

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) SERVICE STANDARDS

Common Standards

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* Areas that have been changed are highlighted yellow

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Introduction

This document describes the “Common Standard” for all services of the HIV Care Program (HCP), a program of the California Department of Public Health (CDPH), Office of AIDS (OA), funded through the Health Resources and Services Administration (HRSA), Ryan White HIV/AIDS Program (RWHAP) Part B.

This document highlights each of the requirements and standards that must be followed by any provider receiving HIV Care Program (HCP) (RWHAP Part B) funding. Common standards addressed here include client eligibility and consent, staffing, cultural and linguistic competency, service management and closure, and quality assurance. These standards must be met or exceeded for all HCP services in all jurisdictions.

Providers must adhere to any service category-specific standards described in the service standard for that service category. Users should refer to service category-specific standards for more detailed or additional requirements. Monitoring is conducted on a yearly basis through desk review and onsite monitoring.

How This Document is Organized

Within this document, the Common Standards are described in terms of (1) Use of HCP Funds and (2) Requirements.

Use of HCP Funds

1. All clients served by providers funded by HCP shall receive services that:
 - Are accessible to all persons living with HIV who qualify and meet eligibility requirements
 - Include a comprehensive intake process that establishes client eligibility, collects client information, and comprehensively informs them about available services
 - Maintain the highest standards of care, including providing experienced, trained, and (as appropriate) licensed staff
 - Are culturally and linguistically competent
 - Guarantee client confidentiality, protect client autonomy, and protect the rights of persons living with HIV
 - Promote continuity of care, client monitoring, and follow-up
 - Ensure a fair process of grievance review and advocacy
2. Providers must make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients (i.e., RWHAP must be the “payer of last resort”).

3. HCP funds are intended to support only the HIV-related needs of eligible individuals. An explicit connection must be made between any service supported with HCP funds and the intended client's HIV status.
4. Affected individuals (partners and family members not living with HIV) may be eligible for HCP services in limited situations, but these services for affected individuals must always directly benefit people living with HIV. For more information see [HRSA PCN 16-02](#) and [ARIES Policy Notice C5](#).

Unallowable Costs

HCP funds may not be used to make cash payments to intended clients of HCP-funded services. This prohibition includes cash incentives and cash intended as payment for HCP core medical and support services.

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services,
- Funeral and Burial Expenses
- Property Taxes
- Pre-Exposure Prophylaxis (PrEP)
- non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- Travel outside of California
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Requirements

Eligibility Determination

The eligibility determination process verifies that a client's HIV status, residency, and income meet HCP eligibility requirements. HCP subrecipients are expected to establish, implement, and monitor eligibility determination policies and procedures for their providers.

Frequency

Eligibility must be determined at initial enrollment and recertified at the client's birthdate following initial enrollment and every year thereafter.

Rather than using the enrollment date, HCP now aligns with the AIDS Drug Assistance Program's (ADAP) use of the client's birthdate for recertification. This change may require two eligibility determinations within the client's first year of service. To illustrate:

Client Birthdate	Initial Enrollment Date	First Recertification Occurs	Subsequent Recertifications
January 15	April 15, 2022	January 15, 2023 (at 9 months)	Every 12 months thereafter on birthdate
April 15		April 15, 2023 (at 12 months)	
July 15		July 15, 2022 (at 3 months)	
October 15		October 15, 2022 (6 months)	

Though HRSA's [Policy Clarification Notice 21-02](#) eliminated the six-month recertification requirement, it is strongly recommended that subrecipients adopt best practices to periodically check for changes to clients income or residence throughout the year. Such practices may include updating language in Client Rights and Responsibility form (see page 13) to require clients to report changes in their income or residence, asking clients when they check in at each visit if there are changes in eligibility, etc.

General Principles for Documentation

Complete eligibility documentation is required for annual recertification. Documentation does not need to be presented by the client in person. Clients may provide legible original, scanned, or photocopied documents via fax, e-mail, or in person. Documents do not need to be notarized.

HCP providers may also use data from "ex parte" sources to determine eligibility for any of the three eligibility requirements detailed below. Ex parte data sources may include state tax filings, Medi-Cal enrollment information, and AIDS Drug Assistance Program (ADAP)¹ eligibility information. HCP providers who utilize ex parte data must:

¹ Health and Safety Code (HSC) § 120970 states in part: "All types of information, whether written or oral, concerning a[n ADAP] client, made or kept in connection with the administration of ADAP services... shall be confidential, and shall not be used or disclosed except for any of the following: ... (2) For coordinating client eligibility with programs funded by the federal Ryan White HIV/AIDS Program (Ryan White HIV/AIDS Treatment Extension Act of 2009)..."

- Maintain a copy of the document from the ex parte data source in the client's paper or digital chart for inspection during site monitoring and
- Enter the individual data elements from the ex parte data source into ARIES so that the data may be reported to HRSA in the provider's annual Ryan White Services Report (RSR). For example, because the provider must be able to report a client's actual FPL, that a client is enrolled in ADAP is not sufficient information for the RSR.

Eligibility Criteria

Eligibility certification includes documentation of the following:

- **HIV-positive status:** At the initial enrollment, clients must provide proof of HIV-positive status. Once HIV status is verified, providers should not request HIV documentation during future recertifications. Acceptable documentation includes the following:
 - HIV positive lab results (antibody test, qualitative HIV detection test, or detectable viral load). Lab results with undetectable viral loads that do not indicate a positive HIV diagnosis will not be accepted during initial enrollment as proof of positive HIV diagnosis.
 - **Note:** Having positive results from only one HIV antibody test should not be a barrier to linkage to care to a RWHAP-funded clinic, or other HIV care providers, since the majority of people receiving a positive result from a single test have HIV infection and would benefit from quick linkage to ongoing care and prevention services. The receiving medical clinic must be informed of the individual's unconfirmed preliminary positive HIV test result and the need for confirmation. RWHAP-funded clinics that receive such individuals may choose to arrange an abbreviated first appointment during which the individual receives counseling about HIV testing and a limited evaluation that includes confirmatory HIV testing and potentially other HIV labs. For more information, see [Dear Colleague Letter of February 25, 2013](#).
 - Letter from the client's physician or licensed health care provider. Acceptable letters of diagnosis must be on the physician's or health care provider's letterhead with the National Provider Identifier (NPI) number or California license number, and the physician's or a licensed health care provider's signature verifying the client's HIV status.
 - Letters already in client charts that do not meet this standard are grandfathered in; this requirement for letters applies to new intakes conducted after April 1, 2018.

- [Diagnosis Form \(CDPH 8440\)](#) completed and signed by the client's physician or licensed health care provider. Any diagnosis form that contains pertinent information is also allowed.
- **Residence:** Individuals eligible for HCP services must reside in the State of California. Acceptable residency verification consists of the client's name and address on one of the following:
 - California driver's license or California Identity Card
 - Dated within the last 30-days:
 - California rent or mortgage receipt
 - Current utility bill with the service address listed in California (a cell phone bill is not acceptable)
 - Employment paycheck stub
 - Dated within one year:
 - Rental/lease agreement or annual lease renewal documentation
 - Voter registration card
 - Vehicle registration (not expired)
 - W-2 or 1099 (prior tax year documents will be accepted until February 15th. After February 15th, only current tax year documents will be accepted.)
 - Social Security/Disability Award Letter (SSI, SSDI)
 - California Employment Development Department (EDD) award letter
 - Filed State or Federal tax return
 - Public housing letter on official letterhead from Housing and Urban Development (HUD) or a county agency
 - Notice of Action from the Department of Health Care Services
 - Medi-Cal beneficiary letter
 - School records
 - Property tax receipt
 - Unemployment document
 - Letter from a shelter, social service agency, or clinic verifying individuals' identity, length of residency, and location designated as

their residence. The letter must be on letterhead and signed by a staff person affiliated with the service agency or clinic

- If no other methods of verification are possible, a completed Residency Verification Affidavit ([CDPH 8727](#), [CDPH 8727 SP](#)) or a letter signed and dated by the client that indicates they are homeless with no connection to any other service provider. In this situation, a referral to assist the client in securing shelter or housing should be a priority.
- **Note:** *Immigration status is irrelevant for the purposes of eligibility for HCP services. HCP subrecipients or subcontractors should not share immigration status with immigration enforcement agencies.*
- **Income:** Clients must provide documentation of all forms of income and meet the income requirements. HCP financial eligibility matches the financial eligibility defined by ADAP in HSC § 120960. Currently, HSC § 120960 defines income eligibility as clients with modified adjusted gross income which does not exceed 500 percent of the federal poverty level (FPL) per year based on family size and household income. Acceptable income verification includes one of the following:
 - Pay stubs
 - Three consecutive months of current paystubs, or
 - If employed more than one year, one paystub showing Year-To-Date (YTD) earnings that includes at least three months of income, or
 - If employed less than one year, one paystub showing YTD earnings that includes at least three months of income and lists the employment start date
 - Private disability award letter (dated within one year)
 - Supplemental Security Income (SSI) award letter (dated within one year)
 - Social Security Disability Income (SSDI) award letter (dated within one year)
 - Bank statement showing direct deposit of Unemployment Insurance, SSI/SSDI benefits. Statement must be dated within one month and clearly identify the deposit/income source (e.g., US Treasury, SSA)
 - State Disability Insurance (SDI) award letter (dated within one year)
 - Social Security Retirement Benefit award letter (dated within one year)

- Retirement/Pension award letter (dated within one year)
 - Unemployment Insurance (UI) award letter (dated within one year)
 - Spousal support court documentation
 - Worker’s Compensation award letter (dated within one year)
 - Investment income documentation (e.g., statement or portfolio summary dated within one month)
 - Veteran’s Administration (VA) Benefits award letter (dated within one year)
 - Rental income documentation (e.g., a signed rental agreement dated within the last year or three current bank statements showing rental income deposits)
 - If self-employed, provide a completed Self-Employment Affidavit form ([CDPH 8726](#), [CHPH 8726 SP](#))
 - If no other methods of verification are possible, a completed Income Verification Affidavit ([CDPH 8441](#), [CDPH 8441 SP](#)) or a letter signed and dated by the client that indicates zero income, or attests to earned income not otherwise confirmed by the above..
- **Screening for Services Needs:** At the time of client intake into any HCP service, the client shall be screened for the need for other services, including but not limited to: medical care, case management, housing, food, mental health, substance use issues, transportation, and benefits counseling. Screening for services can be done using the tools and/or scales of the local jurisdiction, but tools/scales must be consistent within the jurisdiction. Referrals should be made for any services identified as needed but not offered by the screening agency; referrals should be performed utilizing a warm hand off when possible. All referrals must be documented.

ARIES Reference

<p><u>Proof of Diagnosis</u> Eligibility Tab Eligibility Documents Sub-tab Pick one: 1. HIV Letter of Diagnosis 2. Proof of Diagnosis Upload copy of corresponding document</p>	<p><u>Residency</u> Eligibility Tab Eligibility Documents Sub-tab Pick one: 1. Picture ID 2. Proof of Residency</p>
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<i>ARIES Policy Notice No. C3</i>	
<u>Income</u> Eligibility Tab Financial Sub-tab Enter: Household Monthly Income # of People in Household	<u>Insurance</u> Eligibility Tab Insurance Sub-tab Click <i>New</i> Enter: Start Date Source Payer <i>ARIES Policy Notice No. C4</i>

Monitoring

Eligibility Screening - Client eligibility, including HIV-positive status, residency, income, and insurance status must be entered into ARIES. Documentation of service needs must be documented in client chart(s) and made available during site visits

Annual Recertification - Annual recertification of residency, income, and insurance status must be documented in ARIES. Agencies must have updated documentation of these elements in client chart(s), available for review upon request.

Fiscal Responsibility

Payer of Last Resort

Federal legislation states that RWHAP funds are the payer of last resort. This means that no HCP funds can be used for services that could reasonably be paid for or provided by another funding source.

While insurance status is not a program eligibility requirement, providers must screen all clients who receive services that may be billed to third parties. Documentation of insurance status must be entered into ARIES. Acceptable verification of clients' insurance status includes any of the following:

- Copy of current insurance card, including Medi-Cal Beneficiary Identification Card (BIC) if applicable
- Dated screenshots of client insurance status verification using an official insurance screening system
- Denial letter from Medi-Cal
- Statement signed and dated by the client indicating they are not covered by insurance. If client is employed, the statement must include the reason the employer does not provide insurance

Providers should document their efforts to "vigorously pursue" enrolling clients in comprehensive health care coverage (such as Medi-Cal or Covered California). For

more information, please see [Management Memo 14-01](#). All providers should refer clients to Covered California if there is no other insurance option available and the client does not qualify for Medi-Cal. Consult with the Covered California website for specific enrollment periods and special circumstances for client enrollment. Providing benefits counseling to clients must involve working with eligibility workers from other programs to assist HCP clients with the process of signing up for those programs.

Department of Veterans Affairs (VA) – HCP service providers may not deny services, including prescription drugs, to a veteran with VA benefits who is otherwise eligible to receive HCP services. HCP can pay for services that are unavailable from the VA. For more information see [HRSA Policy Clarification Notice 16-01](#).

Indian Health Services (IHS) – Any American Indian or Alaska Native who is otherwise eligible to receive RWHAP-funded services may request and must receive those services regardless of whether or not they are also eligible to receive the same services from the IHS. For more information see [HRSA Policy Clarification Notice 07-01](#).

RWHAP may be utilized to pay for services even if covered by another entity in special situations, such as a medically necessary appointment that is not available in a timely manner, necessary services beyond a client's current health coverage, or copays not covered by a client's insurance. Service providers must provide documentation of the need for additional services beyond what the client's health care coverage or other benefits provide.

PCN 21-02 clarifies subrecipients "are expected to develop protocols to facilitate the rapid delivery of RWHAP services, including the provision of antiretrovirals for those newly diagnosed or re-engaged in care. If services are initiated prior to eligibility being established, RWHAP subrecipients must conduct a formal eligibility determination within a reasonable timeframe and reconcile (i.e., properly account for) any RWHAP funds to ensure that they are only used for allowable costs for eligible individuals."

Monitoring

Compliance with “Payer of Last Resort” requirements and verification of clients' insurance status will be monitored via discussion and clients' chart review during site visits.

Consents

Prior to receiving services, clients must sign the following consent forms:

- **Agency Consent for Service:** At the initiation of services the client must sign a consent form indicating they consent to receiving services from the agency.

- **ARIES Consent:** Providers must obtain a completed ARIES Consent Form for each client and log the form into the Eligibility Documents screen in ARIES. Clients must indicate whether they want to share their ARIES data with other ARIES-using agencies at which they receive services. Information shared may include demographics, contact information, medical history, and service data. However, data related to mental health, substance use issues, and legal services are never shared between service providers regardless of the client's share choice.
 - The form must be renewed once every three years or whenever clients want to change their data-sharing choice. For more information, refer to ARIES Policy Notice C1 on Client Consent and Share Options.

On an as-needed basis, the following must also be documented via forms signed by the client:

- **Consent to Release Confidential Information (not the same as ARIES Consent Form):** When disclosure of confidential information is requested by the client or required for care coordination or other necessary components of high-quality service provision, the client must be informed of this intent to share information and must provide written consent before the information is shared. All documentation of consent to release confidential information should specifically note what information can be shared, to whom it may be shared, and the time-limit within which the sharing may take place.
- **Authorization to Exchange Confidential Information (not the same as ARIES Consent Form):** Similar to the consent to release confidential information, when appropriate, clients may also provide consent for regular exchange of information about their case between providers as it helps with care coordination. Again, the client must provide written consent **before the information is shared**. All documentation of consent to release confidential information should specifically note what information can be shared, to whom it may be shared, and the time-limit within which the sharing may take place.
 - **Note:** Case conferencing between staff of the same organization which takes place on a regular basis and is a standard part of many HCP services does not require additional authorization. However, if staff from outside the organization are needed to conduct thorough case conferencing, prior authorization to exchange information would be required.

All signed consents must be kept in the client's file, and the client must receive a copy.

ARIES Reference

ARIES Consent Form

Eligibility Tab

Eligibility Documents Sub-tab

Pick ARIES Consent Form / Enter date

Share Option

Agency Specifics Tab

Agrees to Share Date / Select Yes or No

Monitoring

Agency Consent for Service - Signed consent forms shall either (1) be uploaded to ARIES, or (2) retained in client chart(s) and available for review upon request.

ARIES Consent - ARIES Consent Forms must be logged into ARIES and the Share option must reflect the client's choice as reflected on the form. For more specifics, see ARIES Policy Notice C1.

Authorization to Exchange Confidential Information - Documentation of consent to release or exchange confidential information must be retained in client chart(s) and available for review upon request.

Notifications

As a part of HCP services, clients should be notified of the following:

- **Case conferencing** among staff involved in the provision of any of their care occurs regularly as a standard part of HCP services
- **Re-engagement services** are routinely provided by this provider and/or the county health department to ensure that clients have uninterrupted access to care services. This requires sharing of contact information as needed for these services
- **After-hours or weekend options** that are available to clients during an emergency (i.e. an on-call number, answering service, or alternative contacts in other agencies)
- **HIPAA:** Clients must be informed of their health information privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) where applicable
- **Client Grievance Procedures:** Clients must be informed of the grievance procedures within their local jurisdiction, and assured that no negative actions will be taken toward them as a client in response to their filing of a grievance

- **Client Rights and Responsibilities:** Clients must receive notice of their rights and responsibilities relative to HCP service provision. This must include the minimum rights and responsibilities outlined later in this Common Standards document.

Clients must receive a written copy of all notifications provided during their first appointment.

Monitoring

Client Notification - Client notification of case conferencing, re-engagement services, and after-hours / weekend emergency options must be documented through submission of agency written forms related to these notifications.

Client Notification with Signature - Client notification of HIPAA, client grievance procedures, and rights and responsibilities must be documented in client chart(s) and available upon request for review. There must be documentation that the client has received these notifications; documentation shall be through client signature that they have received and acknowledged these notifications.

Client Registration into ARIES

ARIES is a centralized, secure, online HIV client management system that allows for coordination of client services among medical care, treatment, and support providers and provides comprehensive data for program reporting and monitoring. ARIES is used by RWHAP-funded service providers throughout California to plan, manage, and report on client data. HCP frequently uses ARIES to conduct monitoring of these Services Standards.

HCP providers must report on the HCP clients they serve using ARIES.

For new clients, HCP providers must explain the "share" options to the client and obtain a signed ARIES Consent Form (see **ARIES Policy Notice C1**). Providers shall also collect the client's identifiers to initiate client registration in ARIES. Identifiers include all of the following:

- First Name
- Middle Initial
- Last Name
- Mother's Maiden Name (see **ARIES Policy Notice C2**)
- Date of Birth
- Current Gender

To initiate ARIES registration, the HCP provider enters these identifiers into ARIES. If the client already exists in ARIES as a share client, ARIES will open the existing client

record for the provider. If the client is non-share or new to ARIES, ARIES will create a new client record for the provider.

While the client is enrolled in the agency, the HCP provider is required to collect and enter into ARIES certain data elements for the annual Ryan White Services Report (RSR). These data elements are identified with large red asterisks in ARIES. For more [details about and provider requirements for the RSR](https://careacttarget.org/category/topics/ryan-white-services-report-rsr), please visit <https://careacttarget.org/category/topics/ryan-white-services-report-rsr>.

Timeframe

The first appointments for new clients should be made as soon as possible to avoid potential drop out. Appointments must be offered no later than 10 calendar days from first client referral. A referral can be from another professional or self-referral. Agencies must have a tracking method to record when first contact was made so it can be tracked. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up, preferably within 24 hours as client missed appointments have been linked to future poor health outcomes. Missed appointments and attempts to reschedule must be documented in the tracking log or the client chart. For appointments offered later than 10 days from first client referral, the reason for the delay must be documented in client chart.

Monitoring

Timeframe- Procedures for ensuring the first appointment for new clients is offered within 10 days will be reviewed through submission of agency written procedures

Service Access, Management, and Closure

Client Access

Services must be planned and implemented in a way that ensures an accessible environment. Services must:

- Provide adequate accommodation for actual or potential physical, psychological, and psychosocial disabilities and/or impairments
- Not be restricted on the basis of age, gender, sexual orientation, race, ethnicity, disability, past or current health condition, ability to pay fees, residence, or any other discriminatory factors, as applicable, under the California Unruh Civil Rights Act and Disabled Persons Act (except as required for eligibility purposes.)

Service Management

Services must take into account client needs and remove barriers to clients' ability to meet the requirements of their care/treatment plans, as follows:

- Services must be managed to achieve:
 - Accessibility
 - Effectiveness
 - Reliability
 - Timeliness
 - Appropriateness to the needs of clients

Monitoring

Accessibility - Existence of adequate physical accommodation(s) for disabilities and/or impairments of clients, will be verified during site visits.

- Services must include activities and educational resources that promote, facilitate, and encourage client self-management and self-sufficiency, including but not limited to:
 - Access to non-HCP-funded services
 - Resource guides to low-cost/free medical and support services, including those not offered as part of HCP

In addition, services must be transparent and fiscally responsible:

- Services should be planned, managed, and monitored to avoid the need for:
 - Urgent or emergency services
 - Service interruption
 - Needing emergency or unplanned funding to continue services during contract periods.
- Data collection and documentation of all services must be manually entered or imported into ARIES for accounting, reporting, compliance, and evaluation purposes. The optimum goal for entering data into ARIES is in real-time. Some providers may not be able to meet this goal due to staffing levels, lack of computers, or other business practices. Providers that are unable to enter data in real-time have up to two weeks from the service date to enter the data. For more information, please see **ARIES Policy Notice E1**.
- Program directors and managers shall ensure contract compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality.
- Service providers must have a way to obtain client input and feedback on an annual basis. The ideal method would be a “client advisory board” that consists of representation of the population served and provides input to the

delivery of services. In lieu of an advisory board, providers can provide a visible suggestion box which is locked or other similar client input mechanism such as client satisfaction survey.

Monitoring

Client Input – Copies of minutes from annual client advisory board meetings, or client suggestions or surveys will be reviewed during site visit.

Case Closure

In some cases (e.g. a client who is incarcerated for longer than 6 months) a client file may be made “inactive,” able to easily be returned to “active” status when the client returns to services as expected. A client file may be permanently “closed” under certain conditions. The reason for and circumstances around all closure actions must be documented in the client file or in ARIES. Acceptable reasons for client file closure include but not limited to:

- The client has requested transfer of services to another agency
- The client has died or moved out of California
 - Providers are strongly encouraged to report clients who have died or moved out of California to the HIV surveillance coordinator at the local public health department. This will allow the coordinator to update the surveillance system and ensure that the county’s data accurately reflect who is in care.
 - Providers should attempt to assist the client with identifying a source of care in the jurisdiction they are moving to.
- The client is lost to follow-up if the client cannot be located after at least three documented attempts per month over a period of three consecutive months. Attempts to contact the client must take place on different days and times of the day during this time period.
 - Providers are strongly encouraged to refer clients who are lost to follow-up to the local public health department for further outreach and re-engagement in care activities.
- RWHAP subrecipients should not disenroll clients until a formal confirmation has been made that the client is no longer eligible
- The client’s actions have put the agency, staff, and/or other clients at risk
- There is evidence of client fraud or deliberate misuse of services

- Additional service-specific circumstances for closing a client file may be found in the Service Standard for an individual service.

How to Close a File: Agencies should close a client’s file according to the written procedures established by the agency.

- **Prior to closure** (for reasons other than death), the agency must attempt to inform the client of the appeal process and re-entry requirements into the system, make clear to the client the consequences of closing the case, and offer to facilitate transfer of information to a new provider.
- **Prior to forced disenrollment and case closure due to evidence of abusive behavior, client fraud, deliberate misuse of services, or program ineligibility**, the client must:
 - Be given at least 10 days’ notice before disenrollment, except in cases of abusive behavior that poses serious physical danger to staff or clients
 - Be sent a letter that verifies the disenrollment date and reason for the action, along with information about the procedure for grievance/appeals. This letter must be legible, signed, and dated, and a copy must be kept in the client record

Record Maintenance: Client files must be retained in a secure place for a minimum of three years plus the current year, or later as is required by law for your facility type, after a case is closed. After that time period, they must be disposed of securely through confidential means such as cross cut shredding and pulverizing.

Monitoring

File Closure - Appropriateness of file closure will be monitored via chart review during in-person site visits. Agency procedures for file closure, as well as compliance with record maintenance standards, will be monitored through agency submission of applicable written procedures.

Client Right and Responsibilities

Information in this section must be included in a client Rights and Responsibilities form. Clients must sign an acknowledgement of having received this information.

All eligible clients have the right to:

- Request and receive approved services consistent with their care/treatment plan
- Receive services that are reliable, timely, respectful, and appropriate to their situation, culture, health status, and level of disability

- Clients have the right to freedom from discrimination because of age, race, ethnicity, gender, disability, religion, sexual orientation, veteran status, or any other protected class.
- Receive accurate and easily understood information about their care plan, health care professionals, and health care facilities
- Participate in decisions about their care and obtain information about treatment options
- Refuse care
- Have their healthcare information be treated confidentially
- Review their client records (including medical records) and request that any inaccurate, irrelevant, or incomplete information be changed as per local policies and procedures.

Clients are responsible for:

- Providing documentation to verify their eligibility for HCP services
- Being involved in their healthcare and adhering to their treatment plan
- Disclosing relevant information
- Clearly communicating their wants and needs
- Treating service providers appropriately and with respect at all times
- Arranging services in a way that avoids emergencies whenever possible
- Maintaining periodic contact with their relevant service provider
- Following provider written policies and procedures and guidelines
- Following written or verbal instructions regarding treatments, activities, safety policies, and utilization of services

Monitoring

Client Rights and Responsibilities – A copy of the client form outlining Client Rights and Responsibilities must be provided. Review of client acknowledgment will be done via chart reviews.

Staffing Requirements and Qualification

Education/Experience/Supervision

All staff must hold the appropriate degrees, certification, licenses, permits or other qualifying documentation as required by Federal, State, County, local authorities, or HCP Service Standards. See each specific service standard for detailed requirements by service.

Monitoring

Staff Education and Experience - Proof of required staff degrees, certification, licenses, permits, or other qualifying documentation must be available for review during site visits.

Staff Orientation and Training

Initial: All staff providing direct services to clients or making decisions about HIV service must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Time and cost associated with training can be charged to the service category under which the staff is billed in the budget. Topics must include:

- General HIV knowledge, such as transmission, care, and prevention
- Navigation of the local HIV system of care, including ADAP
- Confidentiality and Security
- Cultural sensitivity, including but not limited to LGBTQ cultural competence, cultural humility, and social determinants of health

Other topics may include:

- Psychosocial issues
- Health maintenance for people living with HIV
- Client service expectations

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Confidentiality agreements by staff must be reviewed and re-signed annually. Training requirements and updated confidentiality agreements must be clearly documented and completed trainings must be tracked for monitoring purposes.

Monitoring

Staff Orientation and Training - Agencies must maintain a comprehensive list of staff with hire date, all trainings provided, dates of trainings, and dates of refreshed confidentiality agreements; this list must be available for review during site visits or upon request.

Cultural and Linguistic Competency

According to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), culturally and linguistically competent services are those that “provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs

and practices, preferred languages, health literacy and other communication needs.”
Providers shall provide services that:

- Treat people living with HIV with respect, and are skilled and culturally-appropriate for the communities served
- Reflect the culture of the community served
- Comply with American Disabilities Act (ADA) criteria
- Are in a location and have hours that make it accessible to the community served
- Are provided in the client’s primary language. If that language is not English, interpretation must be provided by a staff member or other means
- Are provided in areas with posted and written materials in appropriate languages for the clients served
- Provide interpreters or access to real-time interpreter services (including phone, Skype, etc.) For HIPAA covered services, interpretation services must follow HIPAA requirements; family and friends should not be used for interpretation. For non-HIPAA covered services, family and friends should only provide interpretation as a last resort and with the prior permission of the client.

Monitoring

Culturally and Linguistic Competency - Compliance with CLAS Standards, including ADA criteria and accessible location/hours of services, will be monitored via discussion during site visits.

Quality Assurance

Service Evaluation

Each service provider is responsible for evaluating and reporting its performance relative to care standards, and is subject to client chart, utilization, and other types of audits. Service providers must:

- Collect and examine client satisfaction data, and have a process to act on the information reported
- In response to any findings as part of routine HCP monitoring, develop and implement a Corrective Action Plan (CAP)
- Maintain a grievance procedure which provides for the objective review of client grievances and alleged violations of care and service standards

- Clients must be routinely informed about and assisted in utilizing this procedure
- Clients must not be discriminated against for utilizing the grievance procedure
- Have a client complaint procedure which addresses issues not appropriate to the grievance procedure. Complaints will be investigated and responded to in a timely and respectful manner according to local written policies and procedures. Documentation of investigation and response should be maintained in writing and kept separate from the regular client file

Monitoring

Quality Assurance –A copy of the Grievance Policy must be provided to HCP. Oversight of submitted client grievances will occur during site visits. The Grievance Policy may be incorporated into the Client Rights and Responsibility form

Clinical Quality Management- For clinical services, comply with requirements in the California Ryan White Part B Clinical Quality Management Plan

HIPAA Compliance and Non-HIPAA/HITECH Contractors/Providers

- All providers of HIPAA-covered services will comply with the HIPAA of 1996. All HIPAA regulations must be followed when interacting with or on behalf of a client, and with regards to record maintenance.
- All non-HIPAA covered contractors and providers (including tax preparation professionals, accountants, law firms, etc.) must comply with the Information Privacy and Security Requirements set forth in the HCP/Minority AIDS Initiative contract.
- All contractors, sub-contractors and providers must have their employees and volunteers sign the Agreement by Employee/Contractor to Comply with Confidentiality Requirements ([CDPH 8689](#)) upon hire prior to having access to any confidential information and on an annual basis thereafter.

Monitoring

Confidentiality Compliance - Signed agreements to comply with confidentiality requirements (CDPH 8689) must made available during site visits.