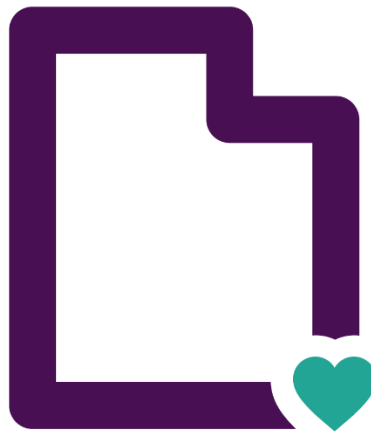


Utah Ryan White Part B manual



Utah Department of
Health & Human Services
Population Health

Division of Population Health
Office of Communicable Diseases
HIV/STD Elimination, Analysis, Response, and Treatment

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Introduction

The Ryan White HIV/AIDS Program (RWHAP) is the biggest federal program focused only on caring for people with HIV/AIDS. It's part of a law called Title XXVI of the Public Health Service (PHS) Act, and it was updated in 2009. This program gives money to help people living with HIV/AIDS who don't have health insurance or whose insurance doesn't cover everything they need. The Ryan White HIV/AIDS Program gives grants to cities, states, and local groups that offer services related to HIV. It helps more than half a million people each year. According to the Health Resources and Services Administration (HRSA):

The main goal of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White HIV/AIDS Program) is to provide services to people who have HIV, including those who have gotten very sick with AIDS.

The Ryan White HIV/AIDS Program has different parts to help communities and people affected by HIV/AIDS in specific ways.

- Part A gives emergency help to the big cities and areas that are most affected by the HIV/AIDS problem.
- Part B gives grants to states and territories.
- Part C offers complete primary health care in clinics for people living with HIV.
- Part D focuses on family care in clinics for women, babies, children, and young people with HIV/AIDS.
- Part F provides money for different programs, including Special Projects of National Significance (SPNS), the AIDS Education and Training Centers (AETC), dental programs, and the Minority AIDS Initiative.

Currently, Utah gets money from Part B, Part C, Part D, and Part F (AETC). This manual is about the rules and steps for the Part B program. For information about Part C, Part D, and Part F, contact the University of Utah Hospitals and Clinics.

The U.S. Department of Health and Human Services (HHS), HRSA, and the HIV/AIDS Bureau (HAB) manage the Ryan White HIV/AIDS Program at the federal level. You can find specific information about the Ryan White laws at <http://hab.hrsa.gov/abouthab/legislation.html>.

Words used in this manual

This manual uses specific words and abbreviations that relate to the Utah Ryan White Part B program.

AIDS Drug Assistance Program (ADAP) is a part of the Utah Ryan White Part B program that offers 2 services: ADAP-Medication Assistance (ADAP-M) and ADAP-Health Insurance Assistance (ADAP-I). In Utah, ADAP usually refers to both of these services.

ADAP-M is a term used only by the Utah Department of Health and Human Services (DHHS) Ryan White program and means help with medications through the AIDS Drug Assistance Program (ADAP).

ADAP-I is a term used only by the Utah DHHS Ryan White program and means help with health insurance through the AIDS Drug Assistance Program (ADAP).

Affordable Care Act (ACA) is a law signed by President Obama on March 23, 2010. It made big changes to health insurance in the U.S., especially by creating an online marketplace where people can buy qualified health plans (QHPs).

Applicants are people living with or affected by HIV/AIDS who are applying to get services through the Utah DHHS Ryan White program but haven't joined the program yet.

APTC refers to the advance premium tax credit, which is money a person might get to help pay for a QHP they buy through the marketplace.

ClientTrack is the computer system the program uses to process applications, keep track of who is eligible, record case management activities, and track all the services provided by the program.

DPI refers to direct purchase insurance, which is a qualified health insurance plan that a person buys directly from an insurance company instead of through the marketplace.

An eligible client is someone living with or affected by HIV/AIDS who meets all the requirements to join the program, including having HIV, living in Utah, and having a certain income level.

An enrolled client is an applicant who has applied, is eligible, and has been approved to receive services from the program.

FPL refers to the federal poverty level. This is a measure used by the government to decide if a person or family's income is low enough to qualify for certain benefits and programs. It's based on guidelines from HHS.

Health Resources and Services Administration (HRSA) is the federal agency that manages the funding for the Ryan White program.

Incarceration means being held in jail or prison because of a crime. This includes being in jail before a trial, after being sentenced, or being under supervision like parole or home detention.

- Transitional basis means giving core medical and support services for a limited time to people with HIV who are in jail or prison and will be eligible for program services when they are released soon (within 180 days). This helps them connect with care and continue their treatment.
- Short-term basis is when the program gives core medical and support services to people in jail or prison for 180 days or less.

Internal sources refers to any information the program can access to help decide if someone continues to be eligible for services.

Marketplace refers to the health insurance marketplace website (www.healthcare.gov).

Med-D refers to Medicare Part D or other Medicare coverage for prescriptions.

Program refers to the Utah DHHS Ryan White Part B program and all the services it offers, including ADAP-M, ADAP-I, core medical care, support services, and case management.

Part B providers are agencies across Utah that directly provide program services to Utahns living with HIV/AIDS. DHHS makes agreements with these providers to offer these services.

PLHIV refers to all people living with HIV and AIDS. If it's important to tell the difference, PLWH refers to people living with HIV who have not been diagnosed with AIDS, and PLWA refers to people living with an AIDS diagnosis.

Public health service includes all groups (public, private, and volunteer) that help deliver important public health services in an area.

QHP refers to a qualified health plan that meets the basic health coverage requirements of the ACA and is available through the marketplace or bought directly from an insurance company.

RWHAP refers to the Ryan White HIV/AIDS Program.

Utah Department of Health and Human Services (DHHS) is the organization in Utah that receives Part B funding from HRSA to provide core and support services, including ADAP-M and ADAP-I.

Viral suppression means having a very low amount of HIV in the blood (fewer than 200 copies per milliliter).

Utah Ryan White Part B Program overview

The goal of the Utah Ryan White Part B program (program) is to develop, organize, coordinate, and run an effective and affordable system for providing important services to people and families affected by HIV.

How the program is organized

The program is part of the Utah Department of Health and Human Services (DHHS), in the Division of Population of Health Office of Communicable Diseases HIV/STD Elimination, Analysis, Response Treatment (HEART) program. The program directly manages the Utah AIDS Drug Assistance Program (ADAP), core medical services, support services, and the quality management program (QM). The Utah ADAP offers both medication help (ADAP-M) and health insurance help (ADAP-I).

The program is managed by a Part B administrator and an ADAP administrator who oversee and guide the program's services. A program manager handles the overall administrative tasks and helps the administrators. The program's rules and steps are kept within specific service areas, and the program manager makes sure these rules are consistent.

The Part B administrator oversees core medical and support services, which include outpatient medical care, case management, and other support. The ADAP administrator oversees ADAP services, like help with medications and insurance premiums. The ADAP administrator also oversees the yearly process of checking whether clients are still eligible for the program.

Utah Continuum of Care

The Utah Department of Health and Human Services HEART program offers a full range of services for people with HIV who live in Utah. The Utah HIV planning group works to coordinate the plans to both prevent and care for HIV.



How the program is funded

- **Formula grants:** The federal government gives these grants based on the number of people reported to be living with HIV/AIDS in the state or territory in the most recent year.
- **ADAP supplemental grants:** The federal government gives extra funds to states that show a big need for medications. Funding is available if a state meets one of these conditions: (1) income limit of 200% of the federal poverty level (FPL) or less; (2) limited choices of the main types of HIV medications; (3) a waiting list for ADAP; (4) limits on enrollment or how much money is spent; and (5) a sudden increase in the number of people with HIV/AIDS who are eligible for ADAP.
- **Part B supplemental grants:** The federal government gives extra funds to states that use data about HIV cases, other health issues people with HIV have, the cost of their care, the needs of new groups of people affected by HIV, unmet needs for basic medical services, and unique challenges in providing services to show the seriousness of the HIV/AIDS problem.
- **Emergency relief funds (ERF):** The federal government gives these funds to states that have taken steps to save money because they don't have enough ADAP funding. Even though the amount of money provided has increased, the demand for ADAP services in many states started to be more than what was available. This led to states creating waiting lists and/or finding ways to cut costs. Therefore, emergency relief funding helps with the increased urgent need for ADAP.
- **Rebates:** In 1992, Congress created Section 340B of the Public Health Services Act. This requires drug companies to make an agreement with the HHS secretary called a pharmaceutical pricing agreement (PPA). Under this agreement, the drug company agrees to give discounts on outpatient drugs to specific providers, called covered entities, that serve the most vulnerable people. Hospitals that serve a high number of low-income patients, ADAPs, and Ryan White clinics all qualify as 340B covered entities.
- **Supplemental discounts:** Extra discounts were first successfully negotiated in the winter of 2003 by a group called the ADAP Crisis Task Force. AIDS directors and ADAP experts from several states met with drug companies to get discounts on medications that were even lower than the guaranteed 340B price for all ADAPs. The amount of these extra discounts varies between drug companies and sometimes even between different

medications from the same company. Negotiations continue to happen regularly to update the ongoing pricing agreements and to get discounts on new medications.

- State funds: Money from the state, if any, also helps pay for program costs.

Federal rules say that Ryan White HIV/AIDS Program funds cannot be used to pay for services that are already covered, or could reasonably be expected to be covered, by any state program, insurance policy, federal or state health benefits program, or by an organization that provides health services for a prepaid fee. The Ryan White HIV/AIDS Program pays only when no one else is expected to pay.

Things you cannot pay for with Ryan White HIV/AIDS Program funds

- Drug use and sexual activity: Ryan White funds cannot be used to support programs or materials that are designed to promote or directly encourage using intravenous drugs or any type of sexual activity.
- Purchase of vehicles without approval: Grantees or sub-grantees cannot use Ryan White funds to buy vehicles without written permission from the HRSA Grants Management Officer (GMO).
- Broad scope awareness activities: Ryan White funds cannot be used for general awareness campaigns about HIV services that target the general public.
- Lobbying activities: Ryan White funds cannot be used to try to influence members of Congress or other federal officials.
- Direct cash payments: Ryan White funds cannot be used to give cash directly to people who receive services.
- Employment and employment readiness services: Ryan White funds cannot be used to support job training, vocational programs, or services that help people prepare for work.
- Maintenance of privately-owned vehicle: Ryan White funds cannot be used for direct maintenance costs (like tires or repairs) for a car owned by an individual or any other car-related costs, such as lease or loan payments, insurance, or license and registration fees.
- Additional prohibitions: Ryan White funds cannot be used for the following activities or to buy these items:
 - Clothing
 - Funeral, burial, cremation, or related expenses
 - Local or state personal property taxes (for homes, cars, or any other personal items that are taxed)
 - Household appliances
 - Pet food or other non-essential items
 - Social or recreational activities off-site or payments for a client's gym membership
 - Buying or improving land, or buying, building, or making major improvements to any building or facility (except for minor remodeling)
 - Pre-exposure prophylaxis (PrEP)

Service overview

All clients must meet minimum eligibility criteria:	CM	SS	ADAP-M	ADAP-I						
HIV+ living in Utah low-income				Group plan	Medicaid	EB-HIPP	Med-D	COBRA	Market-place	DPI
Eligibility	500% FPL	250% FPL	250% FPL	250% FPL	250% FPL	250% FPL	250% FPL	250% FPL	250% FPL	250% FPL
FPL limit										
Services*										
Non-medical case management	√	√	√	√	√	√	√	√	√	√
Medical case management	√	√	√	√	√	√	√	√	√	√
Oral health		√	√	√	√**	√	√	√	√	√
Emergency financial assistance		√	√	√	√	√	√	√	√	√
Food vouchers		√	√	√	√	√	√	√	√	√
Transportation		√	√	√	√	√	√	√	√	√
Prescriptions			√	√	√	√	√	√	√	√
Outpatient ambulatory health services			√							
Medical cost-sharing assistance				√	√	√	√	√	√	√
Insurance premiums						√	√	√	√	√
<i>*Clients may qualify for different services based on their unique circumstances. The Part B Program assists the client in qualifying for the services to provide the greatest level of care.</i> <i>**Oral health is available to Medicaid-enrolled individuals who do not qualify for oral health services through Medicaid.</i>										

Service standards

Service standards are basic care expectations from a provider when they offer a service. These standards define the main parts and activities of a service type and help the program set expectations for how services are obtained. Service standards make sure that no matter where a client gets a service, they will receive the same basic elements of that service. HRSA HAB

requires Ryan White program recipients, like the Utah Ryan White Part B program, to "work toward developing and using service standards for all services funded by the RWHAP," according to Policy Clarification Notice (PCN) 16-02.

The program has created service standards for all the services it provides. These standards are reviewed and updated each year and can be found on the program's website at <https://ptc.health.utah.gov/treatment/ryan-white>.

Clinical quality management

Program recipients are required to have clinical quality management programs to:

- Check if the HIV health services being offered follow the most recent public health service guidelines for treating HIV and related infections; and
- Develop plans to make sure these services follow the guidelines to improve how easy it is to get HIV services and the quality of those services.

The Clinical Quality Management Plan describes the program's structure, priorities, how performance is measured, quality improvement activities, action plans with timelines, and how progress is evaluated. The program works directly with other agencies that provide services to give overall guidance and to collect and share data needed to measure performance and/or quality improvement activities. The program follows a careful and specific process to continuously improve the quality of services. Program evaluation helps make sure we meet or go beyond the legal requirements for quality management, basic medical care, and support services.

How to apply

Application policy

Applications are accepted at any time. Applicants are encouraged to work with a benefits specialist to fill out the application for the program. The program uses ClientTrack. If you need a paper application, you can email RWP@utah.gov or find it online at <http://health.utah.gov/epi/treatment/>.

Applicants need to submit a complete application through ClientTrack and provide the documents listed in the application and in this manual to apply for program services. These documents prove they meet the eligibility requirements.

Approved applications

Clients who submit a complete application that is approved by the program will be considered eligible for Part B services until the program receives information that shows they no longer meet the current requirements. The month their eligibility starts is considered the first month

of their eligibility period. The program will try its best to check if clients are still eligible each year using the information it already has. Clients will be asked to provide any updated information that the program can't verify. Clients can choose not to have the program check their eligibility internally, but then they will need to provide complete documentation to prove they are still eligible every year.

Clients will be approved for all the services they qualify for but will only be signed up for ADAP if they ask for it. The applicant and their case management agency will receive a notification of approval from the program through ClientTrack.

Opt-out

Clients who want to stop the program from checking their eligibility internally can submit a completed opt-out form to the program at any time. If a client wants to cancel a previously signed opt-out form, they need to email rwp@utah.gov to request the cancellation.

Denied applications

Clients who don't meet the basic requirements for the program will be denied all services. The eligibility rules might be different for different types of services. Clients might be denied for some services but approved for others, depending on what they qualify for. If the decision about eligibility is a denial, both the applicant and the case management agency will receive a notification of denial from the program.

Incomplete applications

The program cannot decide on eligibility for applications that are not complete. Incomplete applications will not be reviewed by the program; the case management agency will be told that the application was incomplete. Services cannot be provided until the application is approved and the client is enrolled.

Signature for a minor client

A parent or legal guardian can sign an application/recertification form for a client who is a minor (younger than 18). In these cases, the parent should be listed as the parent/guardian on the form and also listed in the part of the form where they give permission to release information.

Expired signature dates

The program will not review incomplete applications that are not finished within 60 days of the first signature. A new application with all the necessary documents will need to be submitted for review.

Filing an appeal

If an applicant believes a mistake was made in deciding their eligibility, they can submit a written request through their case management agency to ask the program to review the decision again. The written request should explain why they believe they meet the eligibility requirements and include any supporting documents. Submitting an appeal does not

guarantee approval. The basic eligibility rules cannot be appealed. You can only appeal if you think the program made a mistake in how they determined your eligibility.

Exception to policy

The program may approve a request for an exception to the rules if there is a clear need.

Examples of when an exception might be requested include:

- Appealing an eligibility decision
- Requesting an exception to a program policy
- Getting medications for travel or moving
- Asking for an exception to the requirement to actively pursue other sources of payment

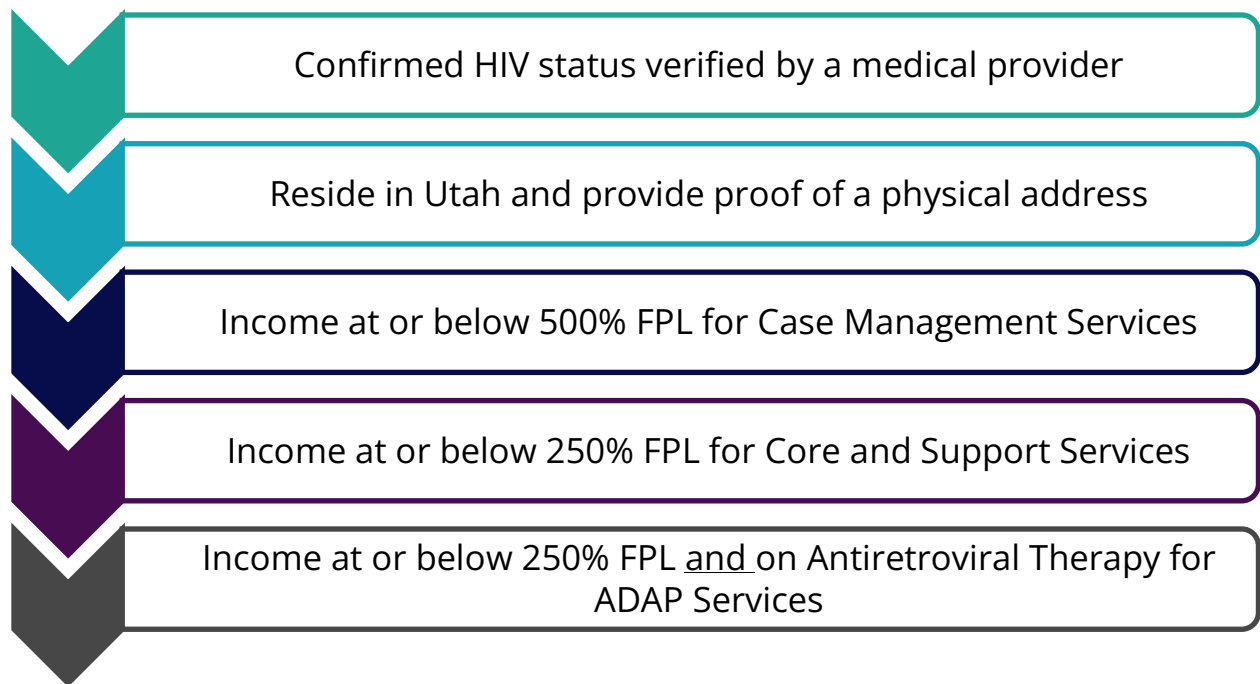
Each exception request will be reviewed individually, and the program will make the final decision. Submitting an exception request does not mean it will be approved. The exception request and the program's decision (approval or denial) will be shared with the case management agency and kept in the applicant's file. Allow at least 1 business day for the program to review an exception request.

Expedited review

The program wants to provide Ryan White services quickly, especially to people who are newly diagnosed or are returning to care and need HIV medications right away. An expedited (faster) review might be granted if an applicant shows an immediate medical need for approval to receive services. Same-day eligibility determination is not guaranteed and is not always possible. Allow at least 1 business day for review.

Eligibility criteria

Clients must meet all the eligibility rules for both individuals and households. Some services might have additional requirements beyond the basic eligibility listed below. Check the information for specific services for more details.



There might be additional requirements to enroll in specific services. Applicants are encouraged to talk to their case management agency to understand all the services they might qualify for and how to sign up.

Eligibility—HIV diagnosis

HIV diagnosis

Applicants must have a confirmed HIV diagnosis verified by a medical provider. Proof of their HIV diagnosis must be sent directly from the provider or case management agency.

Proof of HIV diagnosis

- New applicants must submit 1 of the following to prove their HIV status:
 - A written statement of HIV diagnosis from a medical provider, signed by a doctor.
 - Documentation of HIV diagnosis received from a doctor, medical office, lab, or the previous case management agency.
 - Lab results confirming HIV status, stated in a way that program staff who do not have medical training can understand.
- Re-certifying clients:
 - The program may use HIV surveillance data to re-verify the HIV status of clients.
 - Returning clients: Clients who have been in the program before do not need to provide proof of HIV diagnosis again if the program already has a record.

Eligibility—state residency

Utah residency

- A person is considered a Utah resident if they live in the state voluntarily and plan to continue living here. Someone who moves to Utah from another state and intends to become a Utah resident is a Utah resident, no matter how long they have been in the state.
- Applicants must be physically present in Utah or temporarily away to be considered a resident. Citizenship does not affect whether someone is considered a resident. P.O. boxes are not acceptable as proof of where someone lives, but they can be given as a preferred mailing address in addition to proof of a physical address.
- Temporary absences from Utah after a person has been living there do not affect their eligibility if they plan to return to Utah when the reason for their absence is over. Services will not be stopped because of a temporary absence if the person intends to return to Utah, unless another state has decided the person is a resident of that state for the purpose of Part B or ADAP eligibility. Temporary absences can include things like illness, education, military service, business trips, or vacations.
- The effective date is when Part B services can start. It is the day the person arrives in Utah and intends to become a resident. People who do not plan to be residents of Utah but are only visiting temporarily are not considered residents and are not eligible for Utah Part B services.
- Clients who are unhoused (don't have a permanent home) must work with a case management agency to provide acceptable documentation of residency.

Proof of residency

Clients must show they currently live in Utah. The proof of residency document does not have to have the same mailing or physical address as the clients. P.O. boxes cannot be used as proof of residency but can be used as current mailing addresses. For a minor client, proof of residency can include a guardian's name if they are listed as the parent/guardian on the client's application or recertification form.

Acceptable documentation

All applicants must provide a copy of at least 1 of the following documents if the program cannot verify their residency using its own records. These documents must have the applicant's name and a Utah street address. Documents should not be expired for more than 2 months from the date they are submitted, unless it says otherwise.

Proof of residency documentation	Additional criteria
Utah driver license	Cannot be expired more than 2 calendar months.
Utah state ID	Cannot be expired more than 2 calendar months.

Tribal ID	Cannot be expired more than 2 calendar months.
Paystubs or earning statement	Dated within the last 2 calendar months.
Documents issued by a financial institution	Bank statement, credit card statement, etc. dated within the last 2 calendar months.
Current rental or lease agreement	Signature pages and the length of the agreement must be included.
Recent utility bill	Dated within the last 2 calendar months (cell phone bills are not accepted).
Current mortgage statement	Dated within the last 2 calendar months.
The most recent property tax document	Dated within the last 12 months.
Copy of SSI/SSDI award letter	Current year benefit letter.
Document issued by the state of Utah	Public assistance documents, tax documents, voter registration cards, vehicle title registration cards, etc. dated within the current calendar year or within the last 2 calendar months, depending on the document.
Document issued by the U.S. federal government	Public assistance documents, tax documents, tax transcripts, etc. dated within 12 months.
Military/Veterans Affairs ID	Cannot be expired more than 2 calendar months.
Approved letter from case management agency, transitional housing location, or other transitional service provider	Letter reviewed and approved by DHHS. The letter should be submitted on letterhead, be dated within the last 60 days, have a signature and contact information.
Internal sources used by the program	Utah residency will be verified by the program using information available from internal sources.

Acceptable proof of residency for an unhoused applicant

People without a traditional home can use a fixed location as their residence for identification if it is a recognizable place in Utah that could reasonably serve as a temporary residence. This could be transitional housing or another place where an unhoused person might spend time or return to.

To show that a person without a traditional residence is a qualified Utah resident, they need to provide documentation that shows a connection to a specific shelter or agency. This could be a letter from a shelter or a social service organization (private or public) that helps unhoused individuals. The letter should identify the person and describe the location being used as their residence.

The identification letter should be on the organization's letterhead and signed by someone who works at the social services organization. See Appendix B for an example.

Eligibility—income

Household income

The Ryan White HIV/AIDS Program law says that clients who receive treatment services must have a low income, as defined by the local rules. The income requirements for the program are set by Utah Administrative Rule R388-805.

Program eligibility is based on both the individual's income and the total income of their household. Clients must meet all the eligibility rules set by the program.

“Household” includes the client (and parent(s)/guardian(s) if the client is a minor), the client’s legal spouse, and the client’s financial dependents, including children. If the client is a minor, “household” includes their legal guardian(s) (parent(s)) and their financial dependents, including the minor client.

Asset limits

The Utah Part B program no longer has a limit on how much money or property a person can have. This rule was removed in 2016.

What is income?

Money earned from work and received from other sources count as part of the total yearly income of the household.

Earned income <i>Cash, checks, direct deposits, etc. received for which a service was performed</i>		
Included <i>Required to be reported</i>	Income type	Excluded <i>Not required to be reported</i>
Regular, overtime, holiday, sick, and vacation pay. Employer contributions to HSA accounts.		Certain employee benefits, such as payments to a retirement plan, medical insurance, and FICA taxes paid by the employer. Tax return refunds.

Payments made through contract work	Wages and salaries	In-kind services, including food or shelter, childcare, etc.
Tips, commissions, wage advances and bonuses		Do not count allocated tips as income. The allocated amount is the amount reported by the employer to the IRS based on gross receipts of the business.
Severance pay		Replacement of income that was lost or stolen.
Training incentive payments and work allowances		Rebates, refunds, reimbursements or return of money, including per diem.
Capital gains received from the sale or transfer of assets used in self-employment	Self-employment	Cash received from selling a car, etc. Receipts from the sale, exchange, or replacement of resources.
Profits received from self-employment		Personal services <i>Ex: Mowing the lawn, shopping, babysitting, housecleaning, or other similar services, which are done sporadically and without the intent to establish a self-employment business and render nominal amounts of money are not considered income.</i>
Unearned income <i>Cash, checks, direct deposits, etc. received by an individual for which no service was performed.</i>		
Included <i>Required to be reported</i>	Type of income	Excluded <i>Not required to be reported</i>

Withdrawals from pensions and retirement funds	Retirement	Pension and retirement funds not currently being withdrawn.
Disability benefits, survivor benefits, life insurance benefits, VA benefits	Benefits	Credit life or credit disability insurance payments.
Unemployment income, needs-based income such as SSI		In-kind gifts, cash for medical or social services, including food or shelter, payments of bills by a third party. Benefits intended for a dependent such as SSI.
Alimony, inheritances, tribal fund payments, and cash gifts	Payments received	Child support. Stimulus income, or money sent by the United States or state government to stimulate the economy by providing consumers with some spending money.
Rental income	Investments	Reverse equity mortgages.
Certain business income, such as limited partner payouts and dividends		Proceeds from a loan.
Education assistance including funds used for living expenses and non-education expenses Work-study income that is reported as wages on tax returns	Education	Funds used for tuition, fees, books, and supplies. Education loans.

Proof of income

People applying should provide official papers to show all their income sources if the program can't check them on its own. These papers must be dated within the last 2 months before applying, unless stated otherwise. If an applicant gets money from a source not listed by the program, they should talk to their case manager or the program to find out if this income needs to be reported and what proof is needed.

Acceptable documentation

The following table gives examples of acceptable papers for the most common types of income. Clients can submit other papers not on this list for the program to review and consider. At the very least, proof of income must have a date, the name of the person who earned the money (client, spouse, etc.), and enough information to figure out the total household income. When possible, the program will check a client's income using its own records.

Income type	Acceptable documentation
Wages and salaries from formal employment (<i>wages, tips, commissions, etc.</i>)	<u>One of the following:</u> <i>The equivalent of 1 month's earnings dated within 2 months of submission for ALL jobs. (One month's earnings equals 2 paystubs if paid biweekly or 4 paystubs if paid weekly.)</i> OR <i>Most recent tax statements or W-2 forms may be accepted if the client is still employed with the same company.</i> OR <i>Employer statement displaying current wage, hours worked, pay frequency, and availability of benefits must be signed and dated within 2 calendar months of submission.</i>
Wages and salaries from informal employment with no paystubs (<i>cash earnings, day laborers, etc.</i>)	<i>Depends on the source. Work with a case management agency to determine the most appropriate documentation.</i>
Self-employment	<i>IRS Form 1040 and Schedule C or Schedule E for the most recent tax filing period.</i>
SSI/SSDI	<i>Current year benefit letter.</i>
Benefits (<i>life insurance, disability, educational assistance, survivor's, etc.</i>)	<i>Current year benefit letter.</i>
Capital gains, stocks, bonds, cash dividends, trust, investment income	<i>Tax documentation for the most recent period or documentation from a financial institution.</i>
Public assistance/unemployment	<i>Unemployment statement, award letter or pay stubs, or general assistance letter from the Department of Workforce Services (DWS) for the current period.</i>
Retirement (<i>pensions, annuities, 401k, etc.</i>)	<i>Current benefit statement.</i>
Alimony	<i>Current benefit letter or other official documentation.</i>
Rental income	<i>Current rental agreement, tax documentation, or other official documentation.</i>
Veterans benefits	<i>Current year benefit letter.</i>
"Other" income	<i>Depends on the source. Work with a case management agency to determine the most appropriate documentation.</i>
Legal spouse's income	<i>See above for acceptable documentation by type of income.</i>

Employer statement

The program may accept a statement from an employer that gives enough details to determine the total yearly household income. The preferred way to provide this is using the Employment Verification Form (Appendix A) from the program. At a minimum, the employer statement must include the following:

- Client name
- Current pay rate (hourly or yearly salary)
- Number of hours worked per week or pay period
- How often the client is paid
- Start date of employment and how long the job is expected to last, if it has an end date
- Name, job title, and contact information of the person who filled out the statement
- Submitted on official company letterhead if possible
- Signed and dated within 2 months of when it is submitted
- The program may consider accepting email statements from employers. These emails should have all the required information and be sent from a real email address connected to the employer.

Affidavit of zero income

If a client's household has none of the income sources listed by the program, they can fill out a form called the Affidavit of Zero Income. Clients who receive payments from the list of "Excluded" income sources are considered to have zero income.

Eligibility—health insurance coverage

Assessment of available coverage and vigorous pursuit

The program says that "vigorously pursue" means making a reasonable effort to sign up for health insurance for which a client might be eligible. Agencies that have a contract with Part B should make reasonable efforts in the following ways:

- Check what health coverage is available to the client
- Education about the benefits of health insurance
- Help the client enroll in health coverage

HRSA PCN #13-02 states:

'RWHAP funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by another payment source... Part B Program and contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible. (e.g. Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) The RWHAP will continue to be the payer of last resort and will continue to provide services not covered, or partially covered, by public or private health insurance plans.'

According to HRSA PCN#13-02, a client can remain without enrolling in an eligible health insurance plan and still be eligible for Part B program services if there is detailed proof of vigorous pursuit provided when they re-apply. The details of what is needed to prove these efforts are listed below.

Assessment of available health care coverage

Assessment of available health care coverage happens when someone first applies and each time they re-apply. The client's answers about available payment sources, along with the required papers they submit, are used to decide whether the client is currently enrolled in other coverage or if they need to try to enroll. The program can ask for more information if needed to make sure the information given by the client is correct and complete. If the client becomes eligible for or signs up for other health coverage during their eligibility period, they might be moved to a different ADAP service that better meets their needs and is more cost-effective.

HRSA PCN #13-02 states that Ryan White funds cannot be used for any item or service if another payment source has already paid or can reasonably be expected to pay for it. Those who receive Ryan White funds and their partners are expected to strongly try to get other funding sources (like Medicaid, CHIP, Medicare, other state-funded HIV/AIDS programs, employer-sponsored health insurance, and/or other private health insurance) to allow the limited Ryan White grant money to help new clients and/or provide needed services.

Vigorous pursuit

HRSA HAB requires that those who receive grants must make sure their partners and contractors maximize Ryan White resources by enrolling clients in a health coverage option that costs less than paying the full price for medications and other essential medical services. HAB requires that grant recipients have rules about the steps needed to try to enroll all clients, to keep records of these steps for all clients, and to better monitor and enforce the processes of their partners and contractors to make sure clients enroll in Medicaid if they are eligible.

Ryan White funds, including ADAP funds, can only be used to continue paying for private health insurance for clients who are eligible for Medicaid if it costs less to do so and follows Ryan White policy PCN 13-02.

The Utah Ryan White Part B program will require that affordable insurance be strongly pursued for all clients who seek ADAP services. Clients for whom vigorous pursuit is not shown will not be eligible for continued ADAP services.

All clients eligible for Medicaid will need to strongly try to enroll in Medicaid, unless the program approves otherwise. If a client eligible for Medicaid is not enrolled, the agency providing services needs to give proof of vigorous pursuit to the program. Vigorous pursuit includes, but is not limited to, detailed records showing insurance education and efforts to apply for Medicaid. Clients enrolled in certain Medicaid programs are eligible for the program as long as the program can verify their enrollment and they do not have a spenddown requirement.

Other health care coverage

The following table gives examples of the minimum effort and proof needed to show vigorous pursuit of the most common types of health care coverage. The program may ask for proof not listed below to check if other payment sources are available. The program will use its own records to check other health care coverage.

Type of coverage	Assessment of availability	Vigorous pursuit documentation options
Medicaid	All Medicaid-eligible clients will need to vigorously pursue Medicaid, except if otherwise approved by the program. If a Medicaid-eligible client is not enrolled vigorous pursuit documentation needs to be provided to the program by the contracted agency. Vigorous pursuit includes, but is not limited to, extensive records documenting insurance education and efforts to apply for Medicaid. Clients may continue to receive Part B services while Medicaid enrollment is pursued. All available charges will be back-billed to Medicaid once the client is approved. Primary Care Network (PCN) and Emergency-only Medicaid is considered insufficient coverage as it does not provide comprehensive HIV medical	• Proof of Medicaid enrollment. • Proof of submitted Medicaid application. • Multiple submitted Medicaid applications without a decision will not be accepted without additional explanation as to why the initial application was not accepted, follow-up documentation may be required. • The agency provides documentation of insurance education and efforts to

	care. Clients enrolled in these services are considered underinsured and qualify for all program services, including health insurance. Clients aged 65 or older and at or below 100% FPL must provide vigorous pursuit of Medicaid.	assist the client in enrolling in Medicaid. • The agency provides documentation of insurance education and efforts of the client to enroll in Medicaid.
Medicare Part D	Clients eligible to enroll in Medicare Part D or other Medicare pharmacy benefit plans are encouraged to pursue enrollment. Case management agencies are responsible for assisting clients with their enrollment and may assist clients in requesting the program to assist with paying monthly premiums. Clients who meet the requirements for Medicare extra help found here: https://secure.ssa.gov/i1020/start must vigorously pursue enrollment.	• Proof of enrollment into Medicare Part D insurance. • The agency provides documentation of insurance education and efforts to assist the client in enrolling in Medicare Part D including documentation of efforts to remind the client of Medicare Part D open enrollment and assistance during open enrollment. • Agency provides documentation of insurance education of client efforts to enroll in Medicare Part D.
Group plan—spouse or parent	The program will request information regarding current enrollment or eligibility to enroll in spouse or parent health insurance coverage. If the client is eligible for coverage and not enrolled, the case management agency is expected to help the client vigorously pursue enrollment. If the client is eligible for dual coverage through a spouse/parent plan and an employer plan, the program requests, but cannot require, that the client enroll in both plans.	• Proof of enrollment into group insurance. • The agency provides documentation of insurance education and efforts to assist the client in enrolling in group insurance including documentation of efforts to remind the client of group insurance open enrollment and assistance during open enrollment.

	The program will not require proof of insurance availability from a spouse or parent employer due to confidentiality reasons. The program cannot require a client to enroll in a health plan. The client may decline to enroll in a group plan and remain eligible for program services if vigorous pursuit requirements are met. (HRSA PCN#13-03 and #13-04).	Agency provides documentation of insurance education of client efforts to enroll in group insurance.
Group plan—client employer	The program has the responsibility to verify if a client is currently enrolled in an employer plan. Current enrollment is verified through a variety of sources which may include, but are not limited to. client report, review of paystubs for health insurance deductions, documentation from the employer, and health insurance verification conducted by the pharmacy benefits manager. The program has the responsibility to request information regarding client eligibility for employer coverage. If the client reports they are not eligible for employer insurance, the program may request additional information or documentation as needed to complete the determination. The client is employed and enrolled in employer health insurance: Documentation of plan details will be requested once annually for continuous employment The client is employed but not enrolled in employer health insurance:	- Proof of enrollment into Group insurance - The agency provides documentation of insurance education and efforts to help the client enroll in employer insurance including documentation of efforts to remind the client of employer insurance open enrollment and assistance during open enrollment. - Agency provides documentation of insurance education of client efforts to enroll in group insurance.

	• If a client reports they <u>work fewer than 30 hours</u> per week, which is verified with pay statements, and • Client reports <u>insurance is not</u> available to them, proof of insurance availability <u>will not</u> be required from the employer, or • Client reports <u>insurance is</u> available to them, proof of insurance availability <u>will be</u> required from the employer • If a client reports they <u>work more than 30 hours</u> per week, which is verified with pay statements, proof of insurance availability <u>will be required</u> from the employer Proof of insurance availability will be requested once annually for continuous employment. The program cannot require or force client enrollment into a health plan. The client may decline to enroll in an employer-sponsored health plan and remain eligible for Part B services. However, vigorous pursuit documentation must be provided to continue to be eligible for ADAP services.	
COBRA	Clients eligible for COBRA are encouraged to pursue enrollment to maintain continuous health coverage. However, clients eligible for COBRA also qualify to enroll in a program-sponsored DPI plan. Clients should work with their case management agency to determine the most appropriate plan to enroll in.	Vigorous pursuit is not required

DPI	Clients eligible for DPI are encouraged to pursue enrollment during yearly open enrollment or if the client has a special enrollment period due to a qualifying life event. Clients should work with their case management agency to determine the most appropriate plan to enroll in.	• Proof of DPI enrollment • The agency provides documentation of insurance education and documentation of efforts to contact clients before and during open enrollment • Documentation of insurance education and explanation of why the client, although contacted and educated, is not a good fit for insurance benefits
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Exceptions to the payer of last resort requirement

Ryan White program providers cannot deny services, including prescription drugs, to someone who:

- Receives benefits through Veterans Affairs (VA) and is otherwise eligible for Ryan White services, even if they could get services and medications through the VA (PCN 16-01).
- Is Native American and can also access Ryan White services, including prescription drugs, even if those services are available through Indian Health Service, tribal, or urban Indian health programs (PCN 07-01).

The Ryan White program can ask for more information if detailed proof is not received.

Incarcerated individuals living with HIV/AIDS

The Utah state prison provides HIV medical care, which means the program cannot pay for these services because it is the payer of last resort by law. The program may offer case management services to clients in federal and state prison systems only temporarily, as much as the prison allows.

The program can provide eligible clients with ADAP-M, Medicaid copay assistance, outpatient medical care if they are seen at a contracted facility, and case management services for people in other correctional systems, including those under community supervision, on a short-term and/or temporary basis, as allowed by the facility. Proof must be received from the facility that there is no overlap in services. The program cannot pay for services for incarcerated people who keep their private, state, or federal health benefits while they are incarcerated.

Clients must continue to meet the program's eligibility rules. Confirmation that there is no overlap in services is needed for services offered on both a short-term and temporary basis.

The program must receive an estimated release date to determine if the client is eligible for services temporarily.

There must be a clear connection between any service paid for by the program and the HIV care and treatment of the incarcerated person. All services provided must follow the established HIV clinical practice standards consistent with the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV.

The program can only be used to support people living with HIV who are incarcerated and expected to be eligible for program services when they are released.

Clients can start receiving all other core and support services offered by the program on the day they are released, as long as they continue to meet program and service eligibility. Applications for additional core and support services may be received and decided on by the program before the client's release. If approved, these additional services will not start until the date of release.

Eligibility—AIDS Drug Assistance program (ADAP)

ADAP eligibility

People applying who meet the basic eligibility rules, must currently be taking or plan to start antiretroviral therapy to qualify for ADAP services. Clients who do not use ADAP to get their medications may be removed from ADAP.

Enrollment criteria

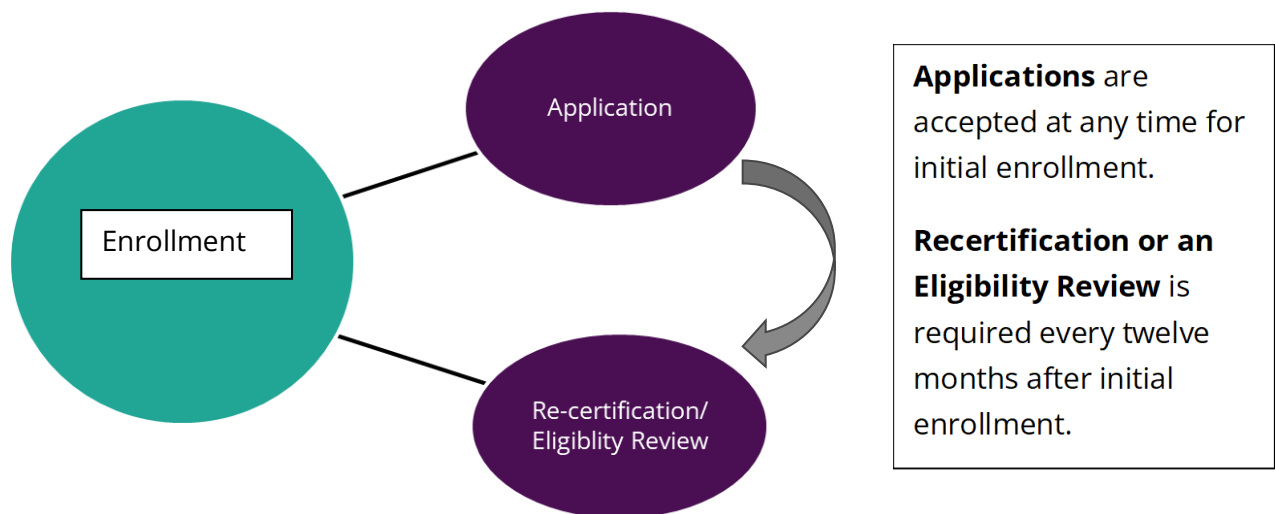
Depending on the client's life circumstances, they may qualify for different ADAP services.

ADAP program	Enrollment criteria
ADAP-M	Clients who are uninsured or underinsured
ADAP-I: COBRA	Clients who are currently enrolled or eligible to enroll in COBRA.
ADAP-I: Direct Purchase Insurance (DPI)	Clients who are not currently enrolled or not eligible for enrollment into a group plan or Medicaid. Some exceptions apply.

ADAP-I: EB-HIPP (<i>Employer</i>)	Clients who are currently enrolled or eligible to enroll in a group plan through an employer
ADAP-I: Group Plan	Clients who are currently enrolled or eligible to enroll in a group plan through a spouse or partner's employer, or a parent's employer
ADAP-I: Marketplace	Clients who are currently enrolled in a marketplace plan.
ADAP-I: Medicaid	Clients who are currently enrolled or eligible to enroll in Medicaid.
ADAP-I: Medicare Part D	Clients who are currently enrolled or eligible to enroll in Medicare Part D or other Medicare pharmacy plans.

Application, re-certification, and eligibility review

Clients who apply for the program will have their eligibility checked for all program services they might qualify for, including ADAP. Clients are approved for a 12-month eligibility period, after which they will need to re-certify to continue.



Applications

A new applicant is someone who has never received services from the program before. The new application submission form includes proof of HIV diagnosis from a medical provider. Program staff determine eligibility; and will tell the applicant and their case management

agency about the decision. New applicants are approved for up to 12 months of eligibility from the application date.

Annual recertification or eligibility review

The client's information must be checked every 12 months to stay eligible for program services. The program will use its own records to check client information. If the program cannot verify information on its own, it will ask the client and the partner agency that provides benefits and eligibility care for it.

A client who was previously removed from the program will need to recertify, no matter how long it has been since they were disenrolled.

Recertification application

- A complete recertification can be required up to once a year.
- Clients who have been disenrolled will need to submit a recertification.
- The program will use its own records to check program eligibility for clients who have not had a break in services.
- A client can choose to leave the program using the program's own records.
- All clients will need to sign the rights and responsibilities statement every year.
- A client will be asked to provide any information that the program cannot verify.
- The program will check client eligibility using its own records. The client will be asked to provide any information that cannot be checked this way. The client will work with the program or its partners to provide the needed information. This information needs to be received by the 12th month of the client's eligibility period to avoid a gap in coverage.
 - The program or its partners will contact the client by mail, email, or phone at least 3 times. These attempts will be documented.
 - If the client does not respond by the end of their 12th month of eligibility, they will be disenrolled from the program.
 - If a client is disenrolled because they didn't respond, they will need to submit a new recertification to reenroll, and the program will not be able to use its own records to help with this process.
 - The program's own records can be used to check program eligibility for a client who has had a break in services, if the client is enrolled in Medicaid and does not have a spenddown requirement.

Signatures

The program accepts an electronic signature instead of a handwritten one for program forms when a handwritten signature is not possible.

- The electronic signature must include the client's electronic communication (email, text message) confirming they agree to the recertification or application.
- If a client does not have a computer, email, or a phone that can send text messages, their case manager or benefits specialist can confirm on their behalf. If the case manager or benefits specialist misrepresents information or does not get confirmation from the client,

the case management agency will have to pay for any services and medications provided during the eligibility period when the electronic signature was given.

- Electronic signatures must be uploaded into the program's client database.

Application period

Clients who need to recertify will be asked to submit information that the program cannot check itself around the 10th month of their eligibility period.

Review period

The Department of Health and Human Services (DHHS) needs at least 30 days after the requested recertification papers are submitted to review and decide if the client is still eligible. Clients are strongly encouraged to submit their requested information by the 11th month of their eligibility period to allow enough time for this decision and prevent a break in services. Part B program services will not continue after the client's eligibility end date until the application has been approved by DHHS.

Required documents

Besides the application forms, clients must submit acceptable papers showing they are eligible for program services when asked. Refer to the Eligibility section of this manual for a list of acceptable documents.

Reporting changes

A client's eligibility is based on their current life situation. Any changes should be reported to the case management agency and the program as soon as the client can, and it must be within 60 days of the change to avoid any limits on services. Certain changes may affect what types of services the client can receive. If a client intentionally hides information about changes, their services may be stopped or ended.

Changes in eligibility criteria	What to report	When
Insurance coverage	• New health coverage • Loss of health coverage • Plan cost (premium)	As soon as possible. Changes to your insurance can result in you owing money to the insurance company or the program. Notify the program immediately of any changes to your insurance or if you become eligible for different insurance.

Residency	• Change in address • Moving out of state	As soon as possible. Report any address change as soon as possible as this may impact the program's ability to communicate with you. A change of address within the state of Utah does not impact eligibility. Moving out of state requires immediate notification to the program.
Household size	• Change in marital status (marriage, divorce, legal separation) • Change in the number of dependents	As soon as possible. Report any household size changes to the program as soon as possible as this may change the FPL requirements for a client's household.
Household income	• Loss of income • New income • Amount of income (decrease or increase)	As soon as possible. Report any changes in household income as soon as possible as this may change program/service eligibility and result ineligibility of services. <i>* Proof of insurance availability may be requested if employment changes.</i>

Failure to report

If the program finds that a client has failed to report changes in available health care coverage as defined by policy, the program can limit the services for which the client can qualify.

Failure to report is defined by the program as any one of the following:

- The client did not take the right steps to tell the program, case management agency, case manager, or benefits specialist about a change in health insurance availability, health care coverage, residency, household size, or household income within 60 days of the change.
- The client gave false information to the program.

If the program finds that the client meets any of the above, the client's services may be restricted or limited for their next eligibility period of up to 12 months.

- The client with limited eligibility would only qualify for ADAP services and services that support medical care, such as cost sharing assistance (CSA), medical transportation, and case management.
- The client would not qualify for support services, including emergency financial assistance (EFA), food vouchers, and oral health care.
- The program will tell the client and their case manager about the restriction of services.
- The client may become eligible for and enrolled in all program services at their next recertification, if they meet all other eligibility rules.
- A case manager can ask for the restrictions to be removed after 6 months following the notice of service restriction. The request from the case manager must be in writing and include the following:
 - A statement that the client has been educated on how to report future changes to the program.
 - A statement explaining why the support services not directly related to medical care are needed.
- Clients who fail to report changes to the program more than 3 times may be permanently restricted from getting support services that are not directly related to medical care.

Service enrollment

The program will only review and consider complete applications. Only program staff can decide if a client is eligible. All applications and recertifications must be completed and submitted to the program within 60 days of the date the applicant (or parent/guardian of a minor client) signed them.

Application date

The date a complete application is received by the program. This must be within 60 days of the start of a new application or the beginning of a draft.

Determination date

The date eligibility determination is conducted and results in an approved or denied status.

Eligibility start date

The date the client's eligibility period begins. For clients re-certifying without a gap in services, this is often the first day of the new eligibility period. For new clients or clients re-certifying after a gap in services, this is often the application date.

Enrollment date

The date the client begins receiving specific program services. Clients may have changes in service enrollment throughout their eligibility period. Service enrollment may not exceed the eligibility period.

Eligibility period

Up to 12 months continuous eligibility from the eligibility start date through the last day of the month 12, with a few exceptions. Once a client is determined to be eligible, they remain eligible for the remainder of their eligibility period. Exceptions to the 12 month eligibility are: client is no longer a Utah resident, the client requests to be disenrolled, or the client is deceased. Client service enrollment may vary throughout their eligibility period.

Eligibility end date

The last day of the client's eligibility period. Generally, this is the last day of the month 12 months after eligibility start date

Eligibility periods

Once approved, clients are eligible from their eligibility start date through the last day of the 12th month of their eligibility period. Changes to insurance availability, income, household size, and residency may affect a client's eligibility end date. If a change results in a change in enrollment or program eligibility, that change will take effect either on the date the changes were reviewed by the program or on the last day of the month that the changes were reviewed, whichever the program decides is best for the client.

Utah Part B Program recertification schedule		
<i>Eligibility Periods may not exceed 12 months. Clients may recertify in the 10th month of their current eligibility period</i>		
Eligibility start month <i>Month 1 of eligibility</i>	Eligibility checks start month <i>Month 10 of eligibility</i>	Eligibility end month <i>Month 12 of eligibility</i>
January	October	December

February	November	January
March	December	February
April	January	March
May	February	April
June	March	May
July	April	June
August	May	July
September	June	August
October	July	September
November	August	October
December	September	November

Changes in service enrollment may happen during the 12-month eligibility period and may require submitting papers to qualify for additional services. For example, a client might enroll in ADAP-M in month 1 and then enroll in a group health plan through their employer in month 4. Changes in service enrollment do not restart a client's eligibility period. Clients must recertify for the next eligibility period to continue receiving services. Clients will be contacted around the 10th month of their eligibility period and will need to submit requested information by the end of the 12th month to avoid a break in service enrollment.

If a client does not recertify during their eligibility period, they will be disenrolled. If they recertify after having a gap in services, their new eligibility period starts with their new application date and does not continue from their previous one.

Service enrollment and activation

Clients who are eligible for the program may have changes in what services they are enrolled in throughout their eligibility period. Service enrollment can start as early as the application date. If a client has a major life event and qualifies for different services than they were first approved for, they may need to provide proof before being enrolled in additional services.

Case management services

All approved clients qualify for and will be enrolled in case management services. Eligibility for case management services will start on the eligibility start date. Case management services will not be covered for applicants who are not approved.

Clients who only apply for case management services will have their eligibility checked for all services and may be enrolled in support services if they qualify. If the client qualifies for ADAP, they will be approved for it but will not be enrolled unless they ask.

ADAP, core medical, and support services

Eligibility for ADAP, core medical, and support services will start on the eligibility start date. All clients must be approved by the program before any services are paid for.

Services provided during the eligibility determination process that need to be paid for at the time of service (like medications) or any service covered by another payment source cannot be

paid for by the program. The program will not pay for any service provided during eligibility determination to a client who is not approved.

COBRA

Services provided to a client between the date their COBRA coverage starts retroactively and the date they enroll in COBRA will be billed back to COBRA when possible. For services that do not have another payment source or that COBRA will not cover, such as pharmacy services, the program will not seek payment from the client. Clients who are eligible for COBRA also qualify to enroll in a program-sponsored direct purchase insurance (DPI) plan. Clients should work with their case management agency to decide which plan is best for them.

Retroactive Medicaid

Providing temporary help to program-eligible applicants while their Medicaid eligibility is being decided is allowed, with the clear understanding that Medicaid will be billed back for Medicaid-covered services once eligibility is confirmed (HRSA PCN #13-01).

Medicaid enrollment is checked when someone first applies and at each recertification or eligibility review. Clients who fail to report enrollment in Medicaid as required by policy may be subject to the failure to report policy found in the application and recertification section of this manual.

All ADAP-M pharmacy services covered by Medicaid that were provided between the date Medicaid coverage started retroactively and the date the client enrolled in Medicaid will be billed back to Medicaid.

In cases that will not potentially harm the client, such as after a client has reached their maximum out-of-pocket (MOOP) costs, ADAP-I services that are covered by Medicaid and were provided to a client between the date Medicaid coverage started retroactively and the date the client enrolled in Medicaid will have the charges reversed and Medicaid will be billed back.

ADAP-I services provided during this same period that Medicaid does not cover or only partially covers, such as health insurance premiums, medical co-pays, and deductibles, cannot be billed back to Medicaid, and the program will not seek payment from the client to avoid harming their overall health, well-being, and engagement in care.

Rights and responsibilities

Client's rights and responsibilities

Client's rights and responsibilities: Clients must review and agree to their rights and responsibilities when they first apply and each time they recertify. This explains how clients can expect to be treated and what the program expects from them (Appendix C and D).

Service provider guidelines and responsibilities

Part B program providers are expected to:

- Check an applicant's enrollment status and eligibility before providing services. Questions about enrollment status and eligibility can be directed to the program by calling (801) 538-6191 OR via email at RWP@utah.gov.
- Help applicants apply and recertify for services; make sure only complete applications are submitted.
- Verify insurance status, both public and private, for all new applicants and for clients during each recertification period.
- Vigorously pursue (strongly try) to enroll clients in health care coverage they may be eligible for (Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance, and/or other private health insurance). Thoroughly document all efforts made to pursue enrollment and the results.
- Make sure individual clients know the consequences of not enrolling in other health coverage for which they are eligible.
- Ensure the privacy of applicants/clients.
- Not use Ryan White Part B funds to replace other funds or submit bills for Part B services that are covered by another program (Medicaid, Medicare, any private or public insurance program, etc.), even if the provider does not participate in that program.
- Maintain records of applicant/client and service data.
- Submit the correct documentation with each billing cycle, including proof that billed services are for enrolled clients only.
- Participate in an annual review visit and other review visits as scheduled by the program.
- Participate in needs assessment or evaluation done by the program, DHHS, or its designated quality management contractor.
- Follow the agreements made with the program (grant agreements, contracts, memorandums of agreement [MOAs], etc.).
- Attend program-hosted meetings as required or invited.
- Ensure agency representation at quarterly Utah HIV Planning Group meetings.

Utah AIDS Drug Assistance program (ADAP)

Purpose

Provide cost-effective drug therapy for people affected by HIV and AIDS who do not have insurance. Medications to manage HIV and AIDS are expensive, and many people living with HIV in the U.S. cannot afford them without ADAP-M help.

ADAP-M

The purpose of ADAP-M is to:

- Help people get medications that can prolong life or prevent serious health decline.

- Provide cost-effective drug therapy for people affected by HIV and AIDS who do not have insurance. Medications to manage HIV and AIDS are expensive, and many people living with HIV in the U.S. cannot afford them without ADAP-M help.

ADAP-I

The purpose of ADAP-I is to:

- Help people maintain the continuity of medical services established through their health insurance coverage, including HIV and AIDS medication(s),
- Help low-income people living with HIV who are not eligible for other insurance coverage get medical services and medication(s) by paying for monthly health insurance premiums, pharmacy deductibles, and pharmacy co-payments.
- Reduce the fiscal impact of HIV and AIDS on publicly funded programs.
- ADAP-I includes the following services:
 - COBRA
 - Direct purchase insurance (DPI)
 - Employer-based health insurance premium payment (EB-HIPP)
 - Marketplace
 - Medicaid
 - Medicare Part D or other Medicare pharmacy benefits
 - Group plan through spouse or parent

The Utah ADAP may also provide services that improve access to, adherence to, and monitoring of medication treatments with the proper approval from HRSA/HAB.

The client will qualify for different ADAP programs and services based on their specific life circumstances.

Overview

The Utah ADAP services are managed by the DHHS program. The main job of ADAP is to authorize the provision and payment of HIV-related medications, health insurance premiums, pharmacy deductible payments, and co-payments for eligible individuals.

ADAP authorizes:

- Appropriate medications
- Payment for prescribed medications
- Payment for health insurance premiums, pharmacy deductible payments, and pharmacy co-payments through an ADAP-covered health insurance plan, including COBRA, EB-HIPP, Medicaid, Medicare Part D, private-individual (DPI), or the health insurance marketplace
- Payment for pharmacy deductibles and pharmacy co-payments for eligible clients enrolled in a private, employer, spouse, or parent health insurance plan
- ADAP keeps client information private.

ADAP enrollment

New applications are accepted at any time. Once approved, a client is eligible for up to 12 months. A client's eligibility will be reviewed every 12 months to continue receiving services. Refer to the eligibility section of this manual for eligibility requirements. Additional requirements specific to ADAP-M and ADAP-I are outlined in the following sections.

ADAP advisory subcommittee

The ADAP advisory subcommittee makes suggestions to the program about ADAP policies to make sure people living with HIV in Utah have access to HIV-related medications to reduce illness and improve their quality of life. The Utah ADAP advisory subcommittee considers topics such as medications on the list of covered drugs, funding issues, cost-saving activities, and more.

Reports and program evaluation

The program prepares and submits the ADAP Data Report (ADR) to HRSA/HAB each year. The ADR helps HRSA/HAB evaluate the impact of ADAP nationwide, describes who uses the program, what ADAP-funded services are used, and the cost of these services.

Waitlist

If the program does not have enough money to support all currently enrolled clients for ADAP services, eligible applicants, both new and those who need to recertify, may be placed on a waiting list.

ADAP medication assistance (ADAP-M)

Clients who are eligible for ADAP-M services through the program can get medications on the Utah ADAP-M list of covered drugs. Every ADAP is required to include at least 1 drug from each class of HIV antiretroviral medications on its list, but each state can decide which specific FDA-approved drugs to cover. ADAPs must follow HHS HIV/AIDS treatment guidelines on managing HIV/AIDS. These guidelines cover many aspects of treatment, including using antiretroviral therapies and medications for opportunistic infections, prevention, and treatment. ADAP-M clients who need help with medical visits and health care costs will be enrolled in outpatient/ambulatory health services.

Eligibility

Refer to the Eligibility section of this manual for eligibility requirements. If a client does not plan to start taking medications or is not currently taking medications on the Utah ADAP-M list, they will not be enrolled in ADAP-M services.

Clients who qualify for ADAP-M are generally:

- Uninsured or underinsured clients who cannot enroll or choose not to enroll in ADAP-I and have shown vigorous pursuit of insurance.
- Clients who need temporary coverage between insurance policies.
- Clients who have private insurance that is not cost-effective, as determined by the program, compared to ADAP-M services
- Clients who have private insurance where the list of covered drugs does not include HIV medications or does not provide access to HIV medical care.
- Clients with Veterans Affairs (VA) benefits. The program's rules do not consider VA health benefits as the veteran's primary insurance. The program follows the veteran's classification policy by treating veterans who receive VA health benefits as uninsured, which exempts them from the "payer of last resort" rule (HRSA PCN# 16-01).
- Clients who have access to insurance are expected to understand the potential negative effects of not enrolling in health care coverage they are eligible for, including the "individual shared responsibility payment" enforced by the federal government. The program cannot help pay for any fees or penalties related to remaining uninsured.
- If the program does not have enough money to support all currently enrolled clients for ADAP services and a waitlist is created. Clients who turned down available health insurance may have their place on the waitlist affected by this choice.

Medication acquisition

Clients who receive ADAP-M services must access medications from a University of Utah pharmacy.

Mail-order medication services are intended to make it easier to get medications and encourage people to stick to their HIV treatment. The program may pay for postage for mail-order medications on the ADAP-M list. All ADAP-M clients can use mail-order medications and should work with their provider or case manager to access this service.

Medications are mailed by the University of Utah Redwood Pharmacy and the University of Utah Hospital Pharmacy. The program does not allow medications to be mailed to an address outside of Utah, even for long trips out of state, or to people who do not live in Utah.

- During a client's eligibility period, ADAP-M will provide one 30-day supply of the client's prescribed medication(s) from the Utah ADAP-M list at a time. Exceptions to the 30-day supply limit may be made in certain situations:
 - Moving: A client who is moving out of Utah may be able to get one extra 30-day supply of medication(s) if their services might be interrupted. The client must fill the medications while they still live in Utah and before they move. Medications are not provided to those who already live outside of Utah or who use a mailing address outside the state. Clients should give the program at least 5 business days notice before moving; a same-day request for quick approval might not allow enough time for approval.
 - Vacation: A client may be able to get one extra 30-day supply of medication(s) if they have a scheduled vacation during which their medications might run out. Clients should give the program at least 5 business days notice before the vacation; a same-day request for quick approval might not allow enough time for approval.

Allow at least 1 business day for processing.

To qualify for an exception to the medication rules, the case manager must submit a request explaining why the exception is needed to the program via secure email. Each request will be reviewed individually, and the program will make the final decision. Submitting a request does not guarantee that it will be approved. The request and the decision (approval or denial) will be shared with the case management agency and kept in the applicant's file for program records.

The program will not replace lost or stolen medications.

Co-infected tuberculosis treatment

If a client enrolled in the program also has active tuberculosis (TB), the program will cover the cost of both ADAP formulary medications and the client's TB medications.

Termination

Clients will be removed from ADAP-M services if they become eligible for drug therapy coverage under another program or payment source.

Applicants and clients who intentionally give false information about their private health insurance coverage, income, and/or any other information used to determine eligibility may be temporarily or permanently removed from the program, including core medical, ADAP-M, ADAP-I, and support services. If necessary, the Office of the Attorney General may act against these individuals to recover the costs of covering them.

ADAP-insurance assistance (ADAP-I)

ADAP-I helps eligible clients with health insurance premiums and cost-sharing. The program, as stated in HRSA PCN #13-05, is "expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance)." All applicants should be checked for health insurance coverage when they first apply and each time they re-apply, and if they are eligible for insurance, the program expects them to enroll in the insurance that is available to them (See Assessment of available coverage).

ADAP-I Includes the following:

- COBRA
- Direct purchase insurance (DPI)
- Employer-based health insurance premium payment (EB-HIPP)
- Marketplace
- Medicaid
- Medicare Part D

- Group plan (spouse/partner or parent)

The program provides the following health insurance premium and cost-sharing assistance:

- Monthly premiums for health insurance plans that qualify
- Pharmacy deductibles, co-payments, and/or co-insurance for medications on the ADAP-I formulary
- Medical deductible, co-payments, and/or coinsurance for medical care related to the treatment of HIV

The type of ADAP-I a client receives depends on the type of health insurance coverage they have. The program does not cover health insurance premium payments for group plans through a spouse, partner, or parent; only employer-based, Medicare Part D, and DPI premium payments are covered by the program. The program expects a client to enroll in a health insurance plan they are eligible for that is most cost-effective for the program. Clients who are eligible to enroll in a health insurance plan but choose not to may be enrolled in ADAP-M services if they meet all other eligibility requirements.

Eligibility

Refer to the eligibility section of this manual for all eligibility requirements. If a client does not plan to start taking medications or is not currently taking medications on the Utah ADAP-I list, they are not eligible for ADAP-I services. All eligible clients who have access to health insurance are considered eligible for ADAP-I services. Clients who turn down available insurance coverage may have restrictions on certain support and ADAP services. Refer to the vigorously pursue section within this manual.

Open enrollment

All eligible clients who do not have access to insurance through an employer, parent, or spouse are expected to enroll in a qualified health plan (QHP) during open enrollment, which happens every year starting in November, as decided by the Centers for Medicare & Medicaid Services (CMS). The program reviews all QHPs in the area for access to HIV providers, drug classifications and costs, and cost-effectiveness for the program. If a client enrolls in a QHP that does not meet the program's standards for minimum access to HIV treatment and care, the program may choose not to provide help with premiums or cost-sharing.

Special enrollment period

After the open enrollment period ends, clients cannot enroll in a QHP unless they qualify for a special enrollment period. If an eligible client has a qualifying life event during the year that makes them eligible to enroll in a QHP, then ADAP-I services will become available, and the client is expected to enroll in a QHP. The program may do a cost analysis to see if the QHP is more cost-effective than ADAP-M services.

Health insurance premium payment assistance

ADAP-I provides help paying health insurance premiums for eligible clients enrolled in a private-individual health insurance plan, employer-based health insurance plan, or Medicare Part D plan. The program considers private-individual insurance coverage to include:

- COBRA
- Employer-based health insurance (employee portion only)
- Health insurance marketplace (marketplace) QHP
- Direct purchase insurance (DPI) QHP

If a client is the policyholder or a dependent on a private double or family plan (not through an employer), then ADAP-I only helps with the client's share of the premium. For employer-based coverage where the client's share of the premium cannot be separated from a family plan, ADAP-I may cover the employee's entire share of the family policy premium. For more information, see the employer-based health insurance section below.

If a client is found to be eligible for Medicaid, they may need to show proof of vigorous pursuit of Medicaid before a premium payment can be made. Premium payments are available to clients while they are strongly trying to get Medicaid and while they are waiting for a decision on their Medicaid application.

COBRA

COBRA requires group health plans (employers) to offer temporary continuation of group health coverage to covered employees, their spouses, former spouses, and dependent children when group health coverage would be lost due to job loss.

The program can help pay for:

- Health insurance premiums
- Pharmacy deductible
- Pharmacy co-payments
- Cost-sharing assistance

Eligibility

If a client is newly eligible for COBRA, the program will compare the cost of COBRA coverage with a program-approved QHP to decide which option is most cost-effective for the program; the length of time assistance is needed will also be considered.

Because COBRA premium and pharmacy deductible amounts vary from plan to plan, and QHP premium amounts depend on the client's income, the program does a cost analysis for each client. If a client does not get a new employer-based insurance plan before their COBRA coverage ends, they should enroll in a program-approved QHP that they are eligible for, either through the marketplace or directly from the insurance company.

Enrollment

The applicant must tell their employer they want COBRA within 60 days of the date on their COBRA notification letter or their termination date (whichever is later). Payment for all health insurance premiums due must be made within 45 days from the date the applicant chooses to continue coverage.

Direct purchase insurance

Insurance bought directly from the insurance company (DPI) is the preferred way for clients to enroll in insurance.

Eligibility

The client is not eligible for a group plan through their employer or as a dependent on a spouse's or parent's plan.

If the client is eligible for other health insurance coverage, that coverage is too expensive and/or not good enough and does not meet the minimum standards set by the program.

Enrollment

- Clients can enroll in a DPI plan during open enrollment or a special enrollment period.
- Clients must agree to pay back any money owed to the program if they received too much in premiums or other services.
- Clients must recertify by their deadline. The program does not pay premiums for clients who have not recertified and been approved by the program by the deadline.
- The program must receive confirmation of enrollment in an approved QHP with enough time to process a payment before the insurance coverage payment deadline.
- Changes in health insurance availability should be reported to the program as soon as possible.

Qualifying life event

If an eligible client has a qualifying life event during the year that makes them eligible to enroll in a QHP, then ADAP-I services will become available, and clients are expected to enroll in a QHP.

Employer-based health insurance premium payment (EB-HIPP)

Clients enrolled in a health insurance plan through their employer are eligible for help paying the employee's share of the premium, pharmacy deductible, pharmacy co-payment/co-insurance, and cost-sharing for HIV-related medical care. If employers cannot separate the client's share of the premium from a family plan, ADAP-I will cover the entire employee's share of the family policy. Premiums are paid directly to the employer or their designated company,

and then the employee is reimbursed by the employer for their share. No cash payments can be made directly to a client.

The program can help pay for:

- Health insurance premiums
- Pharmacy deductible
- Pharmacy co-payments
- Cost-sharing assistance

Eligibility

The client is eligible for, enrolled in, and the primary policyholder of their employer-based health insurance plan.

Enrollment

- Clients must agree to pay back any money owed to the program if they receive too much in premiums or other services.
- Clients must recertify by their deadline. The program does not pay premiums for clients who have not recertified and been approved by the program by the deadline.
- Confirmation of enrollment in an employer-based plan where the client is the primary policyholder is required.
- The program must receive the EB-HIPP application completed by the employer with enough time to process payment before the insurance coverage payment deadline.
- Changes in health insurance availability should be reported to the program as soon as possible.

Health insurance marketplace

Private insurance is purchased through the [healthcare.gov](https://www.healthcare.gov) Marketplace website. This is the non-preferred method of insurance enrollment for clients

Eligibility

- The client is not eligible for a group plan through their employer or as a dependent on a spouse's or parent's plan.
- If eligible for other health insurance coverage, that coverage is not good enough and does not meet the minimum standards set by the program.
- Have household incomes between 138%-400% of the federal poverty level (FPL). Income determination for cost-sharing and subsidies through the marketplace is done by the federal government and is different from the income eligibility for the program.

Enrollment

- Eligible clients can only enroll in a QHP during the open enrollment period or within 60 days after a qualifying life event, as determined by the marketplace.
- Clients must recertify by the deadline. The program does not pay premiums for clients who have not recertified by the recertification deadline and have been approved by the program.

- The program must receive confirmation of enrollment in an approved QHP with enough time to process payment before the payment deadline for insurance coverage.
- Any change in client income or status should be reported to the marketplace and the program within 30 days of the change, as eligibility and/or premium amounts may have changed.

Tax credits

- Clients who are eligible for advanced premium tax credits (APTC) are required to apply these credits upfront to lower the cost of their monthly premiums.
- Clients who receive help from ADAP-I for insurance through the marketplace should file a federal income tax return. This tax return should be given to the program.
- If tax credits are owed back to the program because the client underestimated their income on the marketplace application, the tax refund amount will be owed to the program.

Qualifying life event

If an eligible client has a qualifying life event during the year that makes them eligible to enroll in a QHP, then ADAP-I services will become available, and clients are expected to enroll in a QHP.

Medicare Part D

Clients enrolled in any Medicare Part D plan are eligible to receive help from the program for Medicare Part D premiums, pharmacy deductible, and pharmacy co-payments. Program assistance is limited to Medicare Part D and Medicare pharmacy benefit plans. Clients enrolled in both Medicare Part D and Medicaid will need to provide plan details to show that their HIV medication is not covered by Medicaid to receive pharmacy deductibles and pharmacy co-payments.

Coverage as a dependent

Clients covered by a parent's or spouse's QHP or COBRA plan are eligible to receive help from the program for pharmacy deductible, co-payments, cost-sharing, and the client's share of the premium only

Clients covered by a parent's or spouse's group plan are eligible to receive help from the program for pharmacy deductibles, co-payments, and cost-sharing assistance. Monthly premium assistance is not available.

Group plan (employer)

Clients who are employed are expected to try to enroll in insurance available to them. Similarly, if an employer group plan is available through a spouse or a parent, clients should try to enroll.

The program cannot cover monthly premiums for a group plan when the client is not the primary policyholder. The program can help pay for:

- Employee's share of the policy premium

- Pharmacy deductible
- Pharmacy co-payments
- Cost-sharing assistance

Eligibility

The client is enrolled in a group plan through their employer or as a dependent on a spouse's or parent's plan.

Enrollment

Clients can generally enroll in a group plan when they are first hired, during their employer's annual open enrollment, or during a special enrollment period.

Changes in health insurance availability, including loss of group plan coverage, should be reported to the program as soon as possible.

Stipends and waiver benefits

The program is the payer of last resort. If an applicant receives money from their employer because of their insurance coverage status, such as a waiver benefit for not enrolling in employer-offered insurance or a stipend to buy health insurance, that money must first be used for the cost of premiums, pharmacy deductibles, co-payments, and cost-sharing before the program helps with the remaining balance. The amount paid to the applicant by the employer will be counted as part of the applicant's reported income for eligibility determination.

Health savings accounts

Employer contributions to a health savings account are counted toward household income.

Insufficient coverage

If someone is eligible for group plan coverage but wants to enroll in DPI, at least 1 of the following must be true for the program to consider covering the client's premiums, pharmacy deductible, co-payments, and cost-sharing:

- Health insurance is unaffordable according to the Affordable Care Act (ACA) and program standards.
- The plan requires using a pharmacy that does not accept payments from third parties.
- The plan does not allow access to an HIV provider(s).
- The plan requires prior authorization for HIV medications.
- There are privacy concerns about a shared plan with a spouse or parent.
- The plan does not allow access to HIV or specialty medications.

A case management agency should submit a request for an exception with the required documentation for review and approval by program staff if the client's plan is considered insufficient coverage.

Unaffordable coverage

Clients who have access to a group plan are not required to enroll if the insurance is unaffordable according to the ACA guidelines.

The ACA guidelines say that insurance is considered unaffordable if it costs more than a certain percentage of the total household income. The specific percentage is updated each year. The following rules are used to decide if premiums are unaffordable:

- The premiums for the least expensive plan are used to calculate the cost to the client. The client can choose a more expensive plan, but the least expensive plan is used to determine if it is affordable.
- If the least expensive plan meets the insufficient coverage rules mentioned above, then the premiums of the next least expensive plan would be used to calculate the cost to the client.
- Only the part of the premium paid by the client is considered, not the part paid by the employer.
- If the client has access to employer insurance through someone else (spouse or parent), then the combined premium cost for the employee and the client is considered. The combined premium amount is considered because for the client to get coverage, the policyholder (spouse or parent) must enroll in insurance and pay their share of the premium in addition to the client's share.

A case management agency should submit a request for an exception with the required documentation for review and approval by program staff if the client's plan is considered unaffordable.

Exemption from insurance coverage

- Extensive proof of vigorous pursuit is provided. Refer to the vigorous pursuit policy in this manual.
- Available insurance is unaffordable or insufficient.
- The client is only eligible for a program-sponsored DPI plan and is determined by the benefit specialist or case manager to not be a good candidate for insurance. An explanation must be provided to and approved by the program.

Vigorous pursuit of service funds

- Vigorous pursuit of service funds
Vigorous pursuit of service funds expended for ineligible clients: Clients receiving ADAP-I services for whom health insurance premiums were paid and who are found to be ineligible during their eligibility period will become ineligible for ADAP-I services on the first day of the month after the eligibility decision. Clients must cancel their insurance plan and return any unused insurance premiums sent back by the insurance company to the program.
- Vigorous pursuit of insurance refunds
Clients receiving ADAP-I services whose health insurance premiums were paid by the program might get a refund check from the insurance company. The most common

reason for a refund is when the policy is canceled because the premium was underpaid, and the remaining balance is sent to the client. Premium underpayment can happen when client premium amounts change, and the program is not notified. The program will strongly try to get back any refund a client receives from an insurance company.

Medication acquisition

Insured clients receiving ADAP-I services cannot get medications from a University of Utah pharmacy at any time unless they are enrolled in Medicaid copay assistance. Insured clients can contact the program or their case manager for help choosing a pharmacy. The Apothecary Shoppe and Community, A Walgreens Specialty Pharmacy are the program's preferred pharmacies.

- The Apothecary Shoppe
82 South 1100 East Suite #104
Salt Lake City, UT
801-521-6353
- Community, A Walgreens Specialty Pharmacy
201 1300 E
Salt Lake City, UT
801-736-9309

Mail-order medication services are intended to make it easier to get medications and encourage people to stick to their HIV treatment. The program may pay for postage for mail-order medications on the ADAP-I list. All ADAP-I clients can use mail-order medications and should work with their provider or case manager to access this service through the Apothecary Shoppe.

The program does not allow mailing medications to an out-of-state address, even for long trips out of state, or to people who do not live in Utah.

During a client's eligibility period, ADAP-I will help with the co-payment for one 30-day supply of the client's prescribed medication(s) from the Utah ADAP-I list at a time. Exceptions to the 30-day supply limit may be made once approved by the primary payer source for the following reasons. Allow at least 2 business day to process the request:

- Moving: A client moving out of Utah may be able to get one extra 30-day supply of medication(s) if their services might be interrupted. The client must fill the medications while they still live in Utah and before they move. Medications are not provided to those who already live outside of Utah or use a mailing address outside of the state. Clients should notify the program at least 5 business days before moving; a same-day request for quick approval might not allow enough time for approval.
- Vacation: A client may be able to get 1 extra 30-day supply of medication(s) if they have a scheduled vacation during which their medications might run out. Clients should notify the program at least 5 business days before the vacation; a same-day request for quick approval might not allow enough time for approval.

- A 90-day supply will only be allowed if the client's insurance requires it and the medication is on the current ADAP-I list. A 90-day supply will not be allowed for clients on ADAP-M or for medications not on the list.
- If a client has not filled a prescription(s) within 90 continuous days, their services may be temporarily stopped because they are not using them. A doctor's note or treatment plan may be required for the program to restart services for clients who are not following their treatment plan.

The program will not replace lost or stolen medications.

Termination

Clients will be removed from ADAP-I services if they become eligible for drug therapy coverage or insurance under another program or payment source.

Clients may be removed from ADAP-I services if any of the following happen:

- The client becomes ineligible for the program, moves out of state, does not recertify, or does not follow the program rules.
- The client intentionally hides information about the availability of other insurance coverage.
- The client chooses or is found to no longer be taking HIV antiretroviral medications.
- Applicants and clients who intentionally give false information about their health insurance coverage, income, and/or any other information used to determine eligibility may be temporarily or permanently removed from the program, including ADAP-M, ADAP-I, and support services. If necessary, the Utah Attorney General's Office may act against these individuals to recover the costs of covering them.
- Clients who receive ADAP-I services and do not recertify or are found to be ineligible may have to pay back the program for services received during the ineligible period, including but not limited to health insurance premiums, pharmacy deductibles, or pharmacy co-payments.

Additional information

The program cannot directly reimburse the client. The program cannot pay back clients for payments they made to the insurance company for ADAP-I covered expenses like pharmacy or medical services.

Clients are expected to accept any other coverage that becomes available through employment or other means and must tell the program about any coverage changes. The client must not knowingly drop any insurance coverage and then apply for ADAP-M services. The program will only pay eligible clients' pharmacy deductible and co-payments for medications on the Utah ADAP-I list. Medications not on the list will not be covered.

Co-payment assistance cards issued by drug companies or other organizations cannot be used when someone receives government assistance. Therefore, clients who receive ADAP-I services cannot use co-payment assistance cards. The program recommends these cards be given to and used by people who are not eligible for the program.

Cost sharing assistance

Cost sharing assistance (CSA) is providing financial help to eligible people living with HIV to receive medical benefits under a health insurance program.

Cost sharing refers to an insured client's deductible, co-insurance, and co-payments for HIV-related services.

Covered services

Eligible costs include:

- Medical deductibles
- Coinsurance and copayments for HIV-related medical care

Non-covered services

- HRSA PCN # 13-04 prohibits paying for services the client receives from a provider who is not part of the client's health plan's network, unless the client is receiving services that could not have been obtained from an in-network provider.
- Any service not related to HIV.

Eligibility

Insured clients who receive services through ADAP-I and insured clients who receive services through ADAP-M whose coverage has been determined by the program to be insufficient are eligible. Clients who request CSA should work with their case management agency to submit medical bills and necessary documentation.

Limitations

CSA is limited to the client's share of the payment and only for the covered services received on a date when the client was eligible for ADAP-I. Late fees cannot be paid by the program.

Outpatient/ambulatory health services

Outpatient/ambulatory health services provide diagnostic and treatment activities directly to a client by a licensed health care provider in an outpatient medical setting. These settings can include clinics, medical offices, mobile vans, telehealth technology, and urgent care facilities for HIV-related visits (HRSA PCN #16-02).

Covered services

- Taking medical history
- Physical examination
- Laboratory and diagnostic testing

- Prescribing and managing medication therapy
- Treatment adherence support
- Behavioral risk assessment, counseling, and referral
- Preventive care and screening
- Counseling on health and prevention issues
- Education, treatment, and management of physical and behavioral health conditions
- Pediatric developmental assessment
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Non-allowable services

- Non-HIV related visits to urgent care facilities
- Emergency room visits

Eligibility and enrollment

Clients qualify and are enrolled in outpatient ambulatory health services when they are enrolled in ADAP-M.

Limitations

Services are limited to contracted providers.

Medical case management

Medical case management services help people get access to and stay in medical care. HRSA/HAB defines medical case management as a range of client-focused services that connect clients with health care, psychosocial support, and other services. Coordinating and following up on medical treatments are part of medical case management. These services ensure timely, coordinated access to appropriate levels of health and support services and ongoing care through regular assessment of clients' and their family members' needs and support systems. Medical case management includes counseling to help people get ready for and stick to complex HIV/AIDS treatment plans (HRSA PCN #16-02).

Medical case management services are provided by agencies that have a contract with the program. These contractors make sure that providers follow the current program service standards.

Covered services

Medical case management services include:

- Doing a complete assessment and evaluation.

- Developing, putting into place, and evaluating individual service plans; giving information and recommendations about getting program services, other funding sources, and all other services that help the client get appropriate and timely referrals.
- Checking on clients to see how well their service plan is working, including reviewing and updating the plan every 6 months.
- Counseling on treatment adherence to help clients prepare for and stick to complex HIV treatments.
- Providing timely and coordinated access to appropriate levels of health and support services and ongoing care.
- Regularly assessing the needs and support systems of clients and their key family members.
- Benefit advocacy services provided by the client's case manager, who has been trained and has current information about Ryan White programs and services, knows the basic eligibility rules for government benefits, and has experience helping clients get services like housing, government benefits, and health insurance.
- Benefit advocacy services, including help given to a client to get government benefits like Medicaid, Medicare, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), food stamps, utilities, and the continuation of private health insurance.
- The case manager or case management agency must work with the program's benefits specialist, care coordination, and the client's primary medical care provider when helping a client apply for government benefits where eligibility depends in part on the client's medical condition, and with the housing authority when applying for housing.
- Client-specific advocacy and/or review of how services are being used.
- Providing help and education to clients as needed.

Non-covered services

Providing hands-on clinical services such as mental health or behavioral counseling is not covered under medical case management services.

Other conditions

Minors younger than age 18 who access case management services through the program must also be enrolled in ADAP or support services. Case management only services are provided to minors through the Ryan White Part D program at the University of Utah, Infectious Disease Clinic (IDC).

Medical case management providers must work in conjunction with:

- The client's primary care physician;
- The care coordination;
- Other Ryan White Part B providers as necessary to assist with the application of benefits;
- The client and their family and/or caregivers; and,
- All other persons or entities included at the client's request as pertinent to the case management care plan.

Non-medical case management

As defined by HRSA/HAB, non-medical case management includes advice and help in getting medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordinating and following up on medical treatments (HRSA PCN #16-02).

Non-medical case management services are provided by agencies that have a contract with the program. These contractors make sure that case managers follow the current program service standards.

Covered services

Non-medical case management services include:

- Doing a complete assessment and evaluation.
- Developing, putting into place, and evaluating an individual service plan; giving information and recommendations about getting Ryan White Part B services, other funding sources, and all other services that help the client get appropriate and timely referrals.
- Checking on clients to see how well their service plan is working and reviewing and updating the plan as needed, but at least once a year.
- Providing timely and coordinated access to appropriate levels of health and support services and ongoing care.
- Regularly assessing the needs and support systems of clients and their key family members.
- Benefit advocacy services provided by the client's case manager, who has been trained and has current information about Ryan White programs and services, knows the basic eligibility rules for government benefits, and has experience helping clients get services like housing, government benefits, and health insurance.
- Benefit advocacy services include help given to a client to get government benefits like Medicaid, Medicare, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), food stamps, utilities, and the continuation of private health insurance.
- The case manager or case management agency must work with the program's benefits specialist and the client's primary medical care provider when helping a client apply for government benefits where eligibility depends in part on the client's medical condition, and with the housing authority when applying for housing.
- Client-specific advocacy and/or review of how services are being used.
- Providing help and education to clients.

Other conditions

The case management providers must work in conjunction with:

- The client's primary care physician;
- The benefits specialists;
- Other Ryan White Part B providers as needed to help with benefit applications.
- The client and their family and/or caregivers.

- All other people or organizations included at the client's request that are relevant to the case management care plan.

Medical transportation services

Medical transportation provides non-emergency transportation that allows an eligible client to get to or stay in core medical and support services (HRSA PCN #16-02).

Covered services

Covered services include the following:

- Gas voucher
- Transit pass
- Rideshare
- Other medical transportation services approved by the program

Non-covered services

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Eligibility and enrollment

Medical transportation services are available for clients who qualify for and are enrolled in support services or ADAP. Medical transportation ride-share services or vouchers can be obtained through the client's case management agency. These services can be used to transport clients to and from HIV-related medical appointments or to access support services. The program must be the payer of last resort. If other medical transportation services are available to the client, those must be used first.

Clients can access transportation services through their case management agency or service provider. Service providers should confirm that the client is currently eligible for transportation services before giving any transportation assistance. If transportation assistance is given to someone who is not eligible, the service provider that gave it will be responsible for the costs; the program will not cover the cost of transportation services given to an ineligible individual.

Limitations

- Transportation services are limited to enrolled clients.
- Some transportation services are limited to clients who live within a certain area.
- Clients may only be reimbursed for certain transportation services through a third party. The program cannot directly reimburse a client.

Providers

Transportation services may be provided by approved vendors as identified by provider agreements with the program.

Early intervention services (EIS)

The Ryan White Services program has a collaborative early intervention services (EIS) program that combines efforts across HIV prevention, Ryan White Part B, and STD-related programs. The EIS service category includes 4 service areas, all of which must be present for Ryan White HIV/AIDS Program (RWHAP) funds to be used, although not all parts have to be funded by RWHAP funds. These 4 areas are outlined below with explanations of how they are put into practice.

EIS services areas

- Targeted HIV testing and counseling: This service area helps people who do not know their HIV status become aware of it and receive either a connection to care or a referral for prevention services. EIS efforts in this area cannot copy or replace testing efforts funded by other sources and must work together with other HIV testing and prevention efforts.
- Referral services: This service area aims to improve HIV care and treatment services at important points of entry.
- Access and linkage to HIV care and treatment services: This service area intends to speed up entry into care, such as HIV outpatient/ambulatory health services and medical/non-medical case management.
- Outreach services and health education/risk reduction: This service area is designed to reach individuals, both people living with HIV and those with unknown HIV status, and help them learn about the system of HIV care delivery. The goal is to give patients/clients the skills they need to navigate the HIV care system.

Eligibility

Eligibility: EIS is a unique service category and provides services to people who are not yet enrolled in or eligible for traditional Ryan White Part B services. EIS is meant to find new HIV infections by reaching people who are at the highest risk for HIV infection and/or being lost to care. Because of these factors, EIS does not follow Ryan White Part B eligibility rules, unless specified below:

- Eligibility for EIS activities done by disease intervention specialists (DIS) residency:
 - All clients must be Utah residents. DIS services are only provided to Utah residents. If a client lives outside of Utah, the case is referred to DIS providing services in the client's resident area.
 - Recorded in client's EpiTrax record.

- Eligibility for EIS activities for non-DIS services residency: Follows Ryan White Part B proof of residency guidelines. Refer to the Eligibility—state residency section of the Utah Ryan White Part B program manual.
 - People who are unhoused or living in unstable housing may receive an approved letter from their EIS service provider instead of a case management agency.
 - Proof is kept in the client record with the contracted agency.

Covered services

Covered services include the following:

- Targeted HIV testing
- Health education/risk reduction activities
- Linkage to care activities
- Outreach activities that lead to reengagement in care
- Disease intervention activities

Emergency financial assistance (EFA)

The Ryan White HIV/AIDS Treatment and Modernization Act says that emergency financial help for short-term housing is a support service (HRSA PCN #16-02).

Covered services

Emergency financial assistance (EFA) funds are to be used to help clients who are at risk of becoming unhoused, as this risk affects their ability to get or keep access to and follow HIV-related health services and treatment. Priority will be given to eligible clients with unstable housing. Help may also be given to those with immediate and/or urgent housing needs (due to job loss).

Eligibility and enrollment

Clients who qualify for support services or ADAP can access EFA. Services may be requested with the help of a case manager. Clients must show that they cannot get help from any other sources when they apply for EFA.

The program cannot guarantee that payments will be received by the rent or utility payment due date. The program will not pay late fees under any circumstances. It is up to the client to work with their landlord or utility company about any late payments. Clients are strongly encouraged to submit their EFA requests at least 7 business days before payment is due. Requests will not be accepted after the last day of the month before the rent is due (for example, applications for April rent will not be accepted after March 31).

Limitations

- If there is more than 1 adult in the household, the program will only pay the Part B client's share of the rent and utilities. Proof of payment from the other household member(s) is required upon approval of payment for each month requested.
- If the client has late fees, a written statement from the landlord/case manager saying the late fees will be waived, or proof that the client has paid the late fees, is required.
- An assigned case manager is required if a client asks for more than 1 month of rent assistance. The case manager and client need to create a care plan to show how they will address the housing needs before applying.
- An assigned case manager is not required if this is a one-time payment. If the client applies for EFA again within the next 3 months after the first payment, an assigned case manager and a care plan are required.
- The program can only pay for expenses that happened while the client was eligible and approved for Part B services. Clients may receive up to \$3,000 or 3 months of rent assistance, whichever comes first, in a 12-month period. Clients may not receive more than \$6,000 in rental assistance in a 3-year period.
- Clients may also receive up to \$500 or 3 months of utility assistance, whichever comes first, in a 12-month period. Clients may not receive more than \$1,000 of utility assistance in a 3-year period.
- If the client is more than 3 months behind on their payments, the application will be reviewed on a case-by-case basis.
- EFA cannot be given as direct cash payments to clients and cannot be used for mortgage payments. Assistance may include rent and basic utilities. The program cannot pay late fees.

Oral health care services

Oral health care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants. (HRSA PCN #16-02)

Covered services

Oral health services are provided through contracted partners. Most diagnostic, preventive, basic, and major services are covered through Delta Dental up to a maximum amount set by the program per person each plan year (the amount may vary depending on funding each year).

Eligibility and enrollment

Clients who qualify for support services and ADAP can access oral health services. Clients enrolled in dental services through Medicaid may qualify for oral health service on a case-by-case review by the program. A client should work with their case manager to enroll in oral health care services.

Limitations

Orthodontics are not covered by oral health care services. Clients are responsible for any services provided that are not covered by the dental plan, unless prior authorization is received from the program.

Foodbank/home delivered meals

This refers to providing actual food items, hot meals, or a voucher program to buy food. It also includes providing essential non-food items limited to personal hygiene products, household cleaning supplies, and water filtration/purification systems in communities with water safety issues (HRSA PCN #16-02).

Covered services

All foods, personal hygiene products, and household cleaning supplies are covered and can be bought with food vouchers; however, alcohol and tobacco products cannot be purchased.

Non-covered services

- Unallowable costs include household appliances, pet food, and other non-essential products
- Clients who qualify for support services or ADAP qualify for food vouchers. A client should work with their case manager to request food vouchers.

Limitations

No cash back will be given when food vouchers are used. Lost or stolen food vouchers will not be replaced.

Appendix A

Employment verification form

updated: September 2023

Verification of employment and health insurance availability



Instructions: The Utah Department of Health and Human Services is assisting this individual with access to care. This form is used to confirm income, access to health insurance, and/or termination of employment. In order to fulfill the requirement, please complete all areas in the following section(s): ☐ Section 1, ☐ Section 2, ☐ Section 3.

To be completed by employer/supervisor, authorized Staff ONLY

Employed individual: _____

Employer Information:

Company name: _____ **Email:** _____

Name of contact person: _____ **Phone number:** _____

Street address: _____ **City:** _____ **ZIP code:** _____

Section 1: Employment verification:

- I certify that the above-named individual is a (check one):
☐ Current employee **Or** ☐ Temporary/seasonal employee
Date employment began _____ *If temporary/seasonal, what is the expected end date?* _____
- Wage: Hourly \$ _____/Hour **Or** Salary \$ _____/Yearly **Or** Other: \$ _____/Frequency _____
- Number of hours worked each week: _____
- Will the number of hours worked each week vary? ☐ No ☐ Yes
If yes, what are the minimum hours: _____ **and** *maximum hours:* _____
If yes, do the number of hours vary by the season(s)? ☐ No ☐ Yes
If yes, describe: _____
- Is overtime offered on a regular basis? ☐ No ☐ Yes *Weekly overtime hours:* _____ *Overtime rate:* \$ _____
- Does employment include tips? ☐ No ☐ Yes
If yes, estimated average tip amount (or range): \$ _____/week/month/other: _____

Section 2: Health Insurance verification:

Does employer offer health insurance? ☐ No ☐ Yes

If yes, is the employee currently eligible to enroll in employer sponsored Health Insurance? ☐ No ☐ Yes

If yes, is the employee currently enrolled in health insurance? ☐ No ☐ Yes

If yes, complete the information below and provide a copy of current year health insurance plan details

Health Insurance plan	Enrollment date	Effective date	Benefit plan year Start month/end month	Employer contribution to health savings account
				☐ No ☐ Yes \$ _____ Monthly/Yearly/Other

If no, will the employee be eligible to enroll in employer sponsored health insurance at a future date? ☐ No ☐ Yes

If Yes, what is the enrollment date _____ **and** *effective date* _____

Section 3: Termination of employment:

Is the above named individual a terminated employee? ☐ No ☐ Yes

If yes, last date Worked: _____ **and** *last paycheck date:* _____

Was the terminated employee enrolled in an insurance plan? ☐ No ☐ Yes

If yes, what was the first day of insurance coverage? _____

If yes, what is/was the last day of insurance coverage? _____

Is there an option for continued medical insurance (COBRA)? ☐ No ☐ Yes, *enrollment deadline* _____

Signature: _____ **Title:** _____ **Date:** _____

This form can be returned to the employee listed above or to the Utah Department of Health and Human Services
 Mail: Box 142104, SLC, UT 84114 Fax: 801-536-0978

Appendix B

Residency verification form

Updated: April 2019

(AGENCY LETTERHEAD)

Residency verification form

To whom this may concern:

I verify that _____ is a resident of the state of Utah and is currently residing at _____

The above location is categorized as one of the following types (check one applicable box):

- ☐ Place not meant for human habitation (e.g., vehicle, abandoned building, bus or train station, airport, or anywhere outside)
- ☐ Emergency shelter (including hotel or motel paid for with an emergency shelter voucher)
- ☐ Transitional housing (e.g. halfway house, sober living, etc.)
- ☐ Hospital, residential medical facility, psychiatric hospital, or other psychiatric facility
- ☐ Jail, prison, or juvenile detention facility
- ☐ Substance use disorder treatment facility or detox center
- ☐ A house or home from which the client is currently fleeing to escape domestic or intimate partner violence
- ☐ Unstable or temporary housing (e.g. couch surfing)
- ☐ Other (please specify in each of the following boxes why the client cannot provide any of the following documentation items below):

Utah driver's license, Utah state ID, tribal ID, or military/veteran affairs ID	
Paystubs or earning statement	
Financial institution document (i.e. bank statement, credit card statement, etc.)	
Rental or lease agreement mortgage statement or property tax document	
Utility bill	
Document issued by the state of Utah (public assistance, tax document, vehicle title registration, etc.)	
Document issued by US federal government or social security award letter	

I certify that the above information is accurate and that this individual without traditional proof of residency documentation is a qualified Utah resident.

Staff member name: _____ Title: _____

Staff phone number: _____ Email: _____

Staff member signature: _____ Date: _____

Appendix C

Client rights and responsibilities

updated: September 2023

Clients accessing any Utah Ryan White Part B Program (Program) service:

As a client, you have the *right* to:

- Be treated with respect, dignity, consideration, and compassion.
- Receive services free of any type of discrimination.
- Receive information in a language you can understand which is culturally appropriate.
- Agree with your case manager about a time for an intake assessment and to identify how often you'll have contact, either in person or over the phone.
- Withdraw your voluntary consent to participate in case management services without any change to your medical care or other enrolled services.
- Be informed about services and options you could use, including the cost.
- Know that all your personal information, communication, and records will stay confidential.
- Freedom from physical, sexual, verbal, and/or emotional abuse or threats through the program.
- File a grievance about services you receive or are denied according to the case management agency's grievance policy.

As a client, you have the *responsibility* to:

- Treat other clients, volunteers, and staff with respect and courtesy.
- Protect the confidentiality of other clients.
- Be free of alcohol or mind-altering drugs while you receive services or when you are on the phone with a service provider.
- Let your case manager know any concerns you have about your case management service plan or changes in your needs.
- Make and keep eligibility and case management appointments.
- Respond to program communications (calls, letters, etc.).
- Refrain from causing physical, sexual, verbal, or emotional abuse or threats to clients, staff, or volunteers (including pharmacy staff).
- Be a current resident of Utah and make only true statements regarding your housing status.
- Understand the above client rights and responsibilities and agree to comply with them.
- Understand that violation of these responsibilities may result in termination from the program.
- Understand that I may request and receive a copy of this policy at any time.

Client responsibilities or ADAP services (ADAP-I and ADAP-M):

- I am applying for Utah Ryan White Part B Program services. By signing and submitting the application, I state that I have read this application and understand the conditions for participation.
- The Utah Ryan White Part B Program (Program) is helping to pay for my health insurance premiums, deductibles, co-insurance, co-payments, or ADAP-Medication Assistance.
- I understand that I have the following responsibilities in order to continue getting this help:
 - I understand that I am the policyholder of my insurance plan the program pays for and it is my responsibility to share any letters, bills, and communication I receive from the insurance company with my case manager or benefits specialist.
 - I understand as the policyholder, it is my responsibility to cancel my coverage or pay the premium owed if I become ineligible for premium payment assistance.
 - I understand if I do not provide the required eligibility information each year, I will be ineligible for the program and become responsible to pay back any program money spent on my insurance during the time I did not recertify, which may include monthly premiums, deductibles, co-insurance, and/or co-payments.
 - I understand that if I receive a refund check from the insurance company I have the responsibility to return this money to the program. I understand that if I do not make payment arrangements with the program, I will not be eligible to continue receiving program services.
 - I understand that if I receive a refund on my tax returns due to underpayment of premium tax credits through the health insurance marketplace that I have the responsibility to return this money to the program. I understand that if I do not make payment arrangements with the program, I will not be eligible to continue receiving program services.
 - I understand that if I owe the program money for any reason, I need to set up a payment plan to pay back the program for any ineligible payments made on my behalf. That's the only way I can continue to receive services.
 - If I am enrolled in ADAP-M and don't have health insurance, then I will only be able to get medications listed on the ADAP-M Formulary and I will only be able to see program-contracted doctors and providers.
 - I understand that I need to recertify with the program every year or I risk having my services canceled.
 - I understand it is my responsibility to stay in communication with my case manager/benefits specialist by immediately letting them know about changes in my health, income, health insurance, Medicaid status, residency, address, phone number, marital status, household size, and/or housing/living arrangements and by responding to my case manager's/benefits specialist's communications (calls, letters, etc.) to the best of my ability.

Print name_____Date_____

Signature (guardian signature if minor) _____

Authorization for release of information

This request and authorization apply to information gathered through Utah Ryan White Part B Program activities.

☐ Not applicable

☐ I hereby authorize the Utah Ryan White Part B Program to release information to the following individual(s)

Name (printed) _____

Relation _____

Name (printed) _____

Relation _____

Name (printed) _____

Relation _____

I understand that my records are protected under federal regulations and cannot be disclosed without my written consent unless otherwise provided for under the regulations. This document serves as my consent for the release of information to the individual(s) set forth above. I also understand that I may revoke this consent at any time, in writing, except to the extent that action has been taken in reliance on it.

Print name _____ Date _____

Signature _____
(guardian signature if minor)

Appendix D

Grievance policy

Updated: September 2022

Grievance policy requirements:

1. Included in Utah Ryan White Part B Program Policy and Procedure manual.
2. Applicants/clients/contracted agencies should be given a copy of the grievance policy forms when requested.
3. Staff shall discuss the policy with applicants/clients/contracted agencies to make sure that applicants/clients understand the procedures.
4. The HEART will keep a file documenting all grievances, responses, and outcomes. All documentation will become a part of the applicant's/client's permanent record and will be filed in the applicant's/client's file.

Quality of service:

Staff members are guided by the Utah Ryan White Part B Program Policy and Procedure manual. These policies include federal requirements, state agreements, and assurances, as well as the guidelines and responsibilities for AIDS drug assistance, health insurance assistance, and support services. Reviewing these policies and procedures will help applicants/clients understand the regulations that staff members follow when serving eligible clients.

For a list of client rights and responsibilities and/or a copy of the Client Rights and Responsibilities Agreement, contact the Utah Ryan White Part B Program at (801) 538-6191 or RWP@utah.gov.

Client confidentiality:

Every effort is made within the Utah Ryan White Part B Program to maintain client confidentiality at all times. All staff members are given and required to be familiar with state and federal laws regarding client confidentiality. Reading the confidentiality requirements may help an applicant/client who fears loss of anonymity.

Notification to the Utah Ryan White Part B Program client:

You are receiving services from the Ryan White Part B Program within the Bureau of Epidemiology at the Utah Department of Health (DHHS). The development and operation of this program are supported by The Ryan White CARE Act, Part B funding. Part B funds are administered by the DHHS on a state level.

The Utah Ryan White Part B Program service needs are identified and prioritized through the needs assessment process. Based on this assessment, a plan has been developed for the program to meet the needs of individuals and families affected by HIV/AIDS in Utah.

The Health Resources and Services Administration (HRSA), which is within the U.S. Department of Health and Human Services (HHS), has lead responsibility for the Ryan White Part B Program. Part B funds are received by the Ryan White Part B Program within the Bureau of Epidemiology at the DHHS. The Utah Ryan White Part B Program and the state of Utah must follow federal requirements and contract requirements.

Grievance procedure:

If an applicant/client/contracted agencies (grievant) wishes to express a complaint or suggestion for the Utah Ryan White Part B Program, the following procedures should be followed as outlined below:

Level 1

1. Ryan White Part B Program Manager will address the Level 1 statement of grievance

- A. The grievant must complete and submit in writing the Level 1 statement of grievance form within five (5) business days of the alleged complaint.
- B. Describe the occurrence in detail. Use dates and names if known.
- C. The grievant should retain a copy for their records.
- D. Grievance submission:
 - a. Email the statement of grievance form to RWP@Utah.gov, or;
 - b. Mail the Level 1 statement of grievance form to:
Utah Department of Health and Human Services
Office of Communicable Diseases
(ATTN: Ryan White Part B)
Box 142104
Salt Lake City, UT 84114-2104
- E. The grievant will receive a response in writing by the method of submission (email or USPS mail) within ten (10) business days of the program receiving the grievance.
- F. If the grievant is not satisfied with the response, they must file a Level 2 statement of grievance within five (5) business days of receiving the response.

Level 2

- 2. The HEART program manager will address the Level 2 statement of grievance.
 - A. The Level 2 statement of grievance form must be completed in writing within five (5) business days of receiving their Level 1 response.
 - i. A copy of the Level 1 grievance statement and Level 1 response must be attached to the Level 2 statement of grievance.
 - B. The Heart program manager shall respond to the grievant Level 2 complaint in writing by the method of submission (email or USPS mail) within ten (10) business days of receiving the grievance.

- C. The HEART program manager and the grievant will attempt to work together to resolve the grievance.
- D. If the grievant is not satisfied with the response, they may file the Level 3 statement of grievance within a mandatory five (5) business day period.

Level 3

- 2. The final level of appeal is Level 3. The director of the Office of Communicable Diseases will address the Level 3 appeal.
 - A. The Level 3 statement of grievance form and submission instructions can be obtained from the Level 2 contact person.
 - i. The grievant must complete this form in writing within five (5) business days of receiving their response for the Level 2 appeal.
 - ii. The grievant must attach copies of the Level 1 and Level 2 statements of grievance and their Level 1 and Level 2 responses for the Level 3 appeal.
 - a. The grievance will not be accepted if the grievances and responses are not attached to the Level 3 grievance.
 - b. The Level 3 contact person will not accept the request for appeal if the client has failed to work with the Level 2 contact person.
 - B. The office director shall respond to the grievant complaint in writing within twenty (20) business days of receiving the grievance.

Level 1, 2, and 3 statements of grievance paperwork are provided on the following pages.

Utah Department of Health and Human Services
Office of Communicable Diseases
Utah Ryan White Part B Program

LEVEL 1 statement of grievance

Date submitted: _____

Grievant name: _____

Address: _____

Work phone number: _____

Home phone number: _____

Date of birth: _____

Statement of grievance (Specify in detail)

Grievance is related to: core or support services: _____ ADAP or program eligibility _____

Date of occurrence: _____ Location of occurrence: _____

Summary: _____

Remedy sought: _____

(Continue on the other side if needed)

(Include any paperwork that would help in the decision making)

Signature of grievant: _____ Date: _____

Signature of parent/guardian for minor client _____ Date: _____

Utah Department of Health and Health Resources
Office of Communicable Diseases
Utah Ryan White Part B Program

LEVEL 2 statement of grievance

Date submitted:_____

Date of Level 1 response:_____

Grievant name:_____

Address:_____

Work phone number:_____

Home phone number:_____

Date of birth:_____

Statement of grievance:

“The Level 1 statement of grievance” and “Level 1 response” must be attached.

Summary of why the grievant disagrees with the Level 1 response:

(Continue on the other side if needed)

I request a Level 2 appeal to resolve a grievance, which occurred on_____.
(Date)

The Level 1 response I received on _____ was unacceptable.
(Date)

Signature of grievant:_____ Date: _____

Signature of parent/guardian

(for minor client): _____ Date: _____

Utah Department of Health and Human Services
Office of Communicable Diseases
Utah Ryan White Part B Program

LEVEL 3 statement of grievance

Date submitted: _____

Date of Level 2 response: _____

Grievant name: _____

Date of birth: _____

Address: _____

Work phone number: _____

Home phone number: _____

Statement of grievance and response: "The Level 1" and the "Level 2 statements of grievance" and "Level 1" and "Level 2 responses" must be attached.

Summary of why the grievant disagrees with the Level 1 and Level 2 response:

(Continue on the other side if needed)

(Include any paperwork that would help in the decision making)

I request a Level 3 appeal to resolve a grievance that occurred on _____.
(Date)

The Level 1 response I received on (Date) _____ was unacceptable.

The Level 2 response I received on (Date) _____ was also unacceptable.

I understand that Level 3 is my last level of appeal.

Signature of grievant: _____ Date: _____

Signature of parent/guardian

for minor client: _____ Date: _____

Utah Department of Health and Human Services
Office of Communicable Diseases
Utah Ryan White Part B Program
Client grievance intake and disposition
(for staff use only)

Name of grievant: _____

Grievance Level 1

Client grievance statement received date: _____

Document received by: _____
(Name)

Given to Level 1 contact person: _____
(Name)

Summary of Level 1 response: _____

Response: ☐ Accepted by client ☐ Rejected by client

Grievance Level 2

Client grievance statement received date: _____

All Level 1 documents are enclosed, as required. Yes ____ No ____

Document received by: _____
(Name)

Given to Level 2 contact person: _____

Summary of Level 2 response: _____

Response: ☐ Accepted by client ☐ Rejected by client

Grievance Level 3

Client grievance statement received date: _____

All Level 1 and Level 2 documents are enclosed, as required. Yes ____ No ____

Document received by: _____
(Name)

Given to Level 3 contact person: _____

Level 3 decision: _____

Client response:

