Mary Washington Healthcare

Wellness Program

Eligibility Assessment Determination

☐ New Assessment Date Completed:		☐ Reassessment Date Completed:
SSN:	Age:	DOB:
Date of HIV Diagnosis:	Date of AIDS Diagnosis (if applicable):	

PERSONAL INFORMATION

Legal Last Name:	Legal First Name:	Middle Initial	Name Suffix (Jr., Sr., I, II, Etc.):	Other Names Used
Street Address	City	State	Zip	OK to send mail
				☐ YES; ☐ NO
Mailing Address, If Different	City	State	Zip	OK to send mail
				☐ YES; ☐ NO

I agree and understand that if the subrecipient does not hear from me within 90 days, the subrecipient will mail me a Certified Letter to notify me of discharge from services. ☐ YES; ☐ NO

_____ _____

Client (or legal guardian) Signature **Today's date (day/month/year)**

Housing Status:	☐Stable ☐Unstable ☐Permanent	Housing Type:	☐ HOPWA funded housing assistance; ☐ Institutional setting; ☐ Owning and living in an unsubsidized house or apartment; ☐ Permanent housing for formerly unhoused; ☐ Renting and living in an unsubsidized room or house or apartment; ☐ Subsidized non-HOPWA house/apt including Section 8/HOME/public housing; ☐ Subsidized non-HOPWA house/apt including Section 8/HOME/public housing; ☐ Unsubsidized permanent placement with families or other self-sufficient arrangements; ☐ Hotel or motel paid for without emergency shelter voucher; ☐ Other temporary arrangement such as a RWHAP housing subsidy; ☐ Temporary arrangement to stay or live with family or friends; ☐ Temporary placement in an institution; ☐ Transitional housing for homeless people; ☐ Emergency shelter or a public or private place not designed as regular sleeping; ☐ Hotel or motel paid for with emergency shelter voucher; ☐ Jail or prison or a juvenile detention facility
Veteran: ☐ Yes; ☐ No	Marital Status:	☐Divorced ☐Legal Separation ☐Married ☐Registered Domestic Partnership ☐Single ☐Widowed	

Primary Phone # ( )	Phone Type ☐ Cell ☐ Home ☐ Work ☐ Family ☐ Other	OK to leave message ☐ Yes; ☐ No
Secondary Phone # ( )	Phone Type ☐ Cell ☐ Home ☐ Work ☐ Family ☐ Other	OK to leave message ☐ Yes; ☐ No
E-Mail ☐ Yes; ☐ No	E-Mail Address: _____	
Primary Language:		
Secondary Language:		
Preferred Spoken Language:		
Preferred Written Language:		

Gender:	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Transgender ☐ Other: _____
Sex At Birth	☐ Male ☐ Female
Gender Pronoun	☐ She/Hers ☐ He/Him ☐ They/Them ☐ Other: _____
Ethnicity:	☐ Hispanic/Latino; ☐ Non-Hispanic/Latino
Ethnicity Subcategory:	☐ Mexican; ☐ Puerto Rican ☐ Cuban ☐ Other
Race:	☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ American Indian/ Alaskan Native ☐ Other
Race Subcategory:	Asian: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Native Hawaiian/Pacific Islander: ☐ Guamanian or Chamorro ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Samoan

TO BE COMPLETED BY STAFF:

			( )
Primary HIV Care Clinic/Facility/Practice	Physician Providing HIV Care		Phone Number
			( )
HIV Case Management Agency	HIV Case Manager		Phone Number
	( )		( )
Authorize Representative	Phone Number	Other Subrecipient	Phone Number

Household:

Total Household Size	

Household Members:

Names	Relationship	Date Of Birth	Ok To Contact	Do They Have Income? (If Yes, You Will Need To Include Their Income In The Calculations Below)
			☐ Yes; ☐ No	☐ Yes; ☐ No
			☐ Yes; ☐ No	☐ Yes; ☐ No
			☐ Yes; ☐ No	☐ Yes; ☐ No
			☐ Yes; ☐ No	☐ Yes; ☐ No

TO BE COMPLETED BY STAFF Monthly Income Adjustments		
Type of Income	**Person(s) Receiving Income**	**Monthly Gross Income**
Wages, salaries, tips, etc. (Form W-2)		
Taxable interest (1099-INT form)		
Tax-exempt Interest (Form 1099-INT box 8)		
Ordinary Dividends (1099-DIV box 1a)		
Exempt Interest Dividends (Form 1099-INT box 10)		
Taxable refunds of state/local income taxes		
Alimony/child support Foster care payments		
Business or Self Employed income/loss (Schedule C or C-EZ)		
Capital gain/loss (Schedule D)		
Other gains/losses (Form 4797)		
IRA distributions – taxable amount		
Monthly Income Adjustments		
Type of Income	**Person(s) Receiving Income**	**Monthly Gross Income**
Pension and Annuities		
Rental real estate, trusts (Schedule E)		
Farm income/loss (Schedule F)		
Unemployment Income		

Retirement Income from Social Security		
Social Security Disability (SSDI)		
Supplemental Social Security Income (SSI)		
Other Client Income (Jury Duty Pay, Gambling Winnings)		
Child Support, Workman's Compensation, or Monetary Gift		
TOTAL		**Monthly Total= $**

The Income Adjustments are expenses that the client household may have that qualify as "deductions" against their Gross Income to come up with the Client Household MAGI. These do not in any way impact the Household Gross Income used in determining FPL for VA MAP eligibility.

The Wellness Program utilizes Ryan White Grants. As a reminder, part of the grant standards requires our program utilize a sliding scale for financial assistance towards care for your Ryan White related condition. This sliding scale is based on your current reported income and applied to your co-payment, after insurance is applied (if applicable). Please see your Eligibility Verification Letter for your sliding scale percentage.

TO BE COMPLETED BY STAFF:

Family size:_____ **Federal Poverty Level:** _____

NO INCOME STATEMENT

I declare that my family and I have no income. I (we) get food, housing and clothing in the following ways:

I understand that I must tell my HIV case manager about any changes as part of the client access eligibility review. I understand that if I falsify or do not give complete information, my eligibility for Ryan White-funded services may be denied.

_____ _____

Client (or legal guardian) Signature **Today's date (day/month/year)**

Additional Comments:

Each client must meet all four (4) of the eligibility criteria below every 24-months to be eligible for VA RWHAP B services including ADAP medication services coordinated by VA MAP. Upload copies of supportive documentation into Provide Enterprise® for each criterion and retain a copy at the provider agency.

Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies as outlined in HRSA HAB PCN 16-02.

ELIGIBILITY CRITERION	DOCUMENTATION PRESENTED/UPLOADED	
HIV+ diagnosis Required only once at intake and upload to Provide® for clients' initial assessment.	☐ Confirmatory HIV test results (Western Blot) ☐ Letter from medical provider or case manager patient navigator, confirming diagnosis of HIV disease ☐ HIV viral load testing result with detectable HIV viral load (viral load testing results with an undetectable viral load will not be accepted on their own as proof of diagnosis) ☐ Documentation from electronic medical/health record (EM/HR) of HIV disease diagnosis (progress note, etc.)	
Proof of Residency in Virginia Documentation must include client's full legal name	**<u>Tier 1 (one of the following)</u>** ☐ Unexpired Virginia State ID including drivers and motorcycle licenses, ID cards, Real IDs, or other VA state-issued ID cards that contain an address ☐ American Indian Tribal ID card for tribes in Virginia, Indian Health Services ID card, or Bureau of Indian Affairs ID card for at least one tribe in Virginia if they have addresses listed. ☐ Utility Bill not more than 2 months old with the applicant's name (*cell phone bills not accepted) ☐ Lease, rental, or mortgage agreement, property deed ☐ Current VA property tax document ☐ Case Manager-attestation of Virginia residency on their agency's letterhead	**Tier 2 (<u>two</u> of the following if none from Tier 1 available)** ☐ Letter from lease holding roommate (must include the lease holder's name, address that matches the client's application, and relationship to the client) ☐ Copy of public assistance/ benefits document ☐ Court Corrections Proof of Identity ☐ Official document or correspondence from a federal, state, or local government agency displaying the applicant's name and current address within the last year. ☐ American Indian Tribal ID card for tribes in Virginia, Indian Health Services ID card, or Bureau of Indian Affairs ID card for at least one tribe in Virginia if they do NOT have addresses listed. ☐ Unexpired/current Virginia vehicle title or registration card ☐ Current student photo ID issued by a Virginia college or university

CLIENT COPY

Insurance Status Must provide Health Insurance information to help determine eligibility and payor of last resort	☐ Copy of card for Health Insurance Marketplace coverage (ACA plan) ☐ Copy of insurance card through Employer-Based insurance ☐ Copy of Medicaid card or print out from DMAS portal look-up for coverage (client might not qualify for ADAP/VA MAP services, but may for other Ryan White services) ☐ Copy of Medicare card (and Prescription Drug Plan card if applicable) ☐ Copy of Tricare card (active duty, reserves, retired military, and eligible family members) ☐ Copy of card through other type of Private Insurance (such as Farm Bureau; off-Marketplace plans, or insurance through state-based exchanges)
Not Insurance Coverage, but important information to provide for HIV medication services:	☐ **IF** the client is participating in a clinical trial for new medications, treatments, or approaches for HIV management at the time of eligibility assessment, please upload any documentation that shows participation (copy of informed consent, letter from Principal Investigator, or letter from Clinical Trial Manager)
Proof of Low-Income Status -- Household income must be at or below 500% FPL to qualify for services. The information in the documents uploaded must match data entered in Provide® for the calculation of income based on Modified Adjusted Gross Income.	☐ Proof of current participation in Housing Choice Voucher, SNAP, WIC, Medicaid, or other federal/state benefit program with income limits at or below 500% FPL ☐ Employment income (copies of pay stubs for the most recent month showing gross income and payroll deductions) ☐ Self-employment (complete copy of most recent *individual* Federal Income Tax Return to include form 1040 and Schedule C or one month's accounting records that clearly show income paid to owner) ☐ Government benefits and/or award, (e.g.., Social Security Income/Disability) ☐ Income and unemployment benefits (copy of award letters showing current dollar amount received; if a bank statement or other document is used to verify government benefits, additional information required to document deductions for Medicare premiums) ☐ Veteran's or retirement benefits (copy of benefit award letter or other official document showing the amount received on a regular basis.) ☐ Offer letter or other letter from employer with start date, hours worked, and rate of pay ☐ Client self-attestation of cash income not verifiable through other means ☐ Letter from employer verifying cash income ☐ Net rental income -after expenses (complete copy of most recent Federal Income Tax Return) ☐ Alimony/child support (copy of benefit letter or other official document showing amount received on a regular basis) ☐ Income from participation in clinical trials that do not target a rare condition and therefore do not meet the income the income exclusion for SSI recipients (from the "Orphan Drug Act")

Proof of No Income	☐ Proof of No Income Termination or layoff notice on company letterhead ☐ Letter from Case Manager on agency letterhead stating client has no income based on the Case Manager's assessment ☐ Proof of "No Income" Letter from other individual providing financial or other support to the applicant. The letter must state the following: • The individual's relationship to the applicant • A statement describing the extent/amount of support provided • The individual providing financial support has no knowledge of any other income received by the applicant. For convenience, use the template for this letter on the program's website.

Benefits Tab:

☐ **Medicare**		☐ **Medicaid**	☐ **Medicaid**	☐ **Other**
Effective Date: _____ Medicare Coverage: ☐ Part A Only ☐ Part B Only ☐ Part A & B	☐ Part C: Carrier Name:_____ Plan Name:_____ Pharmacy Benefits: _____ ☐ Part D Carrier Name:_____ Plan Name:_____	☐ Medicaid Checked ☐ Medicaid Changed Medicaid Status: ☐ Active ☐ Applied ☐ No Benefits Date Effective: Medicaid Category:	Category: _____ Medicaid ID Number: _____	☐ VA Benefits #:_____ ☐ Tricare #: _____ ☐ _____ #: _____

☐ **Low-Income Subsidy**	☐ **Full Low Income Subsidy**	☐ **VA Medical Services**	☐ **Indian Health Services**
Status: ☐ Active ☐ Applied ☐ No Benefits Date Effective:	Status: ☐ Active ☐ Applied ☐ No Benefits Date Effective:	Status: ☐ Active ☐ Applied ☐ No Benefits Date Effective:	Status: ☐ Active ☐ Applied ☐ No Benefits Date Effective:

Insurance Tab:

☐ Primary Private Insurance		☐ Dental Care	☐ Vision Care
Status: ☐ Active ☐ Applied ☐ COBRA ☐ No Benefits Start Date:_____ End Date:_____ ☐ No Benefits Effective Date: _____ Policy Source: ☐ ACA Federal Exchange Marketplace ☐ Employer ☐ Individual	Insurance Company Name: _____ Insurance Plan Name: _____ Private Member ID: _____ Family Plan: ☐ Yes ☐ All family members on plan HIV+ ☐ No ☐ Medical Coverage ☐ Mental Health Coverage ☐ Substance Use Disorder Residential Benefits ☐ Pharmacy Benefits	Status: ☐ Active ☐ Applied ☐ COBRA ☐ No Benefits Carrier Name: _____ Plan Name: _____	Status: ☐ Active ☐ Applied ☐ COBRA ☐ No Benefits Carrier Name: _____ Plan Name: _____

Medical Tab:

HIV Status	
Status of Disease: ☐ CDC Defined AIDS ☐ HIV Negative ☐ HIV Positive AIDS Status Unknown ☐ HIV Indeterminate (Infant <2 years only) ☐ HIV Positive Not AIDS Estimated Date HIV Diagnosed: _____ History of Care: ☐ In care ☐ Never in care ☐ Out of care If OUT OF CARE: Date of last doctor's visit:_____	Modes of Transmission: ☐ Receipt of Blood Transfusion, Blood Components, or Tissue ☐ Hemophilia/Coagulation Disorder ☐ Heterosexual Contact ☐ Injection/Intravenous Drug Use ☐ Men Who Have Sex with Men ☐ Mother-at-Risk (Perinatal) ☐ Other ☐ Risk factor not reported or identified/Unknown Currently Taking Antiretroviral Therapy? ☐ Yes ☐ No Date Antiretroviral Therapy Started?

_____ _____

Wellness Program Associate Signature Date

RYAN WHITE GRANTS PROGRAM
AGREEMENT TO RECEIVE/DECLINE SERVICES FORM

Read each clause thoroughly and completely. Please ask or discuss any questions or concerns you may have ***PRIOR*** to signing this document. Once you have reviewed all clauses of the Client Responsibility and Accountability Form and you agree to the terms and conditions, ***please initial the highlighted box next to each clause***. If you choose **not** to receive Ryan White Services, please sign and date the ***Declination of Ryan White Services Statement.***

	I am responsible for providing truthful and accurate information on this application and during the application process to the best of my knowledge. Any false or unreported information may result in loss or delay of determination of eligibility to receive Ryan White Services.
	If I knowingly provide inaccurate and/or withhold information and should receive Ryan White Services that I am not eligible to receive according to Federal guidelines; I may be held financially responsible for repayment of any andall services rendered and may be subject to ineligibility for any future services.
	All information I provide will be subjected to verification through appropriate departments, organizations, employers and family members who provide letters of support. An example would be a Medicaid/Medicare application verified through Dept. of Social Services.
	Inappropriate, uncooperative and disruptive actions and behaviors of office policies and towards staff will result inthe denial of eligibility and/or loss of Ryan White Services.
	I may qualify for financial assistance through the Ryan White Program, even with another source(s) of insurance. Examples may include insurance through my employer, Medicaid, Medicare or a purchased private insurance plan.
	I understand that Ryan White Funding is ***"Payor of Last Resort"*** and it is my responsibility to exhaust all other sources of assistance such as Medicaid, Medicare, Private insurance, etc… before Ryan White funding will be approved for the requested service(s).
	If health insurance is offered through my employer and I *"opt-out"* (decline coverage); I may not qualify for Ryan White Funding assistance.
	Ryan White Funding ***does not*** cover emergency room visits or inpatient hospital costs. I acknowledge that I am solely responsible for any uncovered and/or unapproved costs related to services rendered.
	I am responsible for providing all required and/or requested financial documentation required of the Ryan White Program Eligibility Application Screening as defined in this document to determine my eligibility.
	I agree to immediately report any changes related to my eligibility determination which includes, but not limited to, income, residency, other payer sources, and contact information within **10 days** to continue receiving services funded by Ryan White Federal funding.
	I will comply by completing the Client Access Reviews (CARs) every **six (6) months** from the date of the most current approved eligible date with a Wellness Program Associate as required by Federal regulations to ensure continued funding assistance, or in the event of a life-changing event in my life for example as loss of income, insurance or housing.
	In the event that I do not provide the necessary documentation to determine my financial eligibility under the Ryan White Program, I understand that I will be considered a **SELF-PAY** client; therefore, I will be responsible for any and all services rendered, to include, *but is not limited to*, primary care visits, laboratory, diagnostic tests, specialty visits and co-pays.

RYAN WHITE GRANTS PROGRAM
AGREEMENT TO RECEIVE/DECLINE SERVICES FORM

Client Responsibility & Accountability *(continued)*

I understand that if I fail to provide bills within **30 days** of receipt may result in my financial responsibility to cover charges.

I have the right to ask for a review of my eligibility determination should I disagree with decision, deeming the determination decision unfair or incorrect.

I acknowledge that this is an application for assistance provided through the Mary Washington Wellness/ Ryan White Grants Program. All services requested/rendered must have the approval of the Medical Case Manager or the Practice Manager; otherwise, I will assume the financial responsibility of services rendered.

If the Wellness Program is not able to contact me within 6 months or longer and after 90 days of trying, I agree to the agency mailing me a certified letter to notify me of discharge from services.

I certify that I have read and understand the policies and a copy was offered.
Received/Declined (Circle) Copy _____

MWWP Associate Initials

AUTHORIZATION TO EXCHANGE
RELEASE CONFIDENTIAL INFORMATION

SECTION I: Demographics - *I understand that different agencies provide different services and benefits, and that each agency must have specific information in order to do so. By signing this form, I am giving permission for the agencies below to exchange/ release information so that they can work effectively together to provide/coordinate services and benefits on my behalf.*

Full name, printed | Social Security Number | Date of Birth (month/day/year)

Address | City | State | Zip Code

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other Authorized Representative

SECTION II: Release of Records - *I wish to exchange the following confidential information (check all that apply):*

- ☒ RW HRSA Required Data Elements
- ☐ Family History
- ☐ Psychiatric Records
- ☒ Household Information
- ☒ Assessment Information
- ☒ Financial Information
- ☐ Criminal Justice Records
- ☒ Employment Records
- ☐
- ☒ Medical Diagnosis & Records
- ☐ Mental Health Diagnosis & Records
- ☐ Substance Abuse/Addiction
- ☐ Personal Contact Info.
- ☒ Other_____

SECTION III: Information to Coordinate Care and Benefits - *I wish to exchange the specified information with the following person(s) or agencies (check all that apply):*

- ☐ D.C. Department of Health
- ☒ Virginia Department of Health
- ☒ FAHASS
- ☒ VA Dept of Social Services (Inc. state benefits)
- ☐ INOVA Juniper Program
- ☒ Mary Washington Healthcare
- ☐ Other_____

SECTION IV: Signature Authorization - This information is released with the understanding that I may revoke this authorization at any time except to the extent that the person or entity authorized to release this information has already acted in reliance on it. I have hereby reviewed this consent form and deem it valid for up to one year.

Client or Authorized Signature | Date | Wellness Program Associate

SECTION V: Staying Connected to Care - In the event that I lose contact with *Wellness Program* for 6 months or longer, I hereby give the agency permission to make all reasonable efforts to contact me for up to 1 year after my last date of contact. *I understand that these efforts may include an exchange of my personal and medical information between participating Ryan White CARE Act funded providers. I also understand that this exchange of information is strictly to ensure that my client care and support service needs are continually met and will not be used for any other purposes.*

Client or Authorized Signature | Date | Wellness Program Associate

SECTION VI: Withdrawal of Consent - *I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment or to enroll in services.*

Client or Authorized Signature | Date | Wellness Program Associate

CONSENT TO RECEIVE SERVICES

SECTION I: Consent to Receive Services - *I understand or have been informed that some or all of my treatment and/or services costs will be paid for through the Ryan White CARE Act and /or through HOPWA (Housing Opportunities for Persons with AIDS) programs.*

Client or Authorized Signature | Date | Wellness Program Associate

SECTION II: Information for Reports and Statistics

If I receive Ryan White or HOPWA services from this individual or agency, my name and financial, household and benefits/services information will be stored in a secure database. My records may be reviewed by

1. Federal funding agencies and/or their representatives; and/or by
2. Other Ryan White and/or HOPWA service providers to ensure that only one client record is created for each services user.

I understand or have been informed that federally funded agencies are expected to review the quality of services provided.

Client or Authorized Signature | Date | Wellness Program Associate

SECTION III: Quality Management - *I understand that my information may be reviewed to help guarantee/ensure the quality of the services I receive are the best possible.*

Client or Authorized Signature | Date | Wellness Program Associate

SECTION IV: VDH Communication - *I agree or disagree (circle one) to receive communication from Virginia Department of Health regarding my Ryan White Grant services and eligibility.*

Client or Authorized Signature | Date | Wellness Program Associate

I prefer the following communication with VDH:

- Email
- Phone call
- Text
- Mail

Mary Washington Healthcare

Wellness Program

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY

I,_____, understand that Mary Washington Healthcare (MWHC), of which the Wellness Program is a wholly owned subsidiary, may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Notice of Privacy Practices for MWHC, which provides information about how the physicians, facilities and individuals involved in my care may use and disclose my protected health information. As provided in the Notice, the terms of the notice may change. To obtain a copy of any current Notice, I may contact the Privacy Officer at 1-800-442-8762.

I understand that I have the right to request that The Practice restrict how my protected health information is used or disclosed for treatment, payment, or health care operations, but I also understand that The Practice is not required to agree to a request restriction.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Mary Washington Healthcare Wellness Program to leave messages regarding my treatment, including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates by the following method:

☐ Yes ☐ No Home answering machine:
☐ Yes ☐ No Cell Phone/Voicemail:
☐ Yes ☐ No Work Voicemail:

I authorize Mary Washington Healthcare Wellness Program to release any information regarding my treatment, including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates. This includes leaving message(s) on the designated contact(s) phone number. Mary Washington Healthcare Wellness Program may not release information to the named individuals and or entities unless you identify them below.

Name_____Relationship to Client_____Contact Info_____
Name_____Relationship to Client_____Contact Info _____
Name_____Relationship to Client_____Contact Info _____
Name_____Relationship to Client_____Contact Info _____

Mary Washington Healthcare Wellness Program will use my home phone number and primary address supplied during registration to contact me regarding my treatment, including lab results, x-rays, names(s) of medication(s), and information pertaining to my treatment and/or office updates. I will ensure this information is up to date at every visit.

_____ _____
Client Name Printed Date of Birth

_____ _____
Client Signature Date

_____ _____
Client Representative Relationship to the Client

Mary Washington Healthcare

Wellness Program

Ryan White Client Grievance Resolution Procedure

It is the intent of the Mary Washington Healthcare Wellness Program to provide comprehensive, high quality, services to meet the needs of people with HIV/AIDS and their families. If there is ever a time when you feel you have been treated unfairly and/or discriminated against, or if you have ideas on how to improve services, we have adopted this policy to facilitate resolution of the issue. We encourage you to communicate one-to-one with the manager, or associate if there are issues about the care you are receiving. We are here for you and want to hear how we can best provide services for people within our community.

Mary Washington Healthcare Wellness Program encourages all clients to express their concerns and to suggest remedies or improvements within its services. We will make every effort to be responsive to clients' reasonable concerns and suggestions. We also encourage clients to notify staff members of the office when services are satisfactory and should be continued. If you have suggestions or ideas, please feel free to let the organization know by the following procedures below:

1. Talk with the Program Manager to voice your complaint or grievance verbally or in writing within 14 days of the event or concern. If the complaint is one that is within an associate's power to resolve and it is found to be legitimate, the change shall be made as quickly as circumstances allow. The associate shall inform his/her supervisor of the complaint and its resolution.
2. If the complaint involves something outside of an associate's responsibility or it is beyond their power to resolve, the associate will provide you with a "grievance resolution" form and assist in completion of the form, asneeded.
3. The completed Grievance resolution form will then be given to the case manager, Program manager and/or Practice manager or his/her designee.
4. The Manager or his/her designee will follow up on all client complaints within 72 working hours to conduct fact-finding and inform the client what can or cannot be done to remedy the complaint, implement any suggestions, or provide further consideration of the issue.
5. In the event that your complaint/grievance is not resolved through the steps listed above; you may exercise your right to contact the administrative agent for the funded Program.

_____ _____

Client Signature Date

_____ _____

Wellness Program Associate Signature Date

NMCM Service Plan | MCM Referral

A "Yes" answer to any of the following questions requires a NMCM Individual Service Plan. Additionally, any "yes" to questions 8-20 require referral to a Medical Case Manager for further assessment and acuity.

NMCM Service Plan (Q1 - Q7)		NMCM Service Plan Tasks / Action Steps	Target Date	Date Achieved / Outcome
1. Are you accessing services today to complete Unified Eligibility?	❑ Yes ❑ No			
2. Do you need transportation assistance (gas card, bus pass, etc.) to be able to attend appointments?	❑ Yes ❑ No			
3. Do you need assistance enrolling in Medicaid, ACA, or other insurance programs?	❑ Yes ❑ No			
4. Do you have any HIV-related outstanding medical bills?	❑ Yes ❑ No			
5. Are you seeking assistance accessing dental services?	❑ Yes ❑ No			
6. Are you seeking assistance accessing vision services?	❑ Yes ❑ No			
7. Have you been unable to pay your rent, utilities, or buy food?	❑ Yes ❑ No			
Medical Case Management Referral (Q8 – Q20)				
8. Are you newly diagnosed with HIV?				❑ Yes ❑ No
9. Were you recently (within last 6 months) incarcerated?				❑ Yes ❑ No
10. Are you pregnant? (if applicable)				❑ Yes ❑ No
11. Are you currently unhoused?				❑ Yes ❑ No
12. Do you feel unsafe in your home?				❑ Yes ❑ No
13. Have you had any problems or delays in getting medication?				❑ Yes ❑ No
14. Has your viral load been detectable in the lasts 6 months?				❑ Yes ❑ No
15. Have you missed any medical, mental health or substance abuse treatment appointments in the last three (3) months?				❑ Yes ❑ No
16. Have you experienced any negative changes to your mental health in the last three (3) months?				❑ Yes ❑ No
17. Have you been out of medical care (for HIV) for 6 months?				❑ Yes ❑ No
18. Have you had condomless sex or shared needles in the past 6 months?				❑ Yes ❑ No
19. If you are currently using drugs/ alcohol or tobacco products would you like assistance in seeking treatment or more information about how to stop using drugs/alcohol or stop smoking?				❑ Yes ❑ No
20. Would you like to speak to a Medical Case Manager for any other reason?				❑ Yes ❑ No
Question 8-20 NMCM goal: Referred to Medical Case Manager: _____				

_____ _____

Wellness Program Associate Signature Date

CONSENTS AND SIGNATURES

I give my permission for VDH to obtain, verify, and/or release my race, ethnicity, address, medical, prescription, and/or insurance coverage information, with other agencies as necessary to manage my medication access and services through the Virginia Ryan White Part B program including the Virginia Medication Assistance Program (Ryan White Part B Program). VDH may share my information with, but not limited to: physicians, health department personnel, case managers, other Division of Disease Prevention programs (including HIV Surveillance, HIV Care, and HIV Prevention), treatment center personnel, pharmacy services providers, referral sources for services or agencies, clinics, insurance broker, agencies that pay my insurance premiums or medication copayments, and/or insurance carrier. VDH and these entities agree to treat any and all such information as confidential.

I give permission for VDH to release records or information to necessary agencies to support the application or payment by Medicare, Medicaid, other health care benefits, or services through the Ryan White Part B Program. ☑ Yes ☐ No

I have read (or had read to me) the information and permissions. I understand this information and my signature shows my agreement with these conditions for services from the Ryan White Part B Program. I have verified that the information provided in this application is complete and accurate to the best of my knowledge.

Printed Client Name: _____

Client Signature: _____

Date: _____

Client Responsibilities, Understandings, and Rights

- It is my responsibility to provide information, including medical status and proof of income, changes in address, phone numbers, and any changes to my name every six months, to remain eligible for any VA Ryan White Part B Program services including the Virginia Medication Assistance Program (VA MAP) services.
- It is my responsibility to notify Virginia Department of Health (VDH) of any changes in my contact information, income, insurance status, and insurance premium amount (if applicable) at any time these changes occur. If I do not provide the necessary documentation, I understand it will affect whether I can still receive services through the VDH.
- It is my responsibility to return any checks, cash, or other types of refunds that I receive from any provider if VDH has paid for those services. I understand the money belongs to VDH. This includes checks from insurance companies. I will return any refund or credit to VDH within seven days of receipt. I understand I can send the payment directly to VDH, I can drop it off to VA MAP staff at VDH, or I can give it to my Ryan White Case Manager or medical provider who will return into VA MAP/VDH for me. I understand that keeping these refunds, credits, or checks may result in not being able to get services from VA MAP in the future.
- I understand that VDH enters my information into a confidential database that helps the program provide me the services I need.
- I understand that if I do not sign this form, VDH will not share my information. It is then my responsibility to contact each agency individually to give my information to get services. I also understand that if I change providers, such as a medical provider or case manager, it is my responsibility to inform VA MAP.

- I request third party payers to pay any authorized benefits to or for VDH on my behalf, and I will cooperate with these payers to resolve any issues for payment if needed.
- It is my right to receive quality services in a respectful and culturally appropriate manner from anyagency that receives Ryan White funding from VDH, including VA MAP services provided directly by VDH. It is also my right to file a complaint against the agency or agencies where I get my services including VDH, if I feel I am not receiving services in this manner. I can file the complaint directly with the agency and understand that they are required to send a copy to VDH. Complaints against VDH may be sent directly to VDH or to its federal funder.
- It is my right to request information from my providers and VDH about my care. There may be a formal process to follow for each agency for these requests, but I understand I am entitled to ask for this information.
- I understand that I should send all readable or written documents such as grievances, checks from the insurance company, any insurance-related information related to my care, documents to support my eligibility for the Ryan White Part B program, and any changes in my information related to eligibility status to the Ryan White Part B program including VA MAP. The mailing address is Virginia Department of Health, HCS Unit, 1st Floor, James Madison Building, 109 Governor Street, Richmond, VA 23219. The fax number is 804-864-8050. Call 855-362-0658 with any questions. All checks must be sent through the mail. **Help us protect your personal health information (PHI) and personally identifiable information (PII) and DO NOT EMAIL INFORMATION.**

HIPAA PRIVACY STATEMENT

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulation at §164.508, it is VDH's policy that using and sharing my Protected Health Information (PHI) must be made with my written consent. By signing this form, I give permission to VDH to release records necessary to support my application for payment by Medicare, Medicaid, other health care benefits, and other services under the Ryan White Part B Program. It is VDH's policy to safeguard my PHI when VDH shares it. VDH agrees to treat all PHI as confidential as required by law [HIPAA at §164.530(c)]. At my request, VDH will provide me with how my PHI was used orshared as required by law [HIPAA Privacy Rule at §164.528 and §164.514(d)(3)]. VDH will also allow me the right to look at and ask for a copy of my PHI for as long as VDH keeps the information. This permission will remain in effect as long as I, and any of my dependents remain in VA MAP, or until I withdraw it at any time, which I must send to VDH in writing as required by law [HIPAA, §164.508(b)(5)]. Send your written request to withdraw your permission to the Ryan White Part B Program Privacy Officer, HCS unit, 1st floor, 109 Governor Street, Richmond Virginia, 23219.

RYAN WHITE GRANTS PROGRAM
AGREEMENT TO RECEIVE/DECLINE SERVICES FORM

Please choose ONLY ONE of the following boxes to RECEIVE or DECLINE Ryan White Grant Services

AND choose ONLY ONE option to receive communications:

DECLARATION to *RECEIVE* RYAN WHITE SERVICES

I have thoroughly read and understand the provisions outlined in this application and agree to the terms of this agreement between myself and Mary Washington Wellness Program. I understand that failure to comply with all the Ryan White Program policies and procedures will result in the loss of eligibility.

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____

Client Signature _____ Date _____

DECLARATION *for* DECLINATION *of* RYAN WHITE SERVICES

*By signing below, I **decline services** provided through the Ryan white funding program due to one of the following:*

- *I wish not to provide income information that is required for Ryan White eligibility.*
- *I understand that currently my income exceeds the federal poverty guidelines for Ryan White services.*

I understand that if I wish to receive Ryan White Services in the future, I can provide documentation to the Mary Washington Wellness/Ryan White Program and my eligibility will be reviewed at that date.

Last Name _____ First Name _____ Middle Initial _____

Client Signature _____

COMMUNICATION *with the* MARY WASHINGTON HEALTHCARE WELLNESS PROGRAM

☐ I would like to be involved in and contacted about Wellness Program activities.

☐ I do not want to be contacted, nor involved in program activities.

ϒ I authorize the Mary Washington Medical Group to release the information from the record of:
ϒ I authorize the Mary Washington Medical Group to obtain records from:

Provider or Facility Name:_____

Patient Name:_____ Social Security Number:_____
Date of Birth:_____ Daytime Phone Number:_____

Address:_____

Documentation can be released electronically if stored in an electronic media.

Preferred media: ϒ Paper ϒ CD ϒ Online Record eDelivery email address:_____

Dates of Service:_____ to _____

Information to be released:

ϒ Labs ϒ Pathology Reports ϒ Immunization Record ϒ Progress Notes ϒ Office Visit Notes
ϒ X-Rays or Imaging Reports ϒ Images ϒ Complete Medical Record ϒ Other:_____

Person/Facility to receive information: MWMG Infectious Disease Associates

Street 1101 Sam Perry Blvd., Suite 307 City: Fredericksburg State: VA Zip Code: 22401

This information is being disclosed for the following purpose: Continuation of Care

Authorization to Release Information:

_____

1. I understand that I am giving my permission to disclose confidential health care records, unless indicated below, relating to, if applicable, sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse unless otherwise specified below in Special Instructions;

   Special Instructions, if any:_____
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
3. I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing of my revocation, except where actions have already been taken in reliance upon this authorization. If I do not revoke it earlier, this authorization will expire on the date, event, or condition described as: _____(if none specified, this authorization will expire 6 months after the date specified below).
4. I understand that I will be given a copy of this authorization form, after signing. I understand that copying charges will be applied.

Signature of Patient or Legal Representative:_____ Date:_____

ϒ Parent or Legal Guardian ϒ Medical Power of Attorney ϒ Next of Kin Deceased ϒ Executor of Estate

Mail completed form to: Health Information Management Department
1201B Sam Perry Blvd Suite 210
Fredericksburg, VA 22401

****

Department Use Only

MRN_____ **ID Verified (Type and ID#)**_____

Processed By:_____ **Date Processed:**_____ **Pages Provided:**_____

Mary Washington Healthcare

Mary Washington Medical Group
Authorization to Release Confidential Medical Information

Rev. 11/22