments. 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. The most 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 or her approach accordingly.

7.3.6 Health Promotion (See section 2.2)

7.3.6.1 Pill counting and documentation for patients taking antiretrovirals but not receiving DOT services is described in section 2.2.5.6 and on the Pill Box Log (Appendix Y or Z).

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 will assist the patient in overcoming these barriers.

<table>
<thead>
<tr>
<th>Intervention Intensity</th>
<th>Level subtypes</th>
<th>Intervention Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Intensity</strong></td>
<td></td>
<td></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) | | Health Promotion Curriculum: Delivered quarterly in conjunction with primary care visits and at any home visits. Suggested topics include:  
  • **Topic 1**: Introduction to the Health Promotion Curriculum (Core)  
  • **Topic 2**: Me and HIV (Core) |
<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Health Promotion Curriculum:</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Health Promotion Curriculum: Delivered quarterly 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</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Topic 3: Using a Pillbox (Core)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Topic 4: Handling your ART Medications (Core)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Topic 5: What is Adherence? (Core)</td>
<td></td>
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<td></td>
<td>Topic 6: Side Effects (Discretionary)</td>
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<tr>
<td></td>
<td>Topic 9: Adherence Strengths and Difficulties (Core)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accompaniment to PCP appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication Adherence: Quantitative measurement of adherence by self report in conjunction with PCP and home visits</td>
<td></td>
</tr>
<tr>
<td>High Intensity</td>
<td>Health Promotion Curriculum: Delivered monthly, generally in the patient’s home or other suitable site in the field. ALL health promotion curriculum topics are suggested.</td>
<td></td>
</tr>
<tr>
<td>C1</td>
<td>Accompaniment to PCP appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication Adherence: Pill counting monthly</td>
<td></td>
</tr>
<tr>
<td>C2</td>
<td>Health Promotion Curriculum: Delivered weekly, generally in the patient’s home or other suitable site in the field. ALL health promotion curriculum topics are suggested.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accompaniment to PCP appointments</td>
<td></td>
</tr>
<tr>
<td>Medication Adherence: Pill counting weekly</td>
<td>Health Promotion Curriculum:</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>D (limited to persons prescribed ART)</td>
<td>Delivered weekly, generally in the patient’s home or other suitable site in the field. ALL health promotion curriculum topics are suggested.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accompaniment to PCP appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication Adherence: DOT daily (M-F)</td>
<td></td>
</tr>
</tbody>
</table>

*Subtypes are described in Criteria for Transition (refer to Appendix F).

7.3.6.3 Decisions to scale back, maintain or intensify services

- 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 clinical decision include:
  - Behavioral – medication and care plan adherence;
  - Clinical – interval morbidity and laboratory data; and
  - Social/life stressor – for example, a new episode of homelessness.
- In most circumstances a patient exhibiting improvement at a point of clinical reassessment will step down one level of service while a patient with significant deterioration (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.
- The detailed criteria for movement between levels of service are laid out in Appendix F. These are guidelines and clinical nuance is warranted.
- Any changes in intensity of Care Coordination services (track change) should be logged via the Status Change Information Form (Track and Treatment Status) (Appendix DD).
  - 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 will count toward payment calculations. Identification of the new track in a Case Conference Form is not sufficient to affect payment.
- Patients with brief interruptions in their medication regimen (e.g. brief incarceration, rehabilitation, etc.)
should continue with the intensity service level (track). 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. Any medication interruptions should be noted on the Reassessment Form (Appendix CC) and the Status Change Information Form (Track and Treatment Status) (Appendix DD).

7.3.7 Social services and benefits assistance

7.3.7.1 Reassessment

- The Program will review the plan with regard to social services and benefits assistance twice per year, preferably coinciding with the patient’s primary care visits.
- A brief housing reassessment should be conducted at every regularly scheduled medical visit.
- Reassessment is documented on the Reassessment Form (Appendix CC).
- Programs are responsible for assisting with recertification for HASA and Human Resources Administration (HRA)\(^{32}\).
  - When assisting with recertification, the Program documents on the Reassessment Form (Appendix CC).

7.3.8 Directly Observed Therapy (DOT)

7.3.8.1 Refer to section 2.4 for details.

7.3.9 On-going Comprehensive Care Plan updates

7.3.9.1 The Care Coordinator meets with patients after each HIV primary care appointment to either create a new Comprehensive Care Plan or update the current Comprehensive Care Plan. This ensures that all issues and steps are re-evaluated, and prevents potentially confusing alterations to previously created sections. A new Comprehensive Care Plan must be created at least once per year.
  - The meeting should be held at the HIV primary care site so that the HIV PCP can participate in the meeting and can contribute any necessary documentation.

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.

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7.3.9.2.1 These changes are opportunities to probe the patient about other related circumstances and needs and may result in plan updates. Changes that may necessitate an assessment and plan update may include:

- Homelessness;
- Substance use binge;
- Any event that may require emotional support and counseling services;
- Patient decides to adjust goals or priorities.

7.3.9.3 Programmatic duplication checks are performed quarterly and the patient's status is updated accordingly. See section 4.6.1 for more details.

7.3.9.4 The Reassessment Form (Appendix CC) should be used to document the information collected during this process.

7.3.10 Key management points

7.3.10.1 Progress

- The patient has progressed, is ready to start treatment, and the provider can prescribe antiretrovirals.
- If indicated, the patient consents to DOT and the provider can prescribe ART.

7.3.10.2 Declination of ART despite indication

- The patient has engaged in the program but actively declines ART; declination of service warrants a general scaling back of the frequency of intervention, but the patient should regularly be encouraged to initiate ART.

7.3.10.3 Passive declination of services

- The patient has not substantially engaged in the program. If all efforts fail, it is preferable to scale back to intensity level Low B rather than disenroll the patient. Reasons should be explored as to why the patient declines services and the patient should be encouraged to accept the recommended level of services.

7.3.10.4 Progress toward graduation

- Although there is no time limit for duration of enrollment, it is anticipated that persons with indication for Low Intensity service will not require the service for more than one continuous year. Persons who perceive a sense of emotional attachment to the Care Coordinator or Patient Navigator should be
counseled and can always receive a referral to an affiliated community center with social support accommodations. Continued Program services described above should not however be necessary for prolonged periods.

7.3.10.5 Declination of appropriate level of service

- A patient may decline a higher level of service and therefore continue to receive a lower intensity service than clinically indicated. For example, a patient may have persistent viremia despite weekly health promotion, pill counting, and adherence to primary care encounters with accompaniment. The patient may decline DOT and therefore continue the current level of intervention.
  - When a patient declines a level of service, that level should be re-offered every time the patient has a primary care encounter if the indication continues.
  - The Program retains the clinical autonomy to determine that a service level lower than indicated is clinically ineffective and may disenroll a patient on this basis and refer to a more appropriate program such as mental health or harm reduction service.

7.3.10.6 Case closures and suspensions should be documented on the Status Change Information Form (Case Closure/Suspension) (Appendix EE) and entered into eSHARE in a timely manner.
  - 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 will count toward payment calculations. Identification of the new track in a Case Conference Form is not sufficient to affect payment.

7.3.11 Missed appointment procedure

7.3.11.1 Overview

- The Program monitors each patient’s scheduled calendar of Comprehensive Care Plan activities and documents the disposition of that activity on the same day of its occurrence.
- Missed appointments include missed daily DOT services or weekly health promotion sessions.

7.3.11.2 When a patient misses an appointment or fails to adhere to any part of the medical treatment plan:
  - A supervisor is notified;
• Missed appointment is documented on the Referrals/Appointments Tracking Log (Appendix V);
• 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 catch the patient when he or she is accessible;
• 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 content should be careful to avoid the inclusion of any information that might unwittingly disclose elements of the patient’s protected health information;
• The letter should express concern about the patient’s well being and ask them to contact or come to the Program;
• Internet-based searching for persons whose address may have changed is warranted at any point where phone and field outreach seem unproductive;
• Internet-based searching for persons whose address may have changed should be done at least once in the period between four and six weeks of the patient’s absence. Possible internet resources include, but are not limited to:
  o http://a072-web.nyc.gov/inmatelookup/
  o http://www.411.com/
  o http://www.intelius.com/
  o http://vitalrec.com/
  o http://ssdi.rootsweb.ancestry.com/
  o http://www.lexisnexis.com/terms/privacy/data/people.asp
  o http://www.zabasearch.com/
• A second, certified letter to the patient is necessary after two sequential months of failed outreach by phone and home visit. This letter should specify the patient’s case may be closed;
● Document outreach for client re-engagement activities on the Services Tracking Log (Appendix FF) and document appointment details and disposition on the Referrals/Appointments Tracking Log (Appendix V).

7.3.12 Other care interruptions – out of state care or prison

7.3.12.1 Any anticipated or actual absence from the program for more than three (3) months should lead to the patient’s suspension (with the start date being whenever they became inactive, e.g., became incarcerated 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 will be able to be suspended in eSHARE and easily resumed/reactivated without re-enrolling from the beginning.

7.3.12.2 If the patient is actually lost to care and/or has been unable to return to care for a prolonged period of time, i.e. more than six (6) months, he/she should be closed from the program officially. After being closed, he/she may still be re-enrolled, but will need to start from the beginning with Intake Assessment and the other activities that happen for a new patient being enrolled.

7.3.12.3 Case closures and suspensions should be documented on the Status Change Information Form (Case Closure/Suspension) (Appendix EE) and entered into eSHARE in a timely manner.

o 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 will count toward payment calculations. Identification of the new track in a Case Conference Form is not sufficient to affect payment.

7.4 Patient’s flow in clinical practice

7.4.1 Patients will likely cycle between interventions of varying intensity. Changes in the patient’s life causing some instability may lead to re-institution of DOT even after months or more of stability. On average, a cycle of DOT should last six (6) to nine (9) months. From there, if adherence was > 95%, the intervention is gradually scaled back until the patient is ready for self-administration of medications and graduation approximately twelve (12) months later.
8.0 Case Closure/Patient Graduation

8.1 Overview
8.1.1 Case closure occurs when the patient: (1) graduates; (2) voluntarily withdraws or declines treatment; (3) transfers medical care to a non-affiliated medical provider; (4) experiences difficulty achieving success; (5) is permanently lost to follow-up; or (6) is permanently unable to participate.

8.1.2 All case closures should be documented on the Status Change Information Form (Case Closure/Suspension) (Appendix EE) and the Comprehensive Care Plan Form (Appendix U).

8.2 Graduation
8.2.1 Graduation for patients not on ART therapy
8.2.1.1 Criteria for graduation:
- Self-sufficiency (e.g. seeks solutions to own needs, shows initiative, demonstrates expertise in navigating their health care services, etc.)
- Appointments are kept;
- Needed services are obtained;
- Major issues in the service plan have been resolved and client is adherent with team recommendations for care/treatment.

Note: If substance abuse and mental health issues emerge or re-emerge, then refer to appropriate program.33

8.2.2 Graduation for patients receiving ART therapy
8.2.2.1 Criteria for graduation include but are not limited to:
- Self-sufficiency (e.g. seeks solutions to own needs, shows initiative, demonstrates expertise in navigating their health care services, etc.)
- Appointments are kept;
- Needed services are obtained;
- Major issues in the service plan have been resolved and client is adherent with team recommendations for care/treatment;
- Developed sustainable social support network;
- Consistent medication adherence > 95%;
- Undetectable viral load, sustained for at least six months (three separate measures);
- Other clinical judgment;
- Patient agreement.

33 For a directory of Ryan White programs, refer to http://www.ryanwhitenyc.org/
8.2.3 PCP’s role after patients graduate from the Program

8.2.3.1 The PCP will continually assess the patient’s adherence to the treatment plan, clinical status and behavioral issues that may affect successful treatment of HIV.

8.2.3.2 If appropriate, the PCP may refer the patient back to the Program.

8.3 Voluntary withdrawal or declination of treatment

8.3.1 A patient may decline further service at any time. If a patient chooses permanent disenrollment from the program the patient may continue to receive primary care at the HIV primary care site.

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

8.3.2.1 If an attempt to encourage continued engagement with the patient is not successful, the Program will:
- Notify the HIV PCP of the decision;
- Disenroll the patient from the Program;
- Document the termination of services on the Status Change Information Form (Case Closure/Suspension) (Appendix EE) and close the case as refused;
- If the patient is amenable, referral to a similar program should be offered.

8.3.3 Lateral transfer – A patient may request transfer to another care coordination program in conjunction with a change in primary care provider.

8.3.3.1 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 will subsequently receive care coordination services within the system of the accepting facility.

8.3.3.2 The Program must coordinate such transfer with the current clinical provider, with the patient’s written consent, and assist in transfer of the patient’s medical records and transfer of care coordination records.

8.3.3.2.1 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 close their medical records and transfer the records.
Follow the steps outlined in section 8.3.2.1.

8.3.3.3 The patient’s case remains open at the referring Program until the accepting Program acknowledges receipt of the relevant records and the patient’s first appointment. At that point the Program closes the record.

8.3.3.4 When a patient misses an appointment in the interval between a Program’s referral of a transfer and the closure of the case, it is the responsibility of the referring Program to support the patient to keep all appointments; however, if the Program receives a referral it must continue outreach to the patient to complete the referral.

8.3.3.5 Document transfer to new program provider on the Status Change Information Form (Case Closure/Suspension) (Appendix EE).

8.4 Patient not benefiting from Program
8.4.1 If a patient is not benefiting from enrollment in the Program, not improving, or not adherent with the plan then refer the patient to a more appropriate program such as drug treatment, residential care or adult day care.

8.5 Permanent loss to follow-up
8.5.1 All efforts have been made to locate the patient and patient has not been located after two sequential months of outreach, as described in section 7.3.11.
8.5.2 Inactivate (suspend) the primary care and care coordination records.

8.6 Permanently unable to participate
8.6.1 Close the patient’s record if the patient is permanently unable to participate, reasons may include:
- Death;
- Long term incarceration (>6 months) or commitment to other institution; or
- Moved out of area.

<table>
<thead>
<tr>
<th>9.0 Outreach to Return Persons to Primary Care (RTC)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>9.1 Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1.1 The primary care roster must be reviewed at Program onset to identify persons whose care might have lapsed (this means missed appointments) and must be reviewed, at a minimum, every three months thereafter. This is to ensure that RTC procedures are</td>
</tr>
</tbody>
</table>
conducted for patients who may have been lost to follow-up in the intervening quarter (despite the missed appointment procedure).

- **Initial RTC:**
  - Review the primary care roster to list all patients with a primary care visit at the health facility in the last 2 years but not in the last nine months.

- **Quarterly RTC:**
  - Review those with missed appointments or who are failing treatment based on laboratory parameters in the last quarter and for whom 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 Provider 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 section 4.1.3), 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 an outreach case 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 known to have moved elsewhere by talking to the PCP or other PCP team members. DOHMH has created a Return to Care Tracking Tool in Microsoft Excel to maintain a log of Lost to Care outreach activities and disposition. Contact your DOHMH Project Officer to receive this tracking tool electronically.

### 9.4 Outreach activities
9.4.1 Outreach activities proceed as described above in Section 7.3.11.
9.4.2 Internet searching should be performed earlier in the sequence of outreach activities.
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 will:
• Receive written consent from the patient prior to releasing information to the other program.
• 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 consent for release of medical information.
• Dispose of the patient’s record accordingly and inform the primary care provider that the record can be closed.

9.4.6 For PLWHA not engaged in medical care elsewhere and willing to return the Program will:
• Make an appointment;
• Offer accompaniment; and
• Provide high intensity services.

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 consent from patient prior to releasing patient information.
• Arrange transfer of the patient’s medical and Program record to the new provider (if needed or not done by PCP) including information about the recent unexpected discontinuity of care.
• Maintain the patient on inactive status at the PCP and update patient’s disposition periodically as warranted.

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 to release medical information.
• Update the patient’s record accordingly and inform the primary care provider that the record can be closed.

9.4.9 For PLWHA not located (after two months)
• Follow the case closure procedure outlined in section 8.0.

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

9.4.11 Outreach and patient finding activities should be documented via the Services Tracking Log (Appendix FF) as well as the Return to Care Tracking Tool developed in Microsoft Excel by DOHMH. Contact your DOHMH Project Officer to receive this tracking tool electronically.
10.0 Preventing Further HIV Transmission in the Context of HIV Care

10.1 It is expected that every patient have an assessment of HIV risk behavior (including sex) regularly. If this is not available in the patient's medical chart at the time of the safer sex health promotion topic, then the Program will conduct an assessment immediately prior to the beginning this health promotion topic, and at least every six months from then on. Regular assessment of HIV risk behavior is necessary as individual's social and environmental situations often change. Elements of the sexual and behavioral health assessment are included in the Intake Assessment Form (Appendix R) and the Reassessment Form (Appendix CC).

10.1.1 Condoms should be available to patients; for example, Patient Navigators conducting safer sex education in the field should carry condoms for patients who request them.


10.2 If a patient, in the course of the assessment of risk, discloses an HIV negative sex and/or needle sharing partner, the Program should attempt to elicit the names and contact information of these partners and refer partners to the NYC DOHMH Contact Notification Assistance Program (CNAP) or the HIV Epidemiology and Field Services Unit (FSU).

10.2.1 CNAP can be reached at (212) 693-1419.

10.2.2 Providers from one of the participating FSU facilities (Appendix E) can be reached at (212) 442-6577.

11.0 HIV Patient Confidentiality

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

12.0 Quality Management

12.1 Expectations

12.1.1 The Program’s parent organization and all affiliate organizations are expected to maintain quality management protocols and conduct quality management programs in accordance with the standards of their accrediting organization.

12.1.2 The Program Director is responsible for developing suitable case review protocols, including format and content of case reviews, and developing appropriate quality management reports.

12.1.3 Quality Assurance Chart Review
12.1.3.1 All charts must be reviewed once per quarter by the Program Director with the Care Coordinator and the Navigator.

12.1.3.2 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>

12.1.4 As part of quality management, appointment keeping for patients who graduated should be monitored.

12.1.5 All affiliated PCPs must participate in the statewide Health HIV Quality of Care Program (HIVQUAL).\(^{34}\)

12.1.6 Care Coordination Programs funded by Ryan White Part A must participate in the NYC DOHMH quality management program funded under Part A of the Ryan White Treatment Modernization Act.\(^{35}\)

12.2 Grievances

12.2.1 Each agency must have an established grievance procedure.

12.2.2 Grievances should be reviewed on a monthly basis to ensure they have been appropriately addressed.

13.0 Training Requirements

13.1 DOHMH will provide periodic Train-the-Trainer resources for all aspects of Care Coordination Programs funded through Ryan White Part A.

13.2 All Program personnel should receive at least two weeks of intensive training as a component of their initial Program orientation.

13.2.1 Staff should receive basic work and supervisory management trainings as required by their duty.

\(^{34}\) For more information, refer to \[http://www.hivguidelines.org/Content.aspx?PageID=51\]

\(^{35}\) For more information, refer to \[http://nationalqualitycenter.org\]
13.3 Additional training should be provided by Program Directors no less than once per month. Examples of suitable training topics include patient confidentiality, treatment adherence, motivational interviewing, vicarious trauma, condom application and use, etc.

### 14.0 Monitoring Care Coordination Activities by NYC DOHMH

#### 14.1 Minimum elements for reporting

14.1.1 Patient descriptors and socio-demographic characteristics.
14.1.2 Clinical history and current status.
14.1.3 Completion of Comprehensive Care Plan Form (Appendix U).
14.1.4 Care plan outcomes (e.g. appointments kept) [eSHARE Phase II].
14.1.5 Intervention intensity, i.e. service track level.
14.1.6 Provision of services including health promotion, DOT and logistical support services.

#### 14.2 Detailed reporting specifications

14.2.1 Funded Care Coordination providers are responsible for documenting all required data elements (as specified and occasionally adjusted by DOHMH and HRSA) and entering data in eSHARE for all fields required for data entry.

14.2.2 Reporting requirements include maintaining the specified schedules of updates for data elements being tracked historically over time (e.g., quarterly reassessments).
APPENDIX A – 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 B – 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 service provider providing child care to children of patients receiving medical case management services at the same premises. The medical or social service 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 remains 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 C – 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
APPENDIX D – New York State Authorized Syringe Exchange and Selected Sterile Syringe Access Programs in New York City

36 This list is updated frequently and can be found at http://www.nyc.gov/html/doh/downloads/pdf/basas/syringe_exchange.pdf?b=2
<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Zip Code</th>
<th>Phone</th>
<th>Organization</th>
<th>Address</th>
<th>Days &amp; Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronx</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mott Haven</td>
<td>10451</td>
<td>718.392.7718</td>
<td>CHWIDE Harm Reduction</td>
<td>265 East 14th Street (behind Lincoln Hospital)</td>
<td>M T W Th F Sa Su</td>
</tr>
<tr>
<td></td>
<td>10451</td>
<td>718.395.5544</td>
<td>St. Ann's Corner of Harm Reduction</td>
<td>1010 Walton Avenue, Suite 201 (at 140th Street)</td>
<td>9a-6p</td>
</tr>
<tr>
<td></td>
<td>10454</td>
<td>718.395.5544</td>
<td>St. Ann's Corner of Harm Reduction</td>
<td>168th Street and St. Ann's Avenue</td>
<td>10a-2p</td>
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<tr>
<td></td>
<td>10454</td>
<td>718.395.5544</td>
<td>St. Ann's Corner of Harm Reduction</td>
<td>168th Street and Bergen Avenue</td>
<td>10a-2p</td>
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<tr>
<td></td>
<td>10456</td>
<td>718.642.6605</td>
<td>New York Harm Reduction Educators</td>
<td>168th Street and Bergen Avenue</td>
<td>10a-2p</td>
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<tr>
<td>Huts' Point</td>
<td>10476</td>
<td>718.642.6605</td>
<td>New York Harm Reduction Educators</td>
<td>Garrison Street (between Irene and Hunts Point)</td>
<td>2p-5p</td>
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<tr>
<td>Soundview</td>
<td>10475</td>
<td>718.642.6605</td>
<td>New York Harm Reduction Educators</td>
<td>Corner of Ward Avenue and Watson Avenue</td>
<td>15p-43p</td>
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<td>Morrisania</td>
<td>10457</td>
<td>718.292.3733</td>
<td>PROSTO</td>
<td>Bryant Avenue and 107th Street</td>
<td>12p-230p</td>
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<tr>
<td>Crotona-Tremont</td>
<td>10457</td>
<td>718.292.3733</td>
<td>PROSTO</td>
<td>Third Avenue between East Tremont and Cross Bronx Expressway</td>
<td>8a-6p</td>
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<tr>
<td>University Heights</td>
<td>10453</td>
<td>718.642.6605</td>
<td>New York Harm Reduction Educators</td>
<td>Jerome Avenue and Clinton Place (southwest corner)</td>
<td>3p-7p</td>
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<td>Brooklyn</td>
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<tr>
<td>Buaron Hill</td>
<td>11517</td>
<td>646.785.2019</td>
<td>MYCAHN / VOCAL</td>
<td>646 Fourth Avenue (between Bergen &amp; St. Marks)</td>
<td>M T W Th F Sa Su</td>
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<tr>
<td>Bedford Stuyvesant</td>
<td>11036</td>
<td>718.292.3733</td>
<td>PROSTO</td>
<td>Delson Avenue (between Fulton and Front Street)</td>
<td>M T W Th F Sa Su</td>
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<td>Bushwick</td>
<td>11207</td>
<td>718.573.3358</td>
<td>Pandy Services Network of New York</td>
<td>766 Broadway</td>
<td>M T W Th F Sa Su</td>
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<tr>
<td>Williamsburg</td>
<td>11211</td>
<td>718.292.3733</td>
<td>PROSTO</td>
<td>South 5th Street and Mercury Avenue</td>
<td>1p-30p</td>
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<td>East New York</td>
<td>11312</td>
<td>718.456.9474</td>
<td>Pandy Services Network of New York</td>
<td>6th Mother Gaston Boulevard</td>
<td>M T W Th F Sa Su</td>
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<td>Coney Island</td>
<td>11314</td>
<td>718.292.3733</td>
<td>PROSTO</td>
<td>West 32nd Street and Surf Avenue</td>
<td>1030a-5p</td>
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<tr>
<td>Port Richmond</td>
<td>10302</td>
<td>718.693.1344</td>
<td>Community Health Action of Staten Island</td>
<td>Port Richmond Avenue and Harrison Avenue</td>
<td>12p-3p</td>
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<td>Stapleton</td>
<td>10304</td>
<td>718.806.1344</td>
<td>Community Health Action of Staten Island</td>
<td>283 Van Duzer Street (corner of Beach St.)</td>
<td>12p-3p</td>
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<td>Parkhill</td>
<td>10304</td>
<td>718.806.1344</td>
<td>Community Health Action of Staten Island</td>
<td>Tompkin Avenue and Tompkin Street (alternating weekends)</td>
<td>1p-6p</td>
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<tr>
<td>New Brighton</td>
<td>10310</td>
<td>718.806.1344</td>
<td>Community Health Action of Staten Island</td>
<td>2nd Avenue and Jersey Street (alternating weekends)</td>
<td>430p-730p</td>
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<td>Community Health Action of Staten Island</td>
<td>Easton Avenue and Broadway (alternating weekends)</td>
<td>430p-730p</td>
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<td>Manhattan</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Washington Heights</td>
<td>10503</td>
<td>212.484.7718</td>
<td>CHWIDE Harm Reduction - SRO Residents only</td>
<td>917.504.9931 (Eng)</td>
<td>917.504.9931 (Eng)</td>
</tr>
<tr>
<td>East Harlem</td>
<td>10029</td>
<td>718.642.6605</td>
<td>New York Harm Reduction Educators</td>
<td>109th Street (between Lexington and 3rd Avenue)</td>
<td>917.504.9931 (Eng)</td>
</tr>
<tr>
<td>Central Harlem</td>
<td>10035</td>
<td>718.292.3733</td>
<td>PROSTO</td>
<td>109th Street and Park Avenue</td>
<td>10a-330p</td>
</tr>
<tr>
<td>Upper West Side</td>
<td>10035</td>
<td>718.642.6605</td>
<td>New York Harm Reduction Educators</td>
<td>936th Street (between 2nd and 3rd Avenue)</td>
<td>9a-1p</td>
</tr>
<tr>
<td>Midtown</td>
<td>10016</td>
<td>718.403.9304</td>
<td>Positive Health Project</td>
<td>301 West 37th Street, 3rd floor</td>
<td>12p-5p</td>
</tr>
<tr>
<td>West Village</td>
<td>10018</td>
<td>718.403.9304</td>
<td>Positive Health Project - Transgender only</td>
<td>301 West 27th Street, 3rd floor</td>
<td>4p-730p</td>
</tr>
<tr>
<td>East Village</td>
<td>10019</td>
<td>212.678.3427</td>
<td>Positive Health Project - Transgender only</td>
<td>944 West 37th Street</td>
<td>4p-730p</td>
</tr>
<tr>
<td>Queens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jamaica</td>
<td>11403</td>
<td>718.672.0600</td>
<td>AIDS Center of Queens County</td>
<td>167-23 Archer Avenue (auto shop parking lot)</td>
<td>11a-3p</td>
</tr>
<tr>
<td>Long Island City</td>
<td>11011</td>
<td>718.672.0600</td>
<td>AIDS Center of Queens County</td>
<td>6-37 Hunter Street, 3rd floor</td>
<td>6p-10p</td>
</tr>
<tr>
<td>Far Rockaway</td>
<td>11691</td>
<td>718.672.0600</td>
<td>AIDS Center of Queens County</td>
<td>151-20 Beach 2nd Street, south of Mott Avenue</td>
<td>11a-3p</td>
</tr>
</tbody>
</table>
**APPENDIX E – BHIV Field Services Unit (FSU) Participating Facilities**

Currently, FSU staff members are based at nine medical facilities and also receive reports from their affiliated clinics and medical providers for HIV case investigation and partner services. FSU staff members are also based at Rikers Island and receive reports from the New York City correctional system. In addition, the DOHMH Bureau of Tuberculosis Control refers HIV-infected persons diagnosed at their chest centers to FSU for partner elicitation and linkage to care. The following are the non-DOHMH participating facilities.

<table>
<thead>
<tr>
<th>BRONX</th>
<th>BRONX</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bronx AIDS Services</strong></td>
<td><strong>Bronx AIDS Services</strong></td>
</tr>
<tr>
<td>540 East Fordham Road</td>
<td>953 Southern Boulevard</td>
</tr>
<tr>
<td>Bronx, NY 10458</td>
<td>Bronx, NY 10459</td>
</tr>
<tr>
<td>(718) 295-5605</td>
<td>(718) 295-5690</td>
</tr>
<tr>
<td><strong>Bronx Lebanon Hospital Center</strong></td>
<td><strong>Casa Promesa</strong></td>
</tr>
<tr>
<td>1650 Selwyn Avenue</td>
<td>308 East 175th Street</td>
</tr>
<tr>
<td>Bronx, NY 10456</td>
<td>Bronx, NY 10457-5804</td>
</tr>
<tr>
<td>(718) 590-1800</td>
<td>(718) 960-7600</td>
</tr>
<tr>
<td><strong>Citiwide Harm Reduction</strong></td>
<td><strong>Community Healthcare Network</strong></td>
</tr>
<tr>
<td>226 East 144th Street</td>
<td>975 Westchester Avenue</td>
</tr>
<tr>
<td>Bronx, NY 10451</td>
<td>Bronx, NY 10459</td>
</tr>
<tr>
<td>(718) 292-7719</td>
<td>(718) 320-4466</td>
</tr>
<tr>
<td><strong>Hispanic AIDS Forum</strong></td>
<td><strong>HHC Jacobi Medical Center</strong></td>
</tr>
<tr>
<td>975 Kelly Street, 4th Floor</td>
<td>1400 Pelham Parkway South</td>
</tr>
<tr>
<td>Bronx, NY 11459</td>
<td>Bronx, NY 10461</td>
</tr>
<tr>
<td>(718) 328-4188</td>
<td>(718) 918-5000</td>
</tr>
<tr>
<td><strong>HHC Lincoln Medical and Mental Health Center</strong></td>
<td><strong>HHC North Central Bronx Hospital</strong></td>
</tr>
<tr>
<td>234 E 149th Street</td>
<td>3424 Kossuth Avenue</td>
</tr>
<tr>
<td>Bronx, NY 10451</td>
<td>Bronx, NY 10467</td>
</tr>
<tr>
<td>(718) 579-4815</td>
<td>(718) 519-5000</td>
</tr>
<tr>
<td><strong>Medalliance – Fordham</strong></td>
<td><strong>Medalliance – South Bronx</strong></td>
</tr>
<tr>
<td>625 East Fordham Rd</td>
<td>518 E. 149th Street</td>
</tr>
<tr>
<td>Bronx, NY 10458</td>
<td>Bronx, NY 10455</td>
</tr>
<tr>
<td>(718) 933-1900</td>
<td>(718) 933-1900</td>
</tr>
<tr>
<td><strong>Montefiore Medical Center</strong></td>
<td><strong>Morris Heights Health Center</strong></td>
</tr>
<tr>
<td>111 E 210th Street</td>
<td>625 East 137th Street</td>
</tr>
<tr>
<td>Bronx, NY 10467</td>
<td>Bronx, NY 10454</td>
</tr>
<tr>
<td>(718) 920-4828</td>
<td>(718) 401-6578</td>
</tr>
<tr>
<td><strong>Morris Heights Health Center</strong></td>
<td><strong>Morris Heights Health Center</strong></td>
</tr>
<tr>
<td>85 West Burnside</td>
<td>Health Connections</td>
</tr>
<tr>
<td>Bronx, NY 10453</td>
<td>2042 Grand Avenue</td>
</tr>
<tr>
<td>(718) 716-4400</td>
<td>Bronx, NY 10453</td>
</tr>
<tr>
<td><strong>Morris Heights Health Center</strong></td>
<td>(718) 483-1259</td>
</tr>
<tr>
<td>Walton</td>
<td><strong>Morris Heights Health Center</strong></td>
</tr>
<tr>
<td>25 East 183rd Street</td>
<td>Women’s Health &amp; Birthing Pavilion</td>
</tr>
<tr>
<td>Bronx, NY 10453</td>
<td>70 West Burnside Avenue</td>
</tr>
<tr>
<td>(718) 839-8900</td>
<td>Bronx, NY 10453</td>
</tr>
<tr>
<td><strong>St. Barnabas Hospital</strong></td>
<td>(718) 716-BABY (2229)</td>
</tr>
<tr>
<td>4422 Third Avenue</td>
<td></td>
</tr>
<tr>
<td>Bronx, NY 10457</td>
<td></td>
</tr>
<tr>
<td>(718) 960-9000</td>
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</tr>
</tbody>
</table>
### BROOKLYN

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brookdale University Hospital</td>
<td>One Brookdale Plaza, Brooklyn, NY 11212</td>
<td>(718) 240-5000</td>
</tr>
<tr>
<td>Beth Israel Medical Center Kings Highway Division</td>
<td>3201 Kings Highway, Brooklyn, NY 11234</td>
<td>(718) 252-3000</td>
</tr>
<tr>
<td>Community Healthcare Network CABS Health Center</td>
<td>94-98 Manhattan Avenue, Brooklyn, NY 11206</td>
<td>(718) 386-0390</td>
</tr>
<tr>
<td>Community Healthcare Network Caribbean House Health Center</td>
<td>1167 Nostrand Avenue, Brooklyn, NY 11225</td>
<td>(718) 778-0198</td>
</tr>
<tr>
<td>Community Healthcare Network Dr. Betty Shabazz Health Center</td>
<td>999 Blake Avenue, Brooklyn, NY 11208</td>
<td>(718) 277-8303</td>
</tr>
<tr>
<td>HHC Coney Island Hospital</td>
<td>2601 Ocean Parkway, Brooklyn, NY 11235</td>
<td>(718) 616-3000</td>
</tr>
<tr>
<td>HHC Cumberland Diagnostic and Treatment Center</td>
<td>100 North Portland Avenue, Brooklyn, NY 11205</td>
<td>(718) 260-7500</td>
</tr>
<tr>
<td>HHC Woodhull Medical Center</td>
<td>760 Broadway, Brooklyn, NY 11206</td>
<td>(718) 963-8000</td>
</tr>
<tr>
<td>Lutheran Medical Center</td>
<td>150 55th Street, Brooklyn, NY 11220</td>
<td>718-630-7000</td>
</tr>
<tr>
<td>SONY Downstate Medical Center</td>
<td>445 Lenox Road, Brooklyn, NY 11203</td>
<td>(718) 270-1000</td>
</tr>
<tr>
<td>Wyckoff Heights Medical Center</td>
<td>374 Stockholm Street, Brooklyn, NY 11237</td>
<td>718-963-7272</td>
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### MANHATTAN

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth Israel Medical Center First Avenue at 16th Street</td>
<td>New York, NY 10003</td>
<td>212-420-2000</td>
</tr>
<tr>
<td>Community Healthcare Network Community League Health Center</td>
<td>1996 Amsterdam Avenue, New York, NY 10032</td>
<td>(212) 781-7979</td>
</tr>
<tr>
<td>Community Healthcare Network Downtown Health Center</td>
<td>150 Essex Street, New York, NY 10002 (Lower East Side)</td>
<td>(212) 477-1120</td>
</tr>
<tr>
<td>Community Healthcare Network Helen B. Atkinson Health Center</td>
<td>81 West 115th Street, New York, NY 10026 (Harlem)</td>
<td>(212) 426-0088</td>
</tr>
<tr>
<td>GMHC</td>
<td>446 West 33 Street, New York, NY 10001</td>
<td>(212) 367-1100</td>
</tr>
<tr>
<td>HHC Harlem Hospital Center</td>
<td>506 Lenox Avenue, New York, NY 10037</td>
<td>(212) 939-8202</td>
</tr>
<tr>
<td>Hispanic AIDS Forum</td>
<td>213 West 35th Street, 12th Floor, New York, NY 10001</td>
<td>(212) 868-6230</td>
</tr>
<tr>
<td>Institute for Family Health Family Health Center at North General</td>
<td>1879 Madison Avenue (at 122nd Street), New York, NY 10035</td>
<td>(212) 423-4500</td>
</tr>
</tbody>
</table>
Institute for Family Health
Sidney Hillman Family Practice
16 East 16th Street
New York, NY 10003-3105
(212) 924-7744

Mount Sinai Medical Center
One Gustave L. Levy Place
New York, NY 10029
212-241-6500

New York Presbyterian Hospital
622 W 168th Street
New York, NY 10032
(212) 305-2000

St. Luke’s-Roosevelt Hospital Center
Roosevelt Hospital Division
1000 Tenth Avenue
New York, NY 10019
(212) 523-4000

St. Luke’s-Roosevelt Hospital Center
St. Luke’s Hospital Division
1111 Amsterdam Avenue
New York, NY 10025
(212) 523-4000

**QUEENS**

AIDS Center of Queens County
Far Rockaway
1600 Central Avenue
Far Rockaway, NY 11691
(718) 868-2895

AIDS Center of Queens County
Jamaica
175-61 Hillside Avenue, 2nd Floor
Jamaica, NY 11432
(718) 739-2525

AIDS Center of Queens County
Rego Park
161-21 Jamaica Avenue, 6th Floor
Jamaica, NY 11432
(718) 896-2500

Community Healthcare Network
Long Island City Health Center
36-11 21st Street
Queens, NY 11106
(718) 482-7772

Community Healthcare Network
Queens Health Center
97-04 Sutphin Blvd
Queens, NY 11435 (Jamaica)
(718) 657-7088

HHC Elmhurst Hospital
79-01 Broadway
Elmhurst, NY 11373
(718) 334-4000

HHC Queens Hospital Center
82-70 164th St
Queens, NY 11432
(718) 883-3000

Jamaica Hospital Medical Center
8900 Van Wyck Expressway
Jamaica, NY 11418
(718) 206-6000

Mount Sinai Medical Center
Queens Division
25-10 30th Avenue
Queens, NY 11102
(718) 932-1000

Rikers Island
15-15 Hazen Street
East Elmhurst, NY 11370
(718) 546-4550

<table>
<thead>
<tr>
<th>REGIONAL DOHMH FSU MANAGERS</th>
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<tbody>
<tr>
<td><strong>Region</strong></td>
</tr>
<tr>
<td>Manhattan</td>
</tr>
<tr>
<td>Bronx</td>
</tr>
<tr>
<td>Brooklyn/Queens</td>
</tr>
</tbody>
</table>

37 Never use email to transmit confidential and/or protected patient health information.
<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>Low Intensity - A</td>
<td>Needs navigation support on behavioral grounds and needs continued health promotion(^{38})</td>
<td>N/A</td>
<td>N/A</td>
<td>Starting ART</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Low Intensity - B</td>
<td>ART is discontinued indefinitely.</td>
<td>Undetectable VL AND Treatment Adherence &gt;90% AND no clinical or behavioral complications OR patient has been at this level for less than 75 days(^1)</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 onset of substance abuse OR new opportunistic infection</td>
<td></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;/=6 months on the same treatment, without more effective</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 onset of substance abuse OR new opportunistic infection</td>
<td></td>
</tr>
</tbody>
</table>

\(^{38}\) 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>
<td></td>
</tr>
</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.

iii. 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.

iv. 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.

v. 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 G – 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&lt;br&gt;• Initial adherence assessment&lt;br&gt;• Goal setting&lt;br&gt;• Comprehensive Care Plan&lt;br&gt;• 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&lt;br&gt;• 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&lt;br&gt;• Understand what adherence means for them&lt;br&gt;• Understand and demonstrate ability to incorporate medication regimen into daily routine</td>
</tr>
<tr>
<td>6. Side Effects (Discretionary)</td>
<td>• Understand side effects of medications prescribed to patient&lt;br&gt;• 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&lt;br&gt;• Understand the immune system, CD4 count and HIV viral load&lt;br&gt;• Understand opportunistic infections</td>
</tr>
<tr>
<td>8. Identifying and Building Social support networks (Core)</td>
<td>• Map a non-Program social support network&lt;br&gt;• Understand how to contact identified support people&lt;br&gt;• Comprehend the role of his/her doctors&lt;br&gt;• Understand what kind of support he/she can expect from each of these people</td>
</tr>
<tr>
<td>9. Adherence strengths and difficulties (Core)</td>
<td>• Identify 3 areas of strength in adherence based on time in health promotion&lt;br&gt;• 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&lt;br&gt;• Develop a plan for preparing for appointments&lt;br&gt;• Manage a list of medical providers and their contact information&lt;br&gt;• Demonstrate how to schedule appointments</td>
</tr>
<tr>
<td>Health Promotion Topic</td>
<td>Learning Objectives</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Understand how to coordinate transportation to all relevant appointments</td>
<td></td>
</tr>
<tr>
<td>11. Health maintenance (Discretionary)</td>
<td>• Introduction to health maintenance</td>
</tr>
<tr>
<td></td>
<td>• Routine questions and answers at the doctor’s office</td>
</tr>
<tr>
<td></td>
<td>• Roles of different service providers</td>
</tr>
<tr>
<td>12. Harm Reduction – Sexual Behavior (Discretionary)</td>
<td>• Understand harm reduction and the importance of safe sex</td>
</tr>
<tr>
<td></td>
<td>• Understand risks associated with various sexual behavior</td>
</tr>
<tr>
<td></td>
<td>• Identify a plan for safer sex practices</td>
</tr>
<tr>
<td>13. Harm Reduction – Substance Use (Discretionary)</td>
<td>• Understand strategies for reducing health risks when using substances.</td>
</tr>
<tr>
<td></td>
<td>• Develop a plan for staying adherent to ART when using substances</td>
</tr>
<tr>
<td></td>
<td>• Know how to access available resources</td>
</tr>
<tr>
<td>14. Harm Reduction – Safety in Relationships (Discretionary)</td>
<td>• What is harm reduction</td>
</tr>
<tr>
<td></td>
<td>• Healthy Relationships</td>
</tr>
<tr>
<td></td>
<td>• Identifying Safe/Unsafe situations</td>
</tr>
<tr>
<td></td>
<td>• Personal Safety Plan</td>
</tr>
<tr>
<td>15. Healthy Living: Diet and Exercise (Discretionary)</td>
<td>• Healthy eating assessment</td>
</tr>
<tr>
<td></td>
<td>• Why does eating health matter for HIV</td>
</tr>
<tr>
<td></td>
<td>• Food safety</td>
</tr>
<tr>
<td></td>
<td>• Setting healthy eating goals</td>
</tr>
<tr>
<td>16. Wrap Up</td>
<td>• Review Patient Workbook tools</td>
</tr>
<tr>
<td></td>
<td>• Review goals</td>
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</table>
# APPENDIX H – 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>Program Director</td>
<td>• Provides oversight and management of the program.</td>
<td>• MPH, MSW, MPA, or MBA OR • BSN, PA, NP with formal managerial training OR • Other relevant Master’s degree with formal managerial training • AND 3+ years experience managing services similar to those described in RFP</td>
<td>Care Coordinator</td>
<td>Agency Decision</td>
</tr>
<tr>
<td>Care Coordinator</td>
<td>• Responsible for implementation of the service plan, supported by Patient Navigators.</td>
<td>• BA/BS, LMSW/LCSW/ LMHC or RN/LPN degree • AND at least 2+ years of case management experience</td>
<td>Patient Navigators</td>
<td>Program Director</td>
</tr>
<tr>
<td>Patient Navigators</td>
<td>• Carries out tasks that are needed to execute the medical and support service plans, including the following: • Accompanies patients to appointments when required. • Provides coaching to patients. • Delivers monthly or weekly health promotion encounters. • Performs entitlements reassessment. • Coordinates logistics for plan adherence – reminders, transportation and childcare arrangements.</td>
<td>• High school degree or some college education. • Should have strong socio-cultural identification with the target population. • Strongly discourage the hiring of actively enrolled patients from the program or partner medical provider to protect patient confidentiality.</td>
<td>None</td>
<td>Care Coordinator</td>
</tr>
<tr>
<td>Staff Title</td>
<td>Function</td>
<td>Recommended Minimum Credentials</td>
<td>Supervises:</td>
<td>Supervised by:</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>
| Medical Center Liaison 39   | • Facilitates communication about patient management between primary care providers and Care Coordinators.  
  • Forwards data reports (e.g., appointment dispositions, laboratory results, etc.) produced by clinical information systems to Care Coordinators.  
  • Participates in the generation of and collates the treatment plan and forwards to Care Coordinators.  
  • Collaborates with the clinical team to manage care coordination resources and target the neediest PLWHA for service.  
  • May conduct selected center-based care coordination activities such as health promotion for low-intensity PLWHA as needed. | • BA/BS, LMSW/LCSW/ LMHC or RN/LPN degree  
  • AND at least 2+ years of case management experience  
  • OR current satisfactory employment at the site of the medical provider as a case manager or social worker. | None                       | Medical Facility Decision |
| DOT Specialist – Health Center | • Provides clinic-based DOT. | • BSN, LPN or RN, unlicensed MD, or another staff member with medical background | None                       | Program Director |
| DOT Specialist – Field      | • Responsible for field-based daily DOT.  
  • Field based DOT includes DOT delivered in the home, CBO, work or any other location that is convenient for PLWHA. | • High school degree or some college education.  
  • Should have strong socio-cultural identification with the target population.  
  • Strongly discourage the hiring of actively enrolled patients from the program or partner medical provider to protect patient confidentiality. | None                       | Care Coordinator |
| Medical Provider            | • Provides HIV outpatient "bridge" medical care to patients served by agencies providing activity 9. | • NYS-licensed medical provider (MD, DO, NP, PA,) | None                       | Agency Decision     |

39 This position is intended for affiliation arrangements where the medical organization cannot arrange dedicated co-location of services and is not the applying agency.
APPENDIX I – Pre-Referral to CC Program Form
**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: )

<table>
<thead>
<tr>
<th>What is the client’s primary language?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the client’s current home address:</td>
</tr>
<tr>
<td>What is the client’s primary telephone number? (_______) _______ - ____________</td>
</tr>
<tr>
<td>What is the client’s alternate telephone number? (_______) _______ - ____________</td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date: m m / d d / y y</th>
</tr>
</thead>
</table>

### Primary Care Provider (PCP) Receiving Form:

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date: m m / d d / y y</th>
</tr>
</thead>
</table>
APPENDIX J – PCP Referral Disposition Form
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 toCare 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: / / mm/dd/yyyy

CC Staff Member Receiving Form:

Name

Signature

Date: / / mm/dd/yyyy
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:*
  
  ____________________________________________
  
  ____________________________________________

<table>
<thead>
<tr>
<th>CC Staff Member Completing Section:</th>
<th>Name</th>
<th>Signature</th>
<th>Date:</th>
<th>m m / d d / y y</th>
</tr>
</thead>
</table>

NYC Ryan White Part A Care Coordination Forms – Page 2 of 2 – Revision Date: 2/10/11
APPENDIX K – 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.

NYC Ryan White Part A Care Coordination Forms – Page 3 of 4 – Release Date: 01/25/09
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 L – 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 Promoción de Salud. Promoción 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 Promoción de Salud cada tres meses.
- Si usted sí tiene una receta médica antirretroviral (VIH), recibirá apoyo para el tratamiento adicional de Promoción 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 les 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 comparta 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 hojas 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 han dado 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; proporcionarle 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 M – 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. Confidential 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: [today’s date: mm/dd/yyyy] To: [1-3 years following today’s date: mm/dd/yyyy] OR [X] until case closure out of this program (check if applicable)

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 ___________________________
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.

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____________________

   (Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: ________________________________________________

Print Name___________________________________________________________________________________

Client/Patient Number__________________________________________________________________________
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.

<table>
<thead>
<tr>
<th>Name and address of facility/person to be given general medical and/or HIV-related information.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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.
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

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:
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________
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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:
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

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

If any/all of this page is completed, please sign below:
Signature_______________________________________________________________________________ Date_______________________
Client/Patient Number__________________________________________________________________
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 información 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 divulgar 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 figuren 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.

---

**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.**

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:


Describa 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.

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

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

Desde: __________________________ Hasta: __________________________ (fecha de hoy: mm/dd/yyyy) O □ hasta que se cierre el caso de este programa (seleccione si aplica) (1-3 años después del día de hoy: mm/dd/yyyy)

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 a 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 agencies 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 __________________________

---

* Completa la información de la página 2 y / o páginas 3 y 4.

** Autoriza la divulgación de (marque todas las opciones que correspondan):

- Mi información relativa al VIH
- Ambas (información médica tanto ajena como relativa al VIH)
- Mi información médica ajena al VIH **
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.

<table>
<thead>
<tr>
<th>Número</th>
<th>Nombre</th>
<th>Establecimiento</th>
<th>Dirección</th>
<th>Ciudad/Municipio</th>
<th>Estado</th>
<th>Código postal</th>
<th>No° Teléfono</th>
</tr>
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</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 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 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 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 ____________________________________________________________________________

3
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.
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

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.
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

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.
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________ 

Si alguno o todos los de esta página se completa, por favor firme abajo:
Firma _______________________________________________________________________________ Fecha _______________________
Número de paciente o cliente __________________________________________________________________
**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.**

<table>
<thead>
<tr>
<th>Current Home Address:</th>
<th>Street:</th>
<th>Apartment/Unit:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home ZIP Code:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address:</th>
<th>Street:</th>
<th>Apartment/Unit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Same as Current Home Address</td>
<td>State:</td>
<td>Mail ZIP Code:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Visit Location:</th>
<th>Street:</th>
<th>Apartment/Unit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Same as Current Home Address</td>
<td>☐ Same as Mailing Address</td>
<td>State:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary telephone number:</th>
<th>(_______) _______ -___________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate telephone number:</td>
<td>(_______) _______ -___________</td>
</tr>
<tr>
<td>Primary E-mail:</td>
<td></td>
</tr>
</tbody>
</table>

**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>ZIP Code:</td>
<td></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>

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>ZIP Code:</td>
<td></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>
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: (<em><strong><strong>) _______ -</strong></strong></em>______</td>
<td></td>
</tr>
<tr>
<td>Alternate telephone number: (<em><strong><strong>) _______ -</strong></strong></em>______</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: (<em><strong><strong>) _______ -</strong></strong></em>______</td>
<td></td>
</tr>
<tr>
<td>Alternate telephone number: (<em><strong><strong>) _______ -</strong></strong></em>______</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: (<em><strong><strong>) _______ -</strong></strong></em>______</td>
<td></td>
</tr>
<tr>
<td>Alternate telephone number: (<em><strong><strong>) _______ -</strong></strong></em>______</td>
<td></td>
</tr>
<tr>
<td>Primary E-mail:</td>
<td></td>
</tr>
</tbody>
</table>
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**
Patient Name: ______________________________________

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 __________________________
APPENDIX Q – Common Demographics Form
**COMMON DEMOGRAPHICS**

*Program Staff: Use current client chart and complete and/or update remaining questions via client interview.*

<table>
<thead>
<tr>
<th>Entry Date:  ____ / ____ / ________</th>
<th>Client Chart/Record #:  __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>TC ID/AIRS ID #:  __________________</td>
<td>If applicable, NYSID:  __________________________</td>
</tr>
</tbody>
</table>

- **First Name:**  __________________
- **Middle Name:**  __________________
- **Suffix:**  (Circle one, if applicable) Sr  Jr  III  IV  V  Other (Specify:  ___________________
- **Last Name:**  __________________

- **Date of Birth:**  ____ / ____ / ________ (mm/dd/yyyy)

- **Current self-identified gender:**  (Check only one)
  - [ ] Male  [ ] Female  [ ] Transgender (M→F)  [ ] Transgender (F→M)  [ ] Other (Specify:  __________________

- **Sex at birth:**  (Check only one)
  - [ ] Male  [ ] Female  [ ] Intersex/ambiguous  [ ] Declined

- **Social Security #:  _______ - _______ - _______

- **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

<table>
<thead>
<tr>
<th>Street:</th>
<th>Apt./Unit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
</tbody>
</table>

### PERMANENT/MAILING ADDRESS

- Same as Current Home Address

<table>
<thead>
<tr>
<th>Street:</th>
<th>Apt./Unit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
</tbody>
</table>

- **Primary telephone number:**  (_____) _______ - _______
- **Alternate telephone number:**  (_____) _______ - _______

<table>
<thead>
<tr>
<th>E-mail address:</th>
</tr>
</thead>
</table>

### Race:  (Check all that apply)

- [ ] Black  [ ] White  [ ] Asian  [ ] Native Hawaiian/Pacific Islander  [ ] American Indian/Alaskan Native
- [ ] Other (Specify:  __________________________)  [ ] Unknown  [ ] Declined

### Ethnicity:  (Check only one)

- [ ] Hispanic  [ ] Non-Hispanic  [ ] Unknown  [ ] Declined

### Marital/relationship status:  (Check only one)

- [ ] Single, never married  [ ] Married  [ ] Married, separated  [ ] Partnered  [ ] Divorced  [ ] Widowed
- [ ] Other (Specify:  __________________________)

---

*Program Staff:
 Completing Form: __________________________  Name  __________________________  Signature  __________________________

**Date:**  ____ / ____ / ________

m m / d d / y y

NYC eSHARE Forms  – Page 1 of 1 –  Revision Date: 9/28/11
APPENDIX R – Intake Assessment Form
INTAKE ASSESSMENT
(MCM, TCC, PRS, TSC, OMC)

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=PRS; 4=TSC; 5=OMC

I. Clinical Information

Date of first known visit to this agency for any service: ______/_____/______ (mm/dd/yyyy)

Date of first known outpatient/ambulatory care visit at this agency:
☐ Same as above OR ______/_____/______ (mm/dd/yyyy)

HIV Status: (Check only one) ☐ HIV+, Not AIDS ☐ HIV+, AIDS status unknown ☐ CDC-Defined AIDS

HIV Diagnosis Date: ______/_____/______ (mm/dd/yyyy)

If AIDS, AIDS Diagnosis Date: ______/_____/______ (mm/dd/yyyy)

HIV Risk Factor: (Check all that apply) ☐ MSM ☐ IDU ☐ Heterosexual ☐ Blood transfusion/components
☐ Hemophilia/coagulation disorder ☐ Perinatal ☐ Other (Specify_________) ☐ Unknown

Do you currently have a Primary Care Physician (PCP) / HIV primary care provider?
☐ Yes ☐ No

If you needed medical care in the community tomorrow, would you go back to the same primary care provider you were seeing before your most recent time here (at Rikers)?
☐ Yes ☐ No ☐ Don't Know

If No, Why would you not go back to that same primary care provider in the community?
☐ Location/transportation – not convenient ☐ Comfort – not comfortable asking questions
☐ Location/proximity – too close to stuff that got me here ☐ Language – language barrier
☐ Insurance – changed or is not accepted ☐ Listening – provider did not listen to me
☐ Scheduling difficulties ☐ Competence – did not feel in the best of hands
☐ Wait time – too long ☐ Being seen – fear of being seen/recognized
☐ Staff – treated poorly ☐ Setting – clinic was: noisy, messy, or unpleasant
☐ Rush – too little time with provider ☐ No reason
☐ Trust/privacy – could not trust Dr. with my info ☐ Nothing in particular
☐ Sensitivity/concern – provider had lack of concern ☐ Other (Specify: ________________________)
☐ Care – disagreed about best care

Last PCP visit prior to enrollment: ______/_____/______ (mm/dd/yyyy) OR ☐ Unknown ☐ N/A

Initial/referral visit with PCP within this program: ______/_____/______ (mm/dd/yyyy)
**Client Name: ________________________________**

Most recent CD4 counts and Viral Load measures from on or before the program enrollment date:  
*(Start with the most recent)*

**CD4 Records**  
*If none are available, check box at right:*  
- No CD4 count on record

<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>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Viral Load Records**  
*If none are available, check box at right:*  
- No viral load count on record

<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>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Hospitalizations and 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></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **# of Hospitalizations:**
  - If none, enter “0”

- **# of ED Visits:**
  - If none, enter “0”

**Does client have any other medical conditions requiring treatment?**
- 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 ever received a mental health diagnosis?**
- Yes
- No
- Unknown

*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: ___________________________)  

Legend:
- = Required; 1 = Optional

Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC; 5=OMC
II. Antiretroviral Treatment (ART) Review

Is client currently prescribed ART?  
☐ Yes If Yes, Complete regimen detail below.  ☐ No Skip this table.

<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># per Dose</td>
<td>Dose Unit (pills, ccs, mls)</td>
<td># Doses</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td>Daily</td>
<td>Weekly</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>Daily</td>
<td>Weekly</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>Daily</td>
<td>Weekly</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>Daily</td>
<td>Weekly</td>
</tr>
</tbody>
</table>

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

III. Client Information

Total number in household (including the client):  

Current employment status: (Check only one)
☐ Full-time  ☐ Part-time  ☐ Unemployed
☐ Unpaid volunteer/peer worker  ☐ Out of workforce  ☐ Other (Specify: _______________)

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  ☐ Declined

Primary Language Spoken: (Check only one)
☐ English  ☐ Spanish  ☐ Other (Specify: _______________)

Legend:
= Required; 1= Optional
Service Category Codes: ALL=All Categories, 1=MCM, 2=TCC, 3=PRS, 4=TSC, 5=OMC

NYC Ryan White Part A Forms MCM/TCC/PRS/TSC/OMC – Page 3 of 10 – Revision Date: 9/28/11
IV. Insurance Information

**Insurance Status:**
- [ ] Uninsured
- [ ] Unknown
- [ ] 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></td>
<td></td>
<td>/ / /</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></td>
<td>Unknown</td>
</tr>
<tr>
<td>[ ] ADAP Plus</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>[ ] Medicaid</td>
<td>(Check only one plan type)</td>
<td></td>
<td>/ / /</td>
</tr>
<tr>
<td>[ ] SNP (special needs plan)</td>
<td></td>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>[ ] MCO (managed care organization)</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>[ ] FFS (fee-for-service)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Not sure which type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Medicare</td>
<td></td>
<td></td>
<td>/ / /</td>
</tr>
<tr>
<td>[ ] Military/VA</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

OR select one of the following:
- [ ] Unknown
- [ ] Declined

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.

Legend:
- [ ] Required; [ ] Optional
- Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC; 5=OMC

NYC Ryan White Part A Forms MCM/TCC/PRS/TSC/OMC – Page 4 of 10 – Revision Date: 9/28/11
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>Haven’t used any</td>
<td>☑*</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Orally ☐ Smoked ☐ Injected ☐ Declined (no answer)</td>
</tr>
<tr>
<td>Tobacco</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☑ ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Smoked ☐ Inhaled/snorted ☐ Declined (no answer)</td>
</tr>
<tr>
<td>Alcohol</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☑ ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Smoked ☐ Inhaled/snorted ☐ Declined (no answer)</td>
</tr>
<tr>
<td>Marijuana</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☑ ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Smoked ☐ Inhaled/snorted ☐ Declined (no answer)</td>
</tr>
<tr>
<td>PCP/Hallucinogens</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☑ ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)</td>
</tr>
<tr>
<td>Crystal Meth</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☑ ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)</td>
</tr>
<tr>
<td>Cocaine/Crack</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☑ ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)</td>
</tr>
<tr>
<td>Heroin</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☑ ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)</td>
</tr>
<tr>
<td>Rx Pills to get high</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☑ ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)</td>
</tr>
<tr>
<td>Hormones/steroids</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☑ ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Patch ☐ Injected ☐ Declined (no answer)</td>
</tr>
<tr>
<td>Anything else: _______</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☐ Yes ☐ No ☐ Declined</td>
<td>☑ ☐ &lt; weekly ☐ Declined</td>
<td>☐ Orally ☐ Smoked ☐ Inhaled ☐ Injected ☐ Declined (no answer)</td>
</tr>
</tbody>
</table>

Legend:

☑ = Required; ☐ = Optional

Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC; 5=OMC
Client Name: ______________________________________

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.

### Have you ever injected any drug or substance? If No, go to Section VII.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Declined (no answer)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

- **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

- **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

- **Have you ever shared needles or injection equipment with others?**
  - Yes
  - No
  - Declined

- **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

---

### VII. Behavioral Risk Reduction

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Declined</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**In the past 12 months, did you have sex with anyone (oral, anal, or vaginal sex)?**

- **If Yes to the above question, please ask the following questions:**

**How many sexual partners have you had in the last 12 months?**

- **If Yes to any vaginal sex, then ask:**
  - In the past 12 months, have you had vaginal sex without a condom?
  - Yes
  - No
  - Declined

**In the past 12 months, have you had anal sex with a male?**

- **If Yes to any anal sex, then ask:**
  - In the past 12 months, have you had anal sex without a condom?
  - Yes
  - No
  - Declined

**In the past 12 months, have you had anal sex with a female?**

- **If Yes to any anal sex, then ask:**
  - In the past 12 months, have you had anal sex without a condom?
  - Yes
  - No
  - Declined

**In the past 12 months, have you had anal sex with a transgender person?**

- **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?
  - Yes
  - No
  - Declined

---

*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=PRS; 4=TSC; 5=OMC
### General Health and Well-Being

1. In general, would you say your health is:

   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

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?

   a. Moderate activities, such as moving a table, pushing a vacuum cleaner, sweeping a floor or walking.
   b. 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?

   - 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)?

   - 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 did pain interfere with your normal work (including work within and outside of your living space)?

   - Not at all
   - A little bit
   - Moderately
   - Quite a bit
   - Extremely

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...

   a. Have you felt calm and peaceful?
   b. Did you have a lot of energy?
   c. 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.)?

   - All of the time
   - Most of the time
   - Some of the time
   - A little of the time
   - None of the time
Other general health & well-being assessment used: ☐ Yes ☐ No

☐ If Yes, Type of other assessment used:

☐ PHQ2
☐ PHQ9
☐ BAI
☐ MSSI-SA
☐ BDI-II
☐ SF-36
☐ HAM-A/HAMA/HAS/HARS
☐ HAM-D
☐ BASIS-24
☐ Other (Specify: ________________________________)

Score of other assessment: __________

IX. Living Arrangement/Housing Information

☐ 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
☐ Other (Specify: ________________________________)
☐ Declined

Legend:

= Required; 1= Optional

Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC; 3=PRS; 4=TSC; 5=OMC

NYC Ryan White Part A Forms MCM/TCC/PRS/TSC/OMC – Page 8 of 10 – Revision Date: 9/28/11
### Since what date (month and year) have you been living in your current situation?

---

---

### 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 mo.- <12 mo.
- 1 mo.- <6 mo.
- < 1 month
- Unknown
- Declined

### Were you ever homeless?

- Yes
- No
- Declined

### 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: _______________

### Have you ever served any time in jail, prison, or juvenile detention (JD)?

- Yes
- No
- Declined

### Are you currently on parole/probation?

- Yes
- No
- Declined

### Currently Enrolled? Referral Needed? Service Category:

- ADHC
- SNP
- COBRA Case Management
- Other Medicaid Case Management
- HASA
- Outpatient Bridge Medical Care
- No to all of the above

---

### Legal and Incarceration History

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:** __________________________

### Current Enrollments and Needed Referrals

Check current enrollments and any immediate referrals needed. Provide detail on referrals in Care Plan.
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:

\[ \text{1}=\text{Required}; \text{0}=\text{Optional} \]

Service Category Codes: ALL=All Categories, 1=MCM, 2=TCC, 3=PRS, 4=TSC, 5=OMC

NYC Ryan White Part A Forms MCM/TCC/PRS/TSC/OMC – Page 10 of 10 – Revision Date: 9/28/11
Appendix S – Adherence Assessment (ART Daily Regimens Only)
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 DOES DID YOU MISS …</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1.</strong> Names of your HIV drugs (eg. Kaletra)</td>
<td><strong>Step 2.</strong> # Pills/dose</td>
</tr>
<tr>
<td><strong>Step 1.</strong> Names of your HIV drugs (eg. Kaletra)</td>
<td><strong>Step 2.</strong> # Dose/day</td>
</tr>
<tr>
<td><strong>Step 1.</strong> Names of your HIV drugs (eg. Kaletra)</td>
<td><strong>Step 2.</strong> # Dose/day</td>
</tr>
<tr>
<td><strong>Step 1.</strong> Names of your HIV drugs (eg. Kaletra)</td>
<td><strong>Step 2.</strong> # Dose/day</td>
</tr>
</tbody>
</table>

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: $4 \times \text{total in outlined box from Step 2}$

C. Total doses missed (total in outlined box from Step 3 above)

D. 4-Day Adherence Percentage (%) $[\frac{(\text{b}-\text{c})}{\text{b}}] \times 100 = \text{d}$

(Verified by Supervisor ) (Verified by Supervisor ) (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: ____/____/______

| Staff Member Completing Form: ___________________________ ___________________________ Date: __________ / ______/ ______ |
|--------------------------------------------------------|--------------------------|
| Name __________________——Signature_________________ | m m / d d / y y          |
Appendix T – Adherence Assessment (ART Non-Daily Regiments Only)
ADHERENCE ASSESSMENT (ART NON-DAILY REGIMENS ONLY)

Adherence Assessment Self-Report Date: _____ / _____ / _______ (mm/dd/yyyy)

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>Step 1. 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)

Total Rx’d doses

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 (%)  
\[
\frac{[b-c]}{b} \times 100 = d 
\]

(Verified by Supervisor □)  (Verified by Supervisor □)  (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

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.

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: ____/____/______
Appendix U – Comprehensive Care Plan
**SECTION 1: COORDINATION OF CARE**

### 1a: PCP VISIT ATTENDANCE ISSUE OR GOAL:

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCP</td>
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<td>Client</td>
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<td></td>
<td>Other: __________</td>
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</tbody>
</table>

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>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
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<tbody>
<tr>
<td></td>
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<td>Other: __________</td>
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Completed?: Yes No N/A or Other
Notes: __/__/____

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NYC Ryan White Part A Forms – Page 1 of 5 – Revision Date: 9/29/11
Client Name: ________________________________

1c: OTHER MEDICAL, PROGRAM OR SERVICE (MEDICAL OR SOCIAL) 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>
</tr>
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<tbody>
<tr>
<td></td>
<td>PCP</td>
<td></td>
<td>Completed?: ☐ Yes ☐ No ☐ N/A or Other</td>
<td><em><strong>/</strong></em>/_____</td>
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<td>Client</td>
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<td>Navigator</td>
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SECTION 2: CURRICULUM   
For programs covering health promotion/education topics

2a. CURRICULUM TOPICS TO BE COVERED | Target Date |
Please list topics to be completed before next plan update

<p>| | |</p>
<table>
<thead>
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NYC Ryan White Part A Forms

– Page 2 of 5 –
SECTION 3: ADHERENCE

Please complete Adherence section only if the client is currently prescribed ART.

3a. ADHERENCE ISSUE/GOAL 1: ________________________________________________________________ DATE RESOLVED: ___/___/____

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCP</td>
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<td>CC</td>
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<td>Navigator</td>
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<td>Client</td>
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<td>Other: _________</td>
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<td></td>
<td>Completed?: Yes No N/A or Other</td>
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<td>Notes:</td>
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</tbody>
</table>

3b. ADHERENCE ISSUE/GOAL 2: ________________________________________________________________ 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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<tbody>
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<td>Other: _________</td>
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<td>Completed?: Yes No N/A or Other</td>
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<td>Notes:</td>
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</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
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<td>PCP</td>
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<td></td>
<td>Navigator</td>
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<td>Other: __________</td>
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</table>

**4a. OTHER ISSUE/GOAL 1:** ____________________________________________ DATE RESOLVED: ____/____/____

<table>
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<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
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<td>Navigator</td>
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<td>Other: __________</td>
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</table>

**4b. OTHER ISSUE/GOAL 2:** ____________________________________________ DATE RESOLVED: ____/____/____

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<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
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<td>Navigator</td>
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<td>Other: __________</td>
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</table>

**4c. OTHER ISSUE/GOAL 3:** ____________________________________________ DATE RESOLVED: ____/____/____

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<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
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<td>PCP</td>
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<td>Client</td>
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<td>Navigator</td>
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<td>Other: __________</td>
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</tr>
</tbody>
</table>
Appendix V – 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 record internal (within agency or within formal network) PCP appointments on Page 1. Page 2 should be used for referrals to external primary care, as well as for referrals to internal or external services of other kinds (non-primary care). 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: ❑ Yes ❑ No</td>
<td>Service Type: __________________</td>
<td>1) __________________</td>
<td>Last Name: __________________</td>
<td>❑ Reminder call/message</td>
<td>❑ Completed</td>
<td><strong><strong>/</strong></strong>/____ mm/dd/yyyy</td>
</tr>
<tr>
<td>If Yes, date appt. made: <strong><strong>/</strong></strong>/____</td>
<td>Service Date: __________________</td>
<td>2) __________________</td>
<td>First Name: __________________</td>
<td>❑ Transport – Car/Taxi/Van</td>
<td>❑ Rescheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3) __________________</td>
<td>Date of the Appt.: <strong><strong>/</strong></strong>/____</td>
<td>❑ Transport – MetroCard</td>
<td>❑ Client missed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4) __________________</td>
<td></td>
<td>❑ Childcare – in field</td>
<td>❑ Client showed, but appt incomplete</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5) __________________</td>
<td></td>
<td>❑ Childcare – service site</td>
<td>❑ Other (Specify: ________________)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6) __________________</td>
<td></td>
<td>❑ Accompany from field</td>
<td>❑ N/A (none required)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>__________________</td>
<td></td>
<td>❑ Accompany at service site</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>__________________</td>
<td></td>
<td>❑ Appointment preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>__________________</td>
<td></td>
<td>❑ Interpreting services</td>
<td></td>
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<td></td>
<td></td>
<td>__________________</td>
<td></td>
<td>❑ Other (__________)</td>
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<td></td>
<td></td>
<td>__________________</td>
<td></td>
<td>❑ N/A (none required)</td>
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</tr>
</tbody>
</table>

NYC eSHARE Forms – Page 1 of 2 – Revision Date: 09-28-11
# Referrals/Appointments Tracking Log

## P. 2: Referrals (External Primary Care or Other Services – Internal or External)

<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>
</tr>
</thead>
<tbody>
<tr>
<td>Client has or had a referral for other services:</td>
<td></td>
<td></td>
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<tr>
<td>Yes ☐ No ☐</td>
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<td></td>
</tr>
<tr>
<td>If Yes, date referral made:</td>
<td>Service Type:</td>
<td></td>
<td>Service Type:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service Date:</td>
<td></td>
<td>Agency:</td>
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<tr>
<td></td>
<td>1/1/2023</td>
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<td></td>
</tr>
<tr>
<td>Client has or had appointment scheduled to receive other services:</td>
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<tr>
<td>Yes ☐ No ☐</td>
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<tr>
<td>If Yes, date referral made:</td>
<td>Service Type:</td>
<td></td>
<td>Service Type:</td>
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<td>Service Date:</td>
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<td>Agency:</td>
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<td>1/1/2023</td>
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</tr>
</tbody>
</table>

**Program Staff Completing Form:**

Name: ____________________________

Signature: ________________________

Date: mm/dd/yyyy

NYC eSHARE Forms

– Page 2 of 2 –

Revision Date: 09-28-11
Appendix W – PCSM Update
## PCSM UPDATE

### Program (Part A Service Category) Performing 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)  
- / / (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>
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</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></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td></td>
<td>Yes</td>
<td>No</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 yes, is client currently prescribed ART?  
- Yes  
- No  

If client is not on ART, Why is the client not currently prescribed ART?  
- 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># Doses</th>
<th>Frequency</th>
<th>Date Started (mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># per Dose (pills, ccs, mls)</td>
<td># Doses</td>
<td>Daily</td>
<td>Weekly</td>
</tr>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<tr>
<td>4.</td>
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</tbody>
</table>

### IV. HIV/AIDS Status Information (Required for all service categories)

Most Recent HIV Status: 
- HIV+, Not AIDS  
- HIV+, AIDS status unknown  
- CDC-Defined AIDS  

If AIDS, AIDS Diagnosis Date:  / / (mm/dd/yyyy)  

Optional for ADV, LGL, OHC, TRN
Client Name: ____________________________  Client Record #: ____________________________

Notes:
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_________________________________________________________________________________________________
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Staff Member Completing Form: ____________________________  Date ______ / ______ / ______
Name ____________________________  Signature ____________________________  m m / d d / y y
Appendix X – 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>
<td>Topic 3: Using a Pillbox (Core)</td>
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<tr>
<td>Topic 4: Handling Your ART Medications (Core)</td>
<td>___ / ___ / ___</td>
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<tr>
<td>Topic 5: What is Adherence? (Core)</td>
<td>___ / ___ / ___</td>
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<td>Topic 6: Side Effects (discretionary)</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>
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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>
</tr>
<tr>
<td>--------------------------------------------</td>
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<td>--------------------------------------------------------</td>
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<tr>
<td>Topic 8: Identifying and Building Social Support Networks (Core)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td></td>
</tr>
<tr>
<td>Topic 9: Adherence Strengths and Difficulties (Core)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td></td>
</tr>
<tr>
<td>Topic 10: Medical Appointments and Providers (Core)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td></td>
</tr>
<tr>
<td>Topic 11: Health Maintenance (discretionary)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td></td>
</tr>
<tr>
<td>Topic 12: Harm Reduction: Sexual Behavior (discretionary)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td></td>
</tr>
<tr>
<td>Topic 13: Harm Reduction: Substance Use (discretionary)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td></td>
</tr>
<tr>
<td>Topic 14: Harm Reduction: Safety in Relationships (discretionary)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td></td>
</tr>
<tr>
<td>Topic 15: Healthy Living – Diet and Exercise (discretionary)</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td></td>
</tr>
<tr>
<td>Topic 16: Wrap-up</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td>___ / ___ / ___</td>
<td></td>
</tr>
</tbody>
</table>
Appendix Y – 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.

---

**Weekly Totals**

<table>
<thead>
<tr>
<th>Medication</th>
<th>List antiretrovirals (ARVs) and the # of prescribed pills/day for each</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># pills/day</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Daily pills prescribed (across ARVs)= a1</th>
</tr>
</thead>
<tbody>
<tr>
<td>b1=Total weekly pills taken across ARVs</td>
</tr>
</tbody>
</table>

---

**Weekly Totals**

<table>
<thead>
<tr>
<th>Medication</th>
<th>List antiretrovirals (ARVs) and the # of prescribed pills/day for each</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># pills/day</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Daily pills prescribed (across ARVs)= a2</th>
</tr>
</thead>
<tbody>
<tr>
<td>b2=Total weekly pills taken across ARVs</td>
</tr>
</tbody>
</table>

Cells shaded in gray may be calculated by the Adherence Form Assistance Tool.
<table>
<thead>
<tr>
<th>Medication</th>
<th>List antiretrovirals (ARVs) and the # of prescribed pills/day for each</th>
</tr>
</thead>
</table>

| Week: ___/___/____ to ___/___/____ |
|---|---|---|---|---|---|---|
| # pills/day | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| Total Pills Taken per ARV | Sum of Total Pills Taken (all ARVs) | Total Pills Prescribed (a3 x days in period) | % Adherence ((b3/c3) x 100) |

**Daily pills prescribed (across ARVs)=**

| Week: ___/___/____ to ___/___/____ |
|---|---|---|---|---|---|---|
| # pills/day | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| Total Pills Taken per ARV | Sum of Total Pills Taken (all ARVs) | Total Pills Prescribed (a4 x days in period) | % Adherence ((b4/c4) x 100) |

**Daily pills prescribed (across ARVs)=**

**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:**

\[
\frac{\text{Total Taken}}{\text{Total Prescribed}} \times 100 = \% \text{ Adherence by Pill Box count}
\]

**Date of Pill Box report: ___/___/____**

**Staff Member Completing Form:**

Name ___________________________ Signature ___________________________ Date: m m / d d / y y

**Verified By:**

Name ___________________________ Signature ___________________________ Date: m m / d d / y y
Appendix Z – 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>/______ to__/<strong>/</strong>____</th>
<th>Number of Pills Taken</th>
<th>Weekly Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication</strong></td>
<td><strong>Prescribed Pills and Frequency</strong> (# pills/day, # days/week)</td>
<td>Day 1</td>
</tr>
<tr>
<td>List antiretrovirals (ARVs)</td>
<td>Total Pills Taken per ARV</td>
<td>±</td>
</tr>
<tr>
<td>Pills prescribed (across ARVs)</td>
<td>a1=Total weekly pills prescribed (Rx’d)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week:<strong>/</strong>/______ to__/<strong>/</strong>____</th>
<th>Number of Pills Taken</th>
<th>Weekly Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication</strong></td>
<td><strong>Prescribed Pills and Frequency</strong> (# pills/day, # days/week)</td>
<td>Day 1</td>
</tr>
<tr>
<td>List antiretrovirals (ARVs)</td>
<td>Total Pills Taken per ARV</td>
<td>±</td>
</tr>
<tr>
<td>Pills prescribed (across ARVs)</td>
<td>a2=Total weekly pills prescribed (Rx’d)</td>
<td></td>
</tr>
</tbody>
</table>

% Adherence [(b/a x 100)]

*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
### NYC Ryan White Part A Forms

**Staff Member Completing Form:**
- Name: __________________________
- Date: __________/______/______
- Signature: ______________________

**Verified By:**
- Name: __________________________
- Date: __________/______/______
- Signature: ______________________

---

**Medication**

List antiretrovirals (ARVs)

<table>
<thead>
<tr>
<th>Week: <em><strong><strong>/</strong></strong></em>/______ to <em><strong><strong>/</strong></strong></em>/______</th>
<th>Number of Pills Taken</th>
<th>Weekly Totals</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<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>
</table>

| Pills prescribed (across ARVs) for each day: | a3 = Total weekly pills prescribed (Rx’d) |

---

<table>
<thead>
<tr>
<th>Week: <em><strong><strong>/</strong></strong></em>/______ to <em><strong><strong>/</strong></strong></em>/______</th>
<th>Number of Pills Taken</th>
<th>Weekly Totals</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<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>
</table>

| Pills prescribed (across ARVs) for each day: | a4 = Total weekly pills prescribed (Rx’d) |

---

**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:**

\[
\left( \frac{b1+b2+b3+b4}{a1+a2+a3+a4} \right) \times 100 = \% \text{ Adherence by Pill Box}
\]

---

**Verified By:**

- Name: __________________________
- Date: __________/______/______
- Signature: ______________________
## MONTHLY DOT LOG (ART ONLY)

### Client Name:

### 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.)

### Section 1: Daily Tracking

<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>
</tbody>
</table>

### Total pills Rx’d per day =

a

### Monthly total pills taken (observed only)=

b

### Monthly total pills taken (observed and unobserved) =

c

### Pills Rx’d for each day

Use this row only for ART regimens with varying pills Rx’d per day.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | d |

### Days without DOT

At right, mark an ‘X’ for any day without any DOT (no dose(s) observed).

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | † |

### Symptom Review by client self-report:

- Diarrhea
- Fatigue
- Abdominal pain
- Rash
- Nausea
- Muscle pain
- Headache
- Other
- Sleep disturbance
- Nerve pain
- Dizziness or fainting

(Specify: ______________________)

*In ‘d’ write Total pills Rx’d for the month (for a non-daily regimen)
†Days in DOT month without an observation
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: ______/_____/__________

| Item 1. | Days in period | 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) | a x e | Item 3. | TOTAL pills taken in period (c on p.1) | c | Item 4. | TOTAL pills observed taken in period (b on p.1) | b | Item 5. | Report of adherence by DOT count for a month (Item 3/Item 2) x 100 = % | % | Item 6. | Report of directly observed adherence by DOT for a month (Item 4/Item 2) x 100 = % | % |
|---------|----------------|---------|-------------------------------------------------|------|---------|---------------------------------|------|---------|---------------------------------|------|---------|---------------------------------|------|---------|---------------------------------|------|---------|---------------------------------|------|---------|
|         |                |         |                                                |      |         |                                |      |         |                                |      |         |                                |      |         |                                |      |         |                                |      |         |                                |      |         |                                |      |         |                                |      |         |                                |      |         |

Notes:
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

Staff Member Completing Form: ____________________________ Name ____________________________ Signature ____________________________ Date: ______/_____/______

Verified By: ____________________________ Name ____________________________ Signature ____________________________ Date: ______/_____/______
Appendix BB – 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.

<table>
<thead>
<tr>
<th>Previous Conference (Date: <strong><strong><strong>/</strong></strong><em>/</em></strong>___)</th>
<th>Current Conference From EMR and CC records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous CD4:</td>
<td>Most Recent CD4:</td>
</tr>
<tr>
<td>Previous VL:</td>
<td>Most Recent VL:</td>
</tr>
<tr>
<td>Missed PCP appointments</td>
<td>Hospitalizations since last Case Conference:</td>
</tr>
<tr>
<td></td>
<td>ED visits since last Case Conference:</td>
</tr>
<tr>
<td></td>
<td>PCP appointments missed since last completed appointment:</td>
</tr>
<tr>
<td></td>
<td>Topics covered since last Conference:</td>
</tr>
<tr>
<td></td>
<td>Total # of topics covered to this point:</td>
</tr>
</tbody>
</table>

*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  If checked, skip to Page 2

☐ Regimen changed since last conference  If checked, indicate reason for regimen change below

Reason for regimen change

☐ Treatment failure/ Viral resistance

☐ Intolerance/ Side effects (Specify: __________________________)

☐ Change in guidance/regimen simplification

☐ Other (Specify: __________________________)

<table>
<thead>
<tr>
<th>Current ART Medications:</th>
<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>
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</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.

### Record DOT or pillbox adherence assessment

<table>
<thead>
<tr>
<th>From previous conference:</th>
<th>For current conference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOT or Pillbox at PREVIOUS Conf.</td>
<td>Most recent DOT or Pillbox*</td>
</tr>
<tr>
<td>(Measure: _______)</td>
<td>SINCE LAST Conf.</td>
</tr>
<tr>
<td>Value as % from 0-100</td>
<td>(Measure: _______)</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
<tr>
<td>Value</td>
<td>Value</td>
</tr>
</tbody>
</table>

Value as % from 0-100

*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>Date</td>
<td>Date</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>Value</td>
<td>Value</td>
</tr>
<tr>
<td>Last missed dose score</td>
<td>Last missed dose score</td>
</tr>
<tr>
<td>Value from 0-5, Adherence Assessment P. 2, Question 2</td>
<td>Value from 0-5, Adherence Assessment P. 2, Question 2</td>
</tr>
<tr>
<td>Value</td>
<td>Value</td>
</tr>
<tr>
<td>VAS adherence value</td>
<td>VAS adherence value</td>
</tr>
<tr>
<td>Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 2, Question 4a</td>
<td>Value as % from 0-100 (e.g. 90%), Adherence Assessment P. 2, Question 4a</td>
</tr>
<tr>
<td>Value</td>
<td>Value</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:

______________________________

### Does care plan need to be updated? ☐ Yes ☐ No If Yes, Date Updated: __/__/____

### Client Disposition Summary

Check the appropriate option

- ☐ Continue current Program/Track
- ☐ Change in Program/Track *(Update Client Status Change form)*
- ☐ 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>/____</td>
</tr>
<tr>
<td>Care Coordinator</td>
<td></td>
<td><strong>/</strong>/____</td>
</tr>
</tbody>
</table>
Appendix CC – 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:

Service Category Codes:
ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC; 5=OMC

<table>
<thead>
<tr>
<th>Hospitalizations and ED Visits since last assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong># of Events</strong></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td><strong># of Hospitalizations:</strong></td>
</tr>
<tr>
<td>If none, enter “0”</td>
</tr>
<tr>
<td><strong># of ED Visits:</strong></td>
</tr>
<tr>
<td>If none, enter “0”</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
- Diabetes
- Heart disease/hypertension
- Liver disease
- Kidney disease
- Hepatitis C
- Tuberculosis (TB)
- Other (Specify: ___________________________)

Has client received or newly reported a mental health diagnosis since last assessment?  
[ ] Yes  [ ] No  [ ] Unknown

Legend:

Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC; 5=OMC
ALL If Yes, What diagnosis or diagnoses? (Check all that apply)

- Depression
- Anxiety Disorder (Panic, GAD, etc.)
- PTSD
- Other (Specify: __________________________)
- Bipolar Disorder
- Psychosis (Schizophrenia, etc.)
- HIV-associated Dementia

Pregnant:  □ Yes  □ No  □ Unknown  □ N/A (male) If No, Unknown or N/A, go to Section II.

If Yes, Date of report of client’s pregnancy to program: _____/_____/_______ (mm/dd/yyyy)

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)

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: _____/_____/_______

Or select one of the following:  □ N/A  □ Unknown

Is client prescribed ART to prevent maternal-to-child (vertical) transmission of HIV?

- Yes
- No
- Unknown
- N/A

I. Client Information

Has your employment status changed since the last assessment?  □ Yes  □ No

If Yes, please complete the following:  □ Yes  □ No 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

II. Insurance Information

Has your insurance status changed since the last assessment?  □ Yes  □ No If No, go to Section IV.

If Yes, Insurance Status:  □ Uninsured  □ Unknown  □ 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></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>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend:

□ = Required; 1 = Optional
Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC; 5=OMC
### Financial Information

#### Has there been a change in your income level since the last assessment?

- **Yes**
- **No**  *If No, go to Section V.*

**If Yes,** please complete the following:

**What is your annual household income?** $___________ per year

**OR select one of the following:**

- **Unknown**
- **N/A**

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.

### Use of Prescriptions, Injectables and Other Substances

#### Substance

- **Tobacco**
  - **Yes**
  - **No**
  - **Declined**
  - **How often do you use?** ____ times (units) weekly  
  - **How have you taken this?**
    - Orally
    - Smoked
    - Inhaled/snorted
    - Declined (no answer)

- **Alcohol**
  - **Yes**
  - **No**
  - **Declined**
  - **How often do you use?** ____ times (units) weekly  
  - **How have you taken this?**
    - Orally
    - Smoked
    - Inhaled/snorted
    - Declined (no answer)

- **Marijuana**
  - **Yes**
  - **No**
  - **Declined**
  - **How often do you use?** ____ times weekly  
  - **How have you taken this?**
    - Orally
    - Smoked
    - Inhaled/snorted
    - Declined (no answer)
## Substance Used in the past 3 months?

- **PCP/Hallucinogens**
  - Yes
  - No
  - Declined
  - ___ times weekly
  - < weekly
  - Declined
  - Orally
  - Smoked
  - Inhaled/snorted
  - Injected
  - Declined (no answer)

- **Crystal Meth**
  - Yes
  - No
  - Declined
  - ___ times weekly
  - < weekly
  - Declined
  - Orally
  - Smoked
  - Inhaled/snorted
  - Injected
  - Declined (no answer)

- **Cocaine/Crack**
  - Yes
  - No
  - Declined
  - ___ times weekly
  - < weekly
  - Declined
  - Orally
  - Smoked
  - Inhaled/snorted
  - Injected
  - Declined (no answer)

- **Heroin**
  - Yes
  - No
  - Declined
  - ___ times weekly
  - < weekly
  - Declined
  - Orally
  - Smoked
  - Inhaled/snorted
  - Injected
  - Declined (no answer)

- **Rx Pills to get high**
  - Yes
  - No
  - Declined
  - ___ times weekly
  - < weekly
  - Declined
  - Orally
  - Injected
  - Declined (no answer)

- **Hormones/steroids**
  - Yes
  - No
  - Declined
  - ___ times weekly
  - < weekly
  - Declined
  - Orally
  - Patch
  - Injected
  - Declined (no answer)

- **Anything else: _______**
  - Yes
  - No
  - Declined
  - ___ times weekly
  - < weekly
  - Declined
  - Orally
  - Smoked
  - Injected
  - Declined (no answer)

---

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)

  - **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

  - **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

  - **Have you ever shared needles or injection equipment with others?**
    - Yes
    - No
    - Declined

---

Legend:

- **= Required; 1= Optional**

  **Service Category Codes:** ALL=All Categories, 1=MCM, 2=TCC, 3=PRS, 4=TSC, 5=OMC
VI. Behavioral Risk Reduction

In the past 12 months, did you have sex with anyone (oral, anal, or vaginal sex)?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Declined</th>
</tr>
</thead>
</table>

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

If Yes to the above question, please ask the following questions:

In the past 12 months, have you had sex with anyone (oral, anal, vaginal sex)?

- Yes
- No
- Declined

If No, skip to Section VII.

How many sexual partners have you had in the last 12 months?

- Unknown
- Declined

In the past 12 months, have you had vaginal sex with a male?

- Yes
- No
- Declined

In the past 12 months, have you had vaginal sex with a female?

- Yes
- No
- Declined

If Yes to any vaginal sex, then ask:

In the past 12 months, have you had vaginal sex without a condom?

- Yes
- No
- Declined

In the past 12 months, have you had anal sex with a male?

- Yes
- No
- Declined

In the past 12 months, have you had anal sex with a female?

- Yes
- No
- Declined

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?

- Yes
- No
- Declined

In the past 12 months, have you had oral sex with a male?

- Yes
- No
- Declined

In the past 12 months, have you had oral sex with a female?

- Yes
- No
- Declined

In the past 12 months, have you had oral sex with a transgender person?

- Yes
- No
- Declined

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?

- Yes
- No
- Declined

^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

Since the last assessment, have you changed how you identify in terms of gender or sexual orientation?

- Yes
- No  If No, go to Section VIII.

If Yes, please complete the below questions and update Common Demographics in eSHARE

What is your current self-identified gender? (Check only one)

- Male
- Female
- Transgender (M→F)
- Transgender (F→M)
- 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: ______________________________________)
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>
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<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?

a. Moderate activities, such as moving a table, pushing a vacuum cleaner, sweeping a floor or walking...

b. 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>
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<td></td>
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</tr>
</tbody>
</table>

a. Accomplished less than you would like...

b. 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>
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</tr>
</tbody>
</table>

a. Accomplished less than you would like...

b. 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>
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</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>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Have you felt calm and peaceful?

b. Did you have a lot of energy?

c. 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>
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</tr>
</tbody>
</table>
### IX. Living Arrangement/Housing Information

#### ALL 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:

<table>
<thead>
<tr>
<th>1 2 3 4 5</th>
<th>Are you currently enrolled in a housing assistance program?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>[ ] Declined</td>
<td></td>
</tr>
</tbody>
</table>

- [ ] 1 2 3 4 5 If Yes, Agency: __________________________ OR [ ] Unknown

- [ ] ALL 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

- [ ] ALL 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
- [ ] Other (Specify: ___________________________________________)

- [ ] Declined
### Client Name: ____________________________

**ALL** Since what date (month and year) have you been living in your current situation?  
______/_______ (mm/yyyy)  
OR select one of the following: ☐ Unknown  ☐ Declined

**ALL** 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 mo.- <12 mo.  ☐ 1 mo.- <6 mo.  
☐ < 1 month  ☐ Unknown  ☐ Declined

**ALL** Have you been homeless any time since your last assessment?  
☐ Yes  ☐ No  ☐ Declined  
**ALL** If Yes, When were you last homeless?  
______/_______ (mm/yyyy)

**ALL** Do not ask if client is homeless:  
What are your current housing issues? (Check all that apply) ☐ N/A  
☐ 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: _______________)

**HOUSING COMPOSITION**  
**ALL** Has there been any change in who lives with you (any change in your household)?  
☐ Yes  ☐ No  
*If No, go to Section X.  If Yes, continue:  
**ALL** Total number in Household (including the client): ________

**X. Legal and Incarceration History**  
**FAQ 5**  
Client Interview  
Since the last assessment, 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 via eSHARE Client Demographics screen

**Legend:**

1 Required  1 Optional  
Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC; 5=OMC

NYC Ryan White Part A Forms MCM/TCC/PRS/TSC/OMC – Page 8 of 9 – Revision Date: 9/30/11
XI. Current Enrollments and Needed Referrals

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>COBRA Case Management</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>

Notes:
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_________________________________________________________________________________________
_________________________________________________________________________________________

Staff Member Completing Form: _____________________________

Signature: _____________________________

Date: mm/dd/yyyy

Legend:
□ = Required; □ = Optional
Service Category Codes: ALL=All Categories, 1=MCM; 2=TCC, 3=PRS; 4=TSC; 5=OMC
Appendix DD – 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 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: ___________________________  Date: / / 
Name ___________________________  Signature ___________________________

m m / d d / y y

NYC Ryan White Part A Care Coordination Forms – Page 1 of 1 –  Revision Date: 9/28/11
Appendix EE – Status Change Information Form
(Case Closure/Suspension)
# STATUS CHANGE INFORMATION FORM
(CASE CLOSURE/SUSPENSION)

**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:
__________________________________________________________________________________________________________________________________________________________
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<table>
<thead>
<tr>
<th>Program Staff</th>
<th>Completing Form:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name</td>
<td>Signature</td>
</tr>
</tbody>
</table>

NYC Ryan White Part A Forms – Page 1 of 1 – Revision Date: 9/27/11
Appendix FF – Services Tracking Log
<table>
<thead>
<tr>
<th>Service Date (mm/dd/yyyy)</th>
<th>Service Start Time/End Time</th>
<th>Worker(s) Providing</th>
<th>Site of service delivery (Select only one)</th>
<th>Service Type</th>
<th>Service Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start time: __ <strong>/</strong>/______</td>
<td>am/pm:__ __ : __ __</td>
<td>Program site (Specify: ____________)</td>
<td>Case finding 1</td>
<td>(Select all that apply)</td>
<td></td>
</tr>
<tr>
<td>Travel Time: ___ ___ ___ ___</td>
<td>(hours) (minutes)</td>
<td>Client home</td>
<td>Case identification/search of medical records</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other field site (Specify: ____________)</td>
<td>Case outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone</td>
<td>Case located/made contact (client found)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Case interviewed</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Returned to care</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Enrolled in OBMC</td>
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<td></td>
<td></td>
<td></td>
<td>Other disposition</td>
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<td></td>
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<tr>
<td>End time: ___ ___ __ __</td>
<td>am/pm:__ __ : __ __</td>
<td></td>
<td>Total estimated time spent on case-finding activities:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>___ ___ : ___ ___</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(Hours) (Minutes)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Date (mm/dd/yyyy)</th>
<th>Service Start Time/End Time</th>
<th>Worker(s) Providing</th>
<th>Site of service delivery (Select only one)</th>
<th>Service Type</th>
<th>Service Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start time: __ <strong>/</strong>/______</td>
<td>am/pm:__ __ : __ __</td>
<td>Program site (Specify: ____________)</td>
<td>Intake assessment ALL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel Time: ___ ___ ___ ___</td>
<td>(hours) (minutes)</td>
<td>Client home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other field site (Specify: ____________)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Phone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End time: ___ ___ __ __</td>
<td>am/pm:__ __ : __ __</td>
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<table>
<thead>
<tr>
<th>Service Date (mm/dd/yyyy)</th>
<th>Service Start Time/End Time</th>
<th>Worker(s) Providing</th>
<th>Site of service delivery (Select only one)</th>
<th>Service Type</th>
<th>Service Details</th>
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<tr>
<td>Start time: __ <strong>/</strong>/______</td>
<td>am/pm:__ __ : __ __</td>
<td>Program site (Specify: ____________)</td>
<td>Outreach for client re-engagement 1/2</td>
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<td>Travel Time: ___ ___ ___ ___</td>
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<th>Site of service delivery (Select only one)</th>
<th>Service Type</th>
<th>Service Details</th>
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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 in eSHARE for Phase 2. Except for Accompaniment, Transportation and Escorts, 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 (1*=MCM-NYC only); 2=TCC, 3=PRS; 4=TSC; 5=OMC
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<tr>
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<th>Worker(s) Providing</th>
<th>Site of service delivery (Select only one)</th>
<th>Service Type</th>
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NYC Ryan White Part A Services Log for MCM/TCC/PRS/TCS/OMC

Revision Date: 9/29/11
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<th>Transportation to: (Select only one)</th>
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<th>Program site (Specify: ____________)</th>
<th>Coordination with service providers (Select only one)</th>
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<td>Travel Time: ___ : ___ (hours) (minutes)</td>
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Type of supportive activity:
(Auto-populates as follows for PRS:)
☑ Life Skills Training - Individual

Completed m/d/y

NYC Ryan White Part A Services Log for MCM/TCC/PRS/TCS/OMC
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