

# **AIDS Medi-Cal Waiver Program Protocols**

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**California Department of Public Health  
Center for Infectious Diseases  
Office of AIDS  
HIV Care Branch**

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## **SECTION 1 - INTRODUCTION**

With the advent of complex medical therapies and the changing demographics of HIV transmission, persons living with symptomatic HIV disease or AIDS have increasingly complex medical and psychosocial issues. HIV/AIDS continues to disproportionately affect women, people of color, and traditionally disenfranchised populations. The AIDS Medi-Cal Waiver Program (MCWP) strives to promote 100 percent access to high-quality health care and have 0 percent disparity in health outcomes for persons with HIV disease or AIDS.

MCWP utilizes an interdisciplinary team approach to case management, with each client being assigned both a nurse case manager (NCM) and social work case manager (SWCM). This model is used to ensure that a professional with the necessary specialized knowledge and expertise will address the client's complex needs. MCWP can provide a number of services not available through other funding sources, in addition to case management in order to meet individual client goals.

## **SECTION 2 - ACRONYMS**

ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immune Deficiency Syndrome
ARIES	AIDS Regional Information and Evaluation System
CARE/HIPP	Comprehensive AIDS Resources Emergency Act/Health Insurance Premium Payment Program
CCC	California Civil Code
CCLD	Community-Care Licensing Division
CCR	California Code of Regulations
CCS	California Children's Services
CDC	Centers for Disease Control and Prevention
CDSS	California Department of Social Services
CFA	Cognitive and Functional Ability Scale
CMS	Centers for Medicare and Medicaid Services
COE	Certificate of Eligibility
CSP	Comprehensive Service Plan
DCS	Direct Care Staff
HCP	HIV Care Program
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
IDTCC	Interdisciplinary Team Case Conference
IHSS	In-Home Supportive Services
LCSW	Licensed Clinical Social Worker
MCWP	AIDS Medi-Cal Waiver Program
MFT	Marriage and Family Therapist
MMWR	Morbidity and Mortality Weekly Report
MOU	Memorandum of Understanding
NCM	Nurse Case Manager
NFLOC	Nursing Facility Level of Care
NOA	Notice of Action

PD	Project Director
POM	Program Operations Manual
QA	Quality Assurance
QI/QM	Quality Improvement/Quality Management
RCFCI	Residential Care Facility for the Chronically III
RN	Registered Nurse
SOC	Share of Cost
SWCM	Social Work Case Manager
TAR	Treatment Authorization Request
TB	Tuberculosis
TCM	Targeted Case Management
WIC	Welfare and Institutions Code

## SECTION 3 - DEFINITIONS

**Abuse, neglect, and exploitation** refer to the physical, emotional, sexual, or financial abuse, abandonment, isolation, neglect, or self-neglect of an individual. Please see *Section VIII, Risk Assessment and Mitigation* in these Protocols for information on identifying these types of instances.

**Adult** refers to an individual who is 13 years of age or older.

**AIDS** is Acquired Immunodeficiency Syndrome, as defined by the Centers for Disease Control and Prevention (CDC).

**ARIES (AIDS Regional Information and Evaluation System)** is a custom, Web-based, centralized HIV/AIDS client management system that provides a single point of entry for clients, allows for coordination of client services among providers, meets both federal and state care and treatment reporting requirements, and provides comprehensive data for program monitoring and scientific evaluations. ARIES enhances services for clients with HIV by helping providers automate, plan, manage, and report on client data.

**Attending Physician** is a person licensed as a physician by the Medical Board of California or the Board of Osteopathic Examiners and identified by the client and physician as having the most significant role in the determination and delivery of the client's HIV-related medical care. This may be either the client's primary care physician or a specialist primarily responsible for treating the client's HIV disease or AIDS.

**Benefits Counselor** is a person who may assist the NCM and/or SWCM by providing referrals and information about a client's eligibility for benefits and entitlements. There are no minimum qualifications for the benefits counselor, but knowledge of a community's service resources for persons with HIV disease or AIDS and of eligibility for government programs is desirable.

**Case Aide** is a person who may assist the NCM and/or SWCM with practical arrangements for meeting service needs. There are no minimum qualifications for the case aide, but knowledge of a community's service resources for persons with HIV disease or AIDS and of eligibility for government programs/benefits is required. Functions a case aide may perform include financial assessment/reassessment, home environment assessment/reassessment, resource evaluation, transportation, delivering vouchers, assisting with benefits counseling and referrals, and advocating for the client and client resources. A case aide may not perform nursing or psychosocial assessments or reassessments, or develop the initial service plan.

**Case Management** is the process through which a NCM and SWCM coordinate a core case management team to accomplish the functions of initial and ongoing client assessment; development, implementation and evaluation of a service plan; and the location, coordination and monitoring of cost-effective, quality services provided in

accordance with the client's needs as set forth in a comprehensive service plan. Case management incorporates a collaborative, interdisciplinary team approach. Case management includes: 1) client eligibility and enrollment; 2) comprehensive client assessment and reassessment; 3) resource identification and service planning; 4) service delivery; and 5) evaluation. The NCM and SWCM both perform the functions of case management, as identified in the service plan.

**CDC Classification System for HIV Infection in Children under 13 Years of Age**

classifies children by asymptomatic or symptomatic (N, A, B, or C) and immunologic categories (1, 2, or 3). (Morbidity and Mortality Weekly Report [MMWR] September 30, 1994/Vol.43/No.RR-12) The instrument establishes criteria for classifying a pediatric client's HIV status.

**Cognitive and Functional Ability (CFA) Scale** is a revised form of the Karnofsky Performance Status Scale and was developed to correspond with the Karnofsky Scale. The CFA Scale was developed to include factors affecting cognitive and functional ability that are specific for adults with HIV disease or AIDS. It is used to determine eligibility for MCWP. Both the NCM and SWCM must have input in determining an appropriate score.

**Comprehensive Service Plan** is a client-centered written document that identifies a client's problems and needs, services (interventions) the client will receive, and expected results in measurable terms, with short-term and long-term goals.

**Core Case Management Team** consists of the NCM, SWCM, case aides, and benefits counselors (if applicable) who work for MCWP.

**Cost Avoidance** is the process used to ensure that all available resources are screened for and accessed prior to the utilization of MCWP services. Cost avoidance activities can take one of two forms. First is the use of any private insurance or fee-for-service Medi-Cal, the use of the treatment authorization request system, and other available resources. Second is the screening and access of other local community resources to pay for services such as food, housing, transportation, and utilities prior to utilizing program funds. Cost avoidance is not a routine part of assessment or reassessment activities.

**Department** is the California Department of Public Health, Center for Infectious Diseases, Office of AIDS, HIV Care Program Section.

**Exemption** is a written request from a Waiver Agency, approved in writing by the Department, for a temporary suspension or modification of program requirements. An exemption may be requested for staff qualifications and provision of direct care services. Exemptions must have prior approval by the Department. Waiver Agencies should not make a hiring commitment or begin using the alternative standard until written approval is received.

**Family** includes persons related to each other, sharing the same household, or mutually identifying themselves as such.

**Foster Child** is any child under the age of 18 (unless otherwise specified) who qualifies as a recipient of foster care pursuant to Sections 300 et. seq., 11251, and 11400 et. seq. of the Welfare and Institutions Code (WIC).

**Health Insurance Portability and Accountability Act (HIPAA)** was enacted by the U.S. Congress in 1996. Title II of HIPAA, known as the Administrative Simplification provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.

**HIV** is Human Immunodeficiency Virus.

**HIV Disease** is a medical diagnosis of HIV infection (“HIV positive”), including diagnoses of Asymptomatic HIV and Symptomatic HIV disease. A person who has Asymptomatic HIV is not eligible for MCWP.

**Level of Care** is a description of the care and supervision needs of an individual, based on the assessed deficits and abilities. The Nursing Facility Level of Care (NFLOC) or higher (sub-acute or acute care hospitalization) must be determined for enrollment into MCWP.

**Mandated Reporter** is a person who has assumed full or intermittent responsibility for the care or custody of an individual, whether or not they are compensated for their services. For a complete list of who is a mandated reporter of elder and dependent adult abuse, refer to WIC, Sections 15630 (a), 15610.17, and 15610.37. For a complete list of who is a mandated reporter of child abuse, refer to the California Penal Code, Section 11165.7. The following link will assist in accessing these codes:  
[www.leginfo.ca.gov/calaw.html](http://www.leginfo.ca.gov/calaw.html).

**Memorandum of Understanding (MOU)** is the agreement entered into between the Waiver Agency and the Department. The purpose of the MOU is to clearly identify the roles and responsibilities of the Department and the Waiver Agency as they relate to the provision of services under MCWP.

**Mobile Devices** are defined as laptops, mobile phones, wearable computers, personal digital assistants, USB flash drives, memory sticks, smart cards, diskettes, zip disks, CD-R/CD-W, DVD±, removable/portable hard drives, etc. This definition is applicable to any new mobile device technology as it is developed.

**National Provider Identifier** is the standard unique identifier for health care providers required by HIPAA of 1996.

**Nurse Case Manager (NCM)** is a Registered Nurse (RN) licensed by the State of California who has two years of experience as an RN, with at least one year in community nursing. It is desirable, but not mandatory, that the NCM has obtained a Bachelor of Science degree in Nursing, and/or has a Public Health Nurse certificate. The NCM serves as a member of the core case management team and provides case management services.

**Nursing Facility Level of Care (NFLOC)** is defined in Title 22, California Code of Regulations (CCR), Sections 51334 and 51335. Briefly, the regulations state that a patient qualifies for Nursing Facility services if he/she has a medical condition which requires an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing basis to abate health deterioration. The NFLOC is a combination of the previous Intermediate Care Facility and Nursing Facility (NF) Levels of Care. Guidelines for determining NFLOC are included in *Eligibility, Enrollment, Disenrollment, Transfer Forms* section in this document. For the purposes of eligibility, NFLOC means that the client would be at risk for placement in a facility within 30 days of disenrollment from MCWP.

**Pediatric** refers to those who are under 13 years of age.

**Primary Care Practitioner** may be a physician licensed by the Medical Board of California or the Board of Osteopathic Examiners; an individual licensed as a RN with a certificate to practice as a Nurse Practitioner from the California Board of Registered Nursing; or a Physician Assistant licensed by the California Physician Assistants Examining Committee of the Medical Board of California. The primary care practitioner is identified by the client and provider as having the most significant role in the determination and delivery of the client's HIV/AIDS-related medical care.

**Project Director (PD)** is an individual designated by the Waiver Agency to provide oversight of all MCWP activities. The PD has the overall responsibility for assuring compliance with the terms of the MOU and serves as the primary representative of the Waiver Agency. The Waiver Agency shall notify the Department as soon as possible when a new PD is designated. The Waiver Agency must include the new PDs current resume or curriculum vitae along with written notification. Preferred education and experience are at least a Master's Degree in a health-related field plus one year management experience or a Bachelor's of Arts or Science Degree in a health-related field and at least three years of experience in a management position in the health care field. Knowledge of the interdisciplinary case management model of home- and community-based care is desirable.

**Psychotherapist** is: 1) an individual licensed by the State of California as a Licensed Clinical Social Worker (LCSW) or a Clinical Psychologist; an individual licensed as a Marriage and Family Therapist (MFT) or a nurse with a Master's Degree designated as a Psychiatric and Mental Health Clinical Nurse Specialist or a Psychiatric and Mental Health Nurse Practitioner; or 2) an individual with a Master's Degree in Social Work who is license eligible (registered as an Associate Clinical Social Worker with the State of

California Board of Behavioral Sciences Examiners; an individual with a Master's Degree in Clinical Psychology or Counseling Psychology who is license eligible (registered with the Board of Behavioral Sciences Examiners). For those individuals in 2) above, supervision must be provided by the appropriately licensed individual as approved by the Board of Behavioral Sciences Examiners. The Psychotherapist may provide ongoing therapy to clients with regard to the psychological adjustment to living with HIV/AIDS. The Psychotherapist may also provide therapy to caregivers of clients with end-stage AIDS. This service may be provided with or without the client present. Services may also include information and referral, as well as group and family therapy with the client. The Psychotherapist does not perform any case management activities under MCWP.

**Quality Improvement/Quality Management (QI/QM)** refers to the ongoing assessment, monitoring, and evaluation of client-related activities in a profile of cases. QI/QM involves critical evaluation of the Waiver Agency's operational structure and processes involved with the provision of services and client outcomes. The goal of the QI/QM program is the improvement of client outcomes.

**Risk Assessment and Mitigation** is the process of identifying potential health and welfare risks to clients with the goal of reducing the likelihood of occurrence or recurrence of situations or events.

**Share of Cost (SOC)** is the amount of money a Medi-Cal recipient has to pay or agrees to pay each month for medical goods and services before Medi-Cal begins to pay. Once SOC is met, Medi-Cal pays for goods and services the rest of the month.

**Social Work Case Manager (SWCM)** is an individual licensed by the State of California as an LCSW, MFT, or Psychologist; an individual who has a Master's Degree in Social Work, Counseling, or Psychology; or an individual with similar degree qualifications approved by the Department. The SWCM serves as a member of the core case management team and provides case management services. The SWCM does not perform the functions of the Psychotherapist.

**Subcontract** is an agreement entered into by the Waiver Agency with any provider who agrees to furnish services to clients or agrees to perform any administrative or service function to fulfill the Waiver Agency's obligation to the Department under the terms of the agreement.

**Symptomatic HIV Disease** describes a variety of symptoms found in some persons infected with HIV. These may include recurrent fevers, unexplained weight loss, swollen lymph nodes, fatigue, and persistent diarrhea. For MCWP eligibility, "symptomatic" can refer to symptoms related to HIV disease, AIDS, or HIV disease/AIDS treatment.

**Targeted Case Management (TCM)** consists of case management services that assist Medi-Cal eligible individuals within specified targeted groups to access needed medical, social, educational, and other services. TCM service components include needs assessment, setting needs objectives, individual services planning, service scheduling, crisis assistance planning, and periodic evaluation of service effectiveness. Local government agencies that participate in and claim through the TCM program and other programs providing case management services must include in their Performance Monitoring Plans a description of the systematic controls that ensure no-duplication of TCM services.

**Waiver Agency** is the local health jurisdiction or community-based organization that has entered into an agreement with the Department through a MOU to provide MCWP services.

## **SECTION 4 - GOALS, OBJECTIVES, AND FUNCTIONS OF CASE MANAGEMENT**

### **Goals**

The goals of MCWP are:

- To provide appropriate HIV disease/AIDS treatment services for persons diagnosed with HIV/AIDS and with current symptoms related to HIV/AIDS;
- To assist clients with disease management, preventing disease transmission, stabilizing their health, improving their quality of life, and avoiding costly institutional care;
- To consider enrollment in the program as time limited. As a client's medical and psychosocial status improves, the client should be assisted in transitioning to more appropriate programs and services, freeing valuable MCWP resources for people who are most in need;
- To foster resource development;
- To increase coordination among service providers;
- To eliminate service duplication;
- To enhance utilization of the program by underserved populations; and
- To provide home- and community-based services for persons with disabilities who would otherwise require institutional services (the 1999 Supreme Court decision, *Olmstead*, resulted in an important legal ruling that individuals with disabilities should live in the most integrated setting appropriate to their needs).

### **Objectives**

The objectives of case management within MCWP are:

- To coordinate the efficient use of community resources in a cost-effective, high-quality manner acceptable to the client;
- To foster continuity of services throughout the continuum of care;
- To promote understanding by the client, family, and the client's representative of the HIV disease or AIDS process and the use of health promotion practices;
- To decrease the transmission of HIV through education/harm reduction techniques;

- To assist the client, family, and the client's representative in moving toward self-determination;
- To maintain quality health care along the continuum of illness;
- To decrease fragmentation of care;
- To promote the provision of quality care in the least restrictive environment;
- To establish and maintain linkages with community agencies and institutions; and
- To provide services through culturally and linguistically appropriate service networks.

The above objectives are achieved through an organized, collaborative model of case management in which each member of the interdisciplinary team has responsibility for service activities in his or her area of expertise.

## **Functions**

The functions of case management in the interdisciplinary model include, but are not limited to:

- Community outreach to expand the client base; specifically, to reach populations and/or groups in the community disproportionately affected by HIV/AIDS;
- Eligibility screening to identify appropriate clients for intake and case management; assist with institutional discharge planning to ensure the transition of qualified individuals into MCWP, if needed;
- Comprehensive assessment of the client's physical, psychosocial, environmental, financial, and functional status;
- Identification and proposed resolution of problems in the utilization and delivery of client services and any special client preferences and desires regarding service providers;
- Development, implementation, monitoring, and modification of a comprehensive individual service plan through an interdisciplinary team process in conjunction with the client and his/her caregivers;
- Coordination of the provision of services to the client including but not limited to: in-home skilled nursing care, in-home attendant care, homemaker services, nutritional counseling and supplements, psychotherapy, durable medical equipment, housing assistance, food subsidies, and transportation;

- Reassessment of the client's physical, psychosocial, financial, and functional status at regular intervals and as needed;
- Evaluation of the service plan and specific services through reassessments and case conferences;
- Transition to less intensive case management services when health and functional status improves and stabilizes; and
- Linking the client with the most appropriate resources and advocating for the best interests of the client.

## SECTION 5 - ELIGIBILITY

Each MCWP client must meet all of the following criteria:

- Be Medi-Cal eligible and a recipient on the date of enrollment. The Medi-Cal Aid Code must have: 1) federal financial participation; and 2) full benefits, excluding those in long-term care or those who are restricted (e.g., restricted to emergency room only or pregnancy only). Note: a client may be dually enrolled in Medi-Cal Managed Care Plans except the PACE (Program of All-inclusive Care for the Elderly) Program;
- Not be simultaneously enrolled in the Medi-Cal Hospice Program or other Medi-Cal Waiver Program (may be simultaneously enrolled in Medicare Hospice);
- Must not simultaneously receive case management services or use State Targeted Case Management Program funds to supplement MCWP;
- Adults: Must have a written diagnosis from his/her attending physician of HIV disease or AIDS, including current symptoms related to HIV disease, AIDS, or HIV disease/AIDS treatment. This is documented on the *MCWP Certification of Eligibility (COE) – Physician form*.
- Pediatrics: Must have a written diagnosis classification from his/her attending physician of HIV disease/AIDS, Perinatally Exposed, or Seroreverter, including current symptoms related to HIV disease, AIDS, or HIV disease/AIDS treatment. This is documented on the *CDC Classification System for HIV in Children under 13 Years of Age form*.

The COE/CDC Classification form must be received within 45 days after enrollment. The form may also be obtained up to 45 days prior to enrollment.

- Be certified to meet NFLOC as described in Title 22, CCR, Sections 51334-51335;
- Adults 13 years and older must have a CFA score of 60 or less. Pediatric clients under 13 years of age do not require a CFA score at this time.
- Have an attending physician willing to accept full professional responsibility for his/her medical care;
- Have a health status that is consistent with in-home services; and
- Have a home setting that is safe for both the client and the service providers.

The following table will assist you in determining which documents are required when certifying client eligibility:

<b>Document</b>	<b>Under 13 Years of Age</b>	<b>13 Years of Age and Over</b>
<b>CDC Classification System for HIV in Children under 13 Years of Age</b>	Yes <i>Symptomatic</i>	No
<b>CFA Scale</b>	No	Yes
<b>COE</b>	No	Yes

## **SECTION 6 - ENROLLMENT AND DISENROLLMENT PROCESS**

### **Enrollment Process**

After eligibility for MCWP has been established and the client has chosen to receive MCWP services as an alternative to institutionalization, the Comprehensive Client Assessment shall be completed. The client then must be enrolled in MCWP through the Department. This is accomplished by completing the following steps:

1. The enrollment portion of the most current version of the MCWP Enrollment/Disenrollment form (MCWP3) must be completed fully and accurately;
2. The form must be faxed to the Department on (or as close as possible to) the enrollment date to the Department's designated confidential fax line;
3. Department staff will process the enrollment and contact the Waiver Agency (usually within two business days) with the client's MCWP Identification Number, followed by sending completed Enrollment/Disenrollment documentation to the Waiver Agency;
4. If the information on the Enrollment/Disenrollment form is incomplete, inaccurate, or Department staff cannot complete the enrollment process, the Waiver Agency will be contacted to resolve the problem prior to a MCWP Identification Number being issued; and
5. The client and the case manager must complete the mandatory Informed Consent/Agreement to Participate form, including client initials, acknowledging the receipt of the following information: rights and responsibilities, grievance procedures, and Notice of Action (NOA) information. The Agreement to Participate form must be completed at the time of enrollment and prior to services being provided.

### **Disenrollment Process**

Disenrollment may occur due to death of a client, a client moving out of the Waiver Agency's service area (see transfer of clients between Waiver Agencies, if appropriate), change in a client's Medi-Cal eligibility, if a client no longer meets eligibility criteria, etc. The following steps should be followed when disenrolling a MCWP client:

1. The disenrollment portion of the original Enrollment/Disenrollment form (MCWP3) used to enroll the client must be fully completed, using the actual date of death or discharge from MCWP, the MCWP Identification Number and client Social Security Number. The agency contact person and phone number must be reviewed for accuracy. If either has changed, the information must be updated to reflect current

information. If the original form is unavailable, a new Enrollment/Disenrollment form must be fully completed with all of the required information;

2. The disenrollment date must be the same as the “Date Services Expire” date on the NOA--Denial/Reduction/Termination of MCWP Benefits, or if a NOA is not required, the date the client was actually disenrolled;
3. The form must be faxed to the Department as close as possible to, but no later than, 30 calendar days of the disenrollment;
4. Department staff will process the disenrollment and send written confirmation to the Waiver Agency;
5. State law and Medi-Cal regulations require that waiver programs give standard form MCWP2, *Notice of Action (Denial/Discontinuance) and State Hearing Notice Request, Your Right to Appeal the Notice of Action* to all applicants at initial application and to all existing clients when: 1) a client disputes the reduction or discontinuation of one or more services; or 2) the client is terminated or disenrolled from MCWP. NOA informs the applicant or client of his/her right to a fair hearing. A copy of the completed NOA and supporting documents must be maintained in the client file and the original sent to the client.

The NOA is NOT required when:

- The client dies; or
- The client agrees with a reduction in frequency or units of service, or the discontinuance of one or more existing services within MCWP; and/or
- The post office has recently returned mail indicating no forwarding address and the client's whereabouts are unknown.

Ten-Day Advance Notice: NOA is required at least ten calendar days (excluding the mailing date) before the effective date of termination/disenrollment or disputed reduction in frequency or units of service in whole or in part.

Five-Day Advance Notice: NOA is required five days in advance when the waiver agency has documentation of possible fraud by the client and the facts have been verified, if possible, through secondary sources.

Same-Day Notice: NOA must be mailed or given to the client no later than date of action when:

- The client signs a clear written statement that he/she no longer wants services or signs an “Agreement to Participate” in another program (for example, AIDS Case Management Program); or

- The client gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information (for example, enrollment in a Medi-Cal Hospice or other program which does not permit “dual enrollment”); or
- The client has been institutionalized (for example, admitted to a hospital or nursing facility) or incarcerated for more than 30 days and is ineligible for waiver services; or
- The waiver agency establishes the fact that the client has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

The disenrollment process should not be used to change or correct enrollment information. Contact the Department enrollment coordinator to do so. A wrong Social Security Number cannot be changed in the system; this requires a VOID-not a disenrollment. The original enrollment form must be marked “VOID” and a new enrollment form must be completed with the correct Social Security Number.

The following table will assist you in determining when a ten-day letter or NOA must be sent to a client:

Condition	NOA Required
Client is disenrolled, client agrees.	Yes
Client is disenrolled, client disagrees.	Yes
Client services reduced, client agrees.	No
Client services reduced, client disagrees.	Yes
Client services denied, client agrees.	No
Client services denied, client disagrees.	Yes
Post Office returned mail indicating no forwarding address and the client’s whereabouts are unknown.	No
Client dies.	No

## **Enrollment is Time Limited**

Client enrollment into the program should include discussion with the client that as his/her medical and psychosocial status improves, the client will be assisted in transitioning to more appropriate programs and services, thus freeing valuable program resources for others who are more in need.

## **Transfer of Clients between Waiver Agencies**

A client who has been enrolled in one Waiver Agency's MCWP may not be enrolled in another Waiver Agency's MCWP in the same calendar year without prior approval from the Department. As soon as it is determined that a MCWP client will be moving to a different MCWP Waiver Agency's service area, or wishes to change providers, the steps below shall be taken. If the client does not notify their case manager or the Waiver Agency of his/her intent to change providers, the steps below shall be carried out as soon as either Waiver Agency is aware of the client's move/prior enrollment in MCWP. Usually, the Department informs the Waiver Agency if a client is enrolled in two programs simultaneously when the Social Security Number is entered into the system.

1. The NCM, SWCM, or other MCWP staff will call the Waiver Agency serving the area to which the client will be moving or wishes to transfer to and speak with the PD or other MCWP staff to inform them of the anticipated date of the pending move or transfer;
2. An agreement will be made as to what date the transferring Waiver Agency will disenroll the client. The receiving Waiver Agency may enroll the client on the following date, but not sooner;
3. A mutually agreeable decision will be made as to which Waiver Agency will bill for Case Management Services and Administrative fees for the month the transfer takes place. If the billing is to be divided (Case Management to one Waiver Agency and Administration fees to the other), this will be agreed to by both parties. Neither the Case Management fees nor the Administrative fees may be individually split-billed;
4. The Waiver Agency transferring the client will provide the receiving agency and the Department with an accurate dollar amount of MCWP funds expended (or anticipated to be expended), including case management fees (administrative fees are not included), and the actual amount of funds available for the client as of the transfer date; and,
5. After the disenrollment has taken place and the client has been enrolled in his/her new location, the Department will send confirmation to both Waiver Agencies verifying dates of disenrollment/enrollment, billing for case management and administrative fees, and amount of MCWP funds still available to/for the client.

## **SECTION 7 - COMPREHENSIVE CLIENT ASSESSMENT**

Initial client contact (or attempt of) should be made **within five days of referral**. The face-to-face comprehensive client assessment, in other words the nursing assessment, psychosocial assessment, initial resource evaluation, and home environment assessment, must be completed according to their stated timeframes. The comprehensive client assessment shall be appropriate for age, gender, cultural, and linguistic factors. Identification of barriers to service utilization and delivery should be addressed as well as proposed resolutions to those barriers. The comprehensive client assessment shall include, but not be limited to the following elements:

### **Medical Status**

Medical status means information about the client's physical condition establishing the diagnosis and any other medical problems the client may have. Medical information indicates the need for treatment and assists the case management team in evaluating and following up on issues identified by the client's medical providers. Medical records, including a copy of the most recent history and physical examination from the attending physician or primary care practitioner and discharge summary from an acute-care hospital (if applicable) must be requested for all clients.

### **Nursing Assessment**

The purpose of the initial nursing assessment is to assess the impact of illness on the client in order to establish eligibility and identify the need for services. The assessment shall be for the purposes of the provision of case management services and for facilitating access by referral to needed medical, home, and social services. The initial nursing assessment includes a comprehensive systems review and must be performed, signed, and dated by the NCM **on or within 15 days prior** to enrollment. The initial nursing assessment is vital because it provides the case manager with baseline information that assists in identifying the client's care needs, evaluating changes in the client's health condition, developing the service plan, and coordinating services.

The nursing assessment includes both subjective and objective data that the NCM collects during the visit. Assessment of vital signs and any component of a physical examination as indicated or deemed necessary by the NCM to complete the assessment of the client should be performed in accordance with the Nursing Practice Act. In addition to observation and interview, the initial nursing assessment includes a head-to-toe client assessment that utilizes observation, inspection, auscultation, and palpitation as indicated by the client's medical history, diagnosis and/or current medical symptoms, and health status.

The assessment should also include information regarding pertinent psychological information, level of orientation, cultural information, current health status and habits, and need for and availability of caregivers. The NCM will also discuss transmission prevention with the client, addressing such issues as safe/safer sex, needle sharing,

and harm reduction techniques. A list of medications and known or increasing side effects, complimentary or alternative therapies, client adherence to the medication regimen, and any barriers to adherence should be documented. The nursing assessment must include a summary of the findings and a plan that outlines the responsibilities of the NCM for the next 60 days.

A health history must be obtained and documented by the NCM. In addition to a comprehensive review of HIV/AIDS, the health history should include all past significant medical events. This includes HIV and non-HIV-related illnesses, AIDS-related illnesses, sexually transmitted diseases, surgical interventions, tuberculosis (TB) history, and medications. The medication history should include current medications, over-the-counter medications and nutritional supplements as well as allergic or adverse symptoms. Immunizations (childhood and/or adult) or recall of childhood illness should be documented. Notation of hepatitis A, B, or C status and the need for vaccinations should also be included.

The NCM must also perform a nutritional assessment during the initial visit. The nutritional assessment assists in identifying areas where nutritional intervention is necessary and provides a baseline for later evaluation of the client's decline or progress. The nutritional assessment assists in determining the need for food supplements, assistance with meals, or the need for a nutritional consultation by a registered dietitian. It evaluates the client's current and usual weight, food preferences, and health habits that may be actual or potential problems in achieving optimal nutrition. The client's eating habits, dietary restrictions, food allergies or intolerances, and resources to meet nutritional needs are also ascertained. Physiological, medical, psychosocial, physical, and financial issues affecting nutrition must be addressed.

The nursing assessment must also include documentation of the presence (or lack of) any history of abuse, neglect, or exploitation the client has experienced. If a history exists, the following information, if known, must be documented: the type of abuse that occurred, the identifying instance(s), if a report was made and to whom, and the outcome of that report if known.

### **Initial Functional and Level of Care Assessments**

Every client's functional status shall be assessed as part of the eligibility determination. The CFA score shall be used for the functional assessment of adult clients. Pediatric clients do not require a CFA score at this time. The evaluation of the CFA score may take into account the client's overall abilities over time; it is not required that this evaluation reflect the client's abilities at the moment the evaluation is performed. Enrollment in MCWP requires an appropriate CFA score. Assessment ratings for each element can be any number between 1 and 11.

The NCM should collaborate with the SWCM in determining the initial CFA score. If this is not possible, it is acceptable for the NCM to determine the score independently. The NCM *must* collaborate with the SWCM in determining ongoing CFA scores.

If the CFA score is documented within the nursing assessment (or reassessment) form, both the individual elements/scores and the total scores must be present. The CFA score section must also accommodate space for the SWCM's signature, initials, and date. If such an accommodation cannot be made, then a central CFA score tool must be used.

The client's level of care must be at the nursing facility level or higher (acute, sub-acute) as described in the NFLOC Guidelines in Section XI of this document. As part of eligibility screening, the NCM must evaluate the level of care. For children, the level of care determination must be based on needs and deficits relative to normative developmental progression. An example is that it would be expected that a child would not be able to administer his/her own medications, so that inability by itself would not contribute to determining NFLOC. Complicated medical problems and fragile health status, however, would contribute to NF or higher level of care.

### **Psychosocial Assessment**

The purpose of the initial psychosocial assessment is to assess the psychosocial impact of illness on the client in order to establish eligibility and identify the need for services. The assessment shall be for the purposes of the provision of case management services and for facilitating access by referral to needed medical, therapeutic, home care, and social services. The initial psychosocial assessment must be completed, signed, and dated by the SWCM **between 15 days prior to and 15 days after the date** of enrollment. The assessment provides information about a client's social, emotional, behavioral, mental, spiritual, and environmental status. This assessment includes information about family and support systems, as well as information on the client's coping strategies, strengths and weaknesses, and adjustment to illness. In addition, the psychosocial assessment addresses the client's employment, education, and cultural factors. Legal issues such as legal history, wills, Durable Power of Attorney and/or Durable Power of Attorney for Healthcare, and funeral arrangements are assessed. Substance use/abuse history and current risk behaviors must also be addressed. The SWCM also determines the client's resources and needs in regards to food, housing, and transportation. The SWCM will also discuss transmission prevention with the client, addressing such issues as safe/safer sex, needle sharing, and harm reduction techniques. A financial assessment must also be conducted which provides information regarding the client's current financial status. It should address sources of income as well as expenditures, including housing, utilities, food, transportation, medical, clothing, entertainment, tobacco/alcohol, and other expenses. The psychosocial assessment must include a summary of the findings and a plan that outlines the responsibilities of the SWCM for the next 60 days.

The psychosocial assessment must also include documentation of the presence (or lack of) any history of abuse, neglect, or exploitation the client has experienced. If a history exists, the following information, if known, must be documented: the type of abuse that

occurred, the identifying instance(s), if a report was made and to whom, and the outcome of that report.

### **Resource Evaluation**

As a part of the eligibility process, a full benefits screening is completed. This screening addresses benefits and/or entitlements the client may be receiving or is potentially eligible for. These benefits should include private insurance, Medicare, Medi-Cal, Medi-Cal Managed Care, AIDS Drug Assistance Program (ADAP), Comprehensive AIDS Resources Emergency (CARE) Act/Health Insurance Premium Payment (HIPP) Program, California Children's Services (CCS), and In-Home Supportive Services (IHSS). The resource evaluation must be completed between **15 days prior to and 15 days after** the date of enrollment.

### **Home Environment Assessment**

An assessment of the client's home environment will be performed as part of the initial comprehensive assessment as well as each time the client moves. The home environment assessment may be performed by the NCM, SWCM, or other MCWP staff to determine, at a minimum, whether or not environmental conditions could lead to the endangerment of the client or health care providers. The assessment shall address the structural integrity of the home, the availability of an adequate heating and cooling system, electricity, gas, and hot and cold running water. In addition, food storage and preparation facilities, basic furnishings, cleanliness, presence of hazards, functional plumbing, telephone services, laundry facilities, and care of pets (if any) shall be assessed. The home environment assessment must be performed in the client's home **within 30 days of enrollment**. If deficiencies are noted during the home environment assessment, there must be further description of planned interventions and appropriate follow up.

If a client is homeless, the person performing the assessment must provide sufficient documentation that the client is receiving assistance with obtaining temporary or permanent housing.

## **SECTION 8 - REASSESSMENTS**

Face-to-face reassessments provide information on the client's medical and psychosocial status necessary to update and maintain the service plan. Reassessments must be made at least every 60 days

### **Nursing Reassessments**

The nursing reassessment must be performed, signed, and dated by the NCM **at least every 60 days** for all clients enrolled in MCWP. The nursing reassessment must include, at a minimum, the client's current medical status including a systems review, nutritional review, and medication and treatment update (see Medication Sheet attached to Initial Nursing Assessment) of the past 60 days. NCM will also discuss transmission prevention with the client, addressing such issues as safe/safer sex, needle sharing, and harm reduction techniques; documentation of annual TB screening should be included. Follow up on previously identified problems or concerns and identification of potential problems or concerns is required, as well as a summary of the findings and a plan that outlines the responsibilities of the NCM for the next 60 days. An evaluation and certification of the client's level of care (NFLOC) should be performed at this time. Both NCM and SWCM must determine, initial, and date the CFA score reassessment. The client's ongoing program eligibility is determined during the nursing reassessment for MCWP. The Comprehensive Service Plan (CSP) and any changes to it may be reviewed with the client during the reassessment.

The nursing reassessment must also include documentation of the presence (or lack of) any instances of abuse, neglect, or exploitation the client has experienced in the past 60 days. If an instance has occurred, the following information must be documented: the type of abuse that occurred, the identifying instance(s), if a report was made and to whom, and any outcome(s) of the report if known.

### **CFA Score Reassessments**

Both NCM and SWCM must determine, initial, and date the CFA score reassessment.

### **Psychosocial Reassessments**

The psychosocial reassessment must be performed, signed, and dated by SWCM **at least every 60 days** for all clients enrolled in MCWP. The psychosocial reassessment must include an evaluation of the client's current (within the past 60 days) social, emotional, behavioral, mental, spiritual, and environmental status, including support systems, employment, legal issues, substance abuse, and risk behaviors. SWCM will also discuss transmission prevention with the client, addressing such issues as safe/safer sex, needle sharing, and harm reduction techniques. A reassessment of the client's ongoing financial status must also be conducted. It should address income and expenditures, including housing, utilities, food, transportation, medical, clothing,

entertainment, tobacco/alcohol, and other expenses. Follow up on previously identified areas of concern and identification of potential problems or concerns are required, as well as a summary of the findings and a plan that outlines the responsibilities of the SWCM for the next 60 days. CSP and any changes to it may be reviewed with the client during the reassessment.

The psychosocial reassessment must also include documentation of the presence (or lack of) any instances of abuse, neglect, or exploitation the client has experienced in the past 60 days. If an instance has occurred, the following information must be documented: the type of abuse that occurred, the identifying instance(s), if a report was made and to whom, and the outcome of that report if known.

### **Ongoing Resource Evaluation**

The ongoing resource evaluation provides information regarding the client's ongoing benefits eligibility status. A review must be performed **at least every 60 days**. It addresses benefits and/or entitlements the client may be receiving or is potentially eligible for, including private insurance, Medicare, Medi-Cal, Medi-Cal Managed Care, ADAP, CARE/HIPP, CCS, and IHSS.

### **Home Environment Reassessment**

A reassessment of the client's home environment will be performed **annually from the date of enrollment and when the client moves**. The home environment reassessment may be performed by NCM, SWCM, or other MCWP staff to determine, at a minimum, whether or not environmental conditions could lead to the endangerment of the client or health care providers. The reassessment shall address the structural integrity of the home, the availability of an adequate heating and cooling system, electricity, gas, and hot and cold running water, In addition, food storage and preparation facilities, basic furnishings, cleanliness, presence of hazards, functional plumbing, telephone services, laundry facilities, and care of pets (if any) shall be addressed. If deficiencies are noted during the home environment reassessment, there must be further description of planned interventions and appropriate follow up.

### **Client Contact**

Telephone or face-to-face contact with the client between reassessments will be initiated as indicated by NCM, SWCM, or other MCWP staff.

### **Interdisciplinary Team Case Conferences**

The Interdisciplinary Team Case Conference (IDTCC) is an integral part of the model of care in MCWP. The interdisciplinary team consists of those individuals participating in the process of assessing the multi-service needs of clients, planning for the provision of services to meet those needs, and evaluating the effectiveness and ongoing need for

interventions as identified in the service plan. The team consists of the client and/or his/her legal representative, NCM, SWCM, attending physician or primary care practitioner, and parent or guardian (if the client is a child). Although there is no specific requirement as to when the first IDTCC is to be held, it is imperative that case management staff discuss the client when developing the initial CSP. Waiver Agencies are encouraged to conduct the first official IDTCC **within 30 to 60 days** of client enrollment. Subsequent interdisciplinary case conferences shall be **held at least every 60 days** for each client. All participants in attendance must be documented in the client record. At a minimum, the client's NCM and SWCM must be present, and it is strongly recommended that the PD also be present. The client and/or his/her legal representative, the client's service providers, and attending physician or primary care practitioner are encouraged to attend; if providers are unable to attend, information regarding the client's status and continued need for services will be collected prior to the case conference as appropriate. If unable to attend, the client and/or his/her legal representative may provide input to NCM or SWCM during reassessments and other contacts. A review of the service plan and an evaluation of the services the client is receiving may be performed, as well as a review of the client's current status. NCM and SWCM are expected to address the medical, psychosocial, housing, and financial needs of each client and to discuss the roles each will play in fulfilling the client's service plan in the coming months. It is expected that participants will also discuss any changes in the client's status and the length of time case managers anticipate the client remaining on the program. Appropriate documentation will be maintained in the client chart including the names, licenses, and/or degrees and titles of those attending the case conference, relevant information discussed, and whether the client or legal representative had input into the conference. Each Waiver Agency must have a system in place to protect client confidentiality during IDTCC with multiple providers present.

## **SECTION 9 – CARE SERVICES PLAN**

The client-centered service plan shall include information regarding all of the services the client is receiving regardless of funding source. The service plan is based on the service needs identified and documented in the Comprehensive Client Assessment and Reassessments. Any service provided by MCWP funds must be a part of the service plan prior to the provision of that service

### **Initial CSP**

The interdisciplinary team utilizes the baseline information from the Comprehensive Client Assessment to develop the initial CSP. Both NCM and SWCM are responsible for the development of the initial service plan which they must sign and date. **CSP must be initiated at the time of enrollment.** The services provided shall not exceed the needs as identified. Services paid by MCWP must not exceed the client's legitimate medical need. The plan shall demonstrate input and agreement from the client or legal representative as well as documentation showing that the physician/primary care practitioner has been notified of the contents. The initial and updated service plans shall include, but are not limited to, the following elements:

- **Long-Term Goals**

One or more brief statement(s) expressing the primary reason(s) for the client's enrollment in the program and the purpose for the provision of case management services.

- **Identified Problems or Needs**

A simple phrase stating the problem or need identified by the client, NCM and/or SWCM during the assessment, reassessment, or through other contact with the client. Documentation in the client record must support or describe the identified problem or need in more specific detail.

- **Stated Goals/Objectives**

The stated goals and objectives must include the desired outcome. The outcome should address the resolution or management of the identified problem or need.

- **Services and Interventions**

A brief description of the services the client is receiving, or will receive, which addresses the identified problem(s) or need(s) and whose aim is to meet the stated goals and objectives. The service, type of provider, the frequency, quantity, and duration of the service, the payment source, and signature of the case manager

authorizing or documenting the service must be included in the service plan (e.g., attendant care, XYZ Home Health Agency, four hours per day, twice weekly, for two months, case manager signature). The start date of the service must also be documented. Needs and/or interventions must be identified prior to the provision of services.

### **Review, Updates, and Revisions to CSP**

The client's service plan shall be updated and revised as problems and/or service needs change. All of the elements identified in the initial CSP are required for revisions and updates.

A review and evaluation of all components of the service plan may be documented during IDTCC with evidence of both NCM and SWCM review. This must occur at least every 60 days.

The date of the review as well as the **NCM** and **SWCM's** initials must be documented on the service plan.

CSP must be reviewed with the client during reassessments, with revisions as necessary.

### **Documentation Practices**

Any and all problems identified, referrals made, services received, etc. (as documented in assessments, reassessments, or progress notes) must be carried over and documented on the service plan. If an appropriate problem/need category does not exist on the form, a new one should be added, including all other required elements of the service plan.

### **Home Health Agency Plan of Care**

For clients receiving attendant care and/or skilled nursing care, a plan of care from the agency providing the services must be in the client chart. The plan of care only needs to be updated when the services change.

### **Start of Service Date and Date Problem Identified**

If the service plan form is used only for MCWP, the "Start of Service" date cannot be prior to the "Date Problem Identified." If there is a lapse between the time a client is disenrolled and enrolled or reenrolled, a new service plan would have to be developed. With a new service plan, the "Start of Service" date cannot be prior to the date of enrollment.

If the service plan form is used for other programs in addition to MCWP, two options exist:

1. If a client transfers from one program to another within the same agency, the date the client began receiving services when first enrolled can be documented. For the purpose of MCWP chart reviews, it is essential that this start date be identified as the date of enrollment into a program other than MCWP.
2. If a client transfers from one program to another within the same agency, a new service plan can be developed each time the client is enrolled in a different program. The "Start of Service" date would then be the same date or any date after enrollment.

## **SECTION 10 - RISK ASSESSMENT AND MITIGATION**

The Centers for Medicare and Medicaid Services (CMS) has placed emphasis on the identification and follow up of instances of abuse, neglect, and exploitation that bring harm or create the potential for harm to clients. As a result, CMS is requiring the Department to collect and report instances of abuse, neglect, or exploitation affecting MCWP clients. Waiver Agency staff must document whether or not there is a history or recent occurrence of critical events and any risk assessment and mitigation activities in their assessments, reassessments, comprehensive service plans, and progress notes. The risk assessment and mitigation information will be included in the semi-annual progress reports submitted to the Department. The following information will assist case managers and/or other MCWP staff in appropriately handling such instances:

### **Types of Abuse and Identifying Instances**

Examples include:

- **Physical abuse**: bodily injury, cuts, bruises, burns, unexplained injuries, physical restraints, evidence of sexual abuse, deprivation of food and water, pushing or hitting, intentional misuse of medications, causing pain, unlawful corporal punishment or injury, willful harming or injuring, endangering the person or health of a child.
- **Isolation**: preventing receipt of mail, phone calls, visitors, or contact with concerned persons.
- **Financial**: misuse of funds, unusual activity in bank accounts, checks cashed by others, suspicious changes in ownership, unpaid bills, missing belongings, undue influence to change documents, theft, embezzlement, misuse of property.
- **Abandonment**: left alone and unable to provide for own basic necessities of daily living.
- **Sexual abuse**: inappropriate exposure, inappropriate sexual advances, sexual exploitation, molestation, rape.
- **Neglect by self or others**: inadequate clothing, food, dehydrations, untreated medical conditions, misuse of medications, unsafe housing.
- **Emotional or verbal abuse**: threats, threats of harm or abandonment, isolation, intimidation.

## Who Must Report

Instances involving adults: Endangered individual, community agency, social worker, nurse, other service provider, relative, or other concerned individual.

“Mandated Reporters” (WIC Section 15630) are persons who have assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not they are compensated for their services. Also included are administrators, supervisors, and licensed staff of a public or private facility that provides care or services for elders or dependent adults, and elder or dependent adult care custodians (WIC Section 15610.17), health practitioners (WIC Section 15610.37), clergy members, employees of county adult protective services agencies, and local law enforcement agencies.

Instances involving children: Mandated child abuse reporters include all those individuals and entities listed in California Penal Code Section 11165.7.

All Mandated Reporters should become familiar with the detailed requirements as they are set forth in California Penal Code Sections 11164 – 11174.3.

## When to Report

Whenever, in a professional capacity or within the scope of employment, the following occurs:

- You observe or have knowledge of an incident that reasonably appears to be abuse; or
- You are told of an incident by the victim; or
- You reasonably suspect abuse.

Two exceptions to the reporting requirement can be found in WIC Section 15630 (b)(2) and (3).

## How to Report

### Instances involving adults

- By telephone immediately or as soon as practically possible.
- By written report sent within 36 hours to the appropriate agency.
  - Form SOC 341 (6/04) Report of Suspected Dependent Adult/Elder Abuse.

### Instances involving children

- By telephone immediately or as soon as practically possible.
- By written report sent within 36 hours of receiving the information concerning the suspected incident.
  - Form SS 8572 (12/02) Suspected Child Abuse Report.

### **Whom to Report to**

#### Instances involving adults

If the occurrence happened in a long-term care facility, report to local law enforcement or the Long-Term Care Ombudsman.

If the occurrence happened in the community, report to local law enforcement or Adult Protective Services.

#### Instances involving children

Report to local law enforcement, county probation department, county welfare department, or Child Protective Services.

### **Additional Information for Mandated Reporters**

- Reporter may not be subjected to sanctions for making a report.
- Whenever two or more mandated reporters have knowledge about a suspected incident, they can agree that one of them will make a report.
- Law provides civil and criminal liability protection for anyone who makes a report in good faith.
- Reports made under the law are confidential.
- All mandated reporters are required to sign statements with their employers or with the State agency issuing their license or certificate, confirming knowledge of the reporting requirements and agreement to comply with the law.

The risk assessment and mitigation sections in assessments, reassessments, and service plans do not require documentation of who made a report. If a case manager makes an anonymous report regarding a client, the case manager's name will not be documented in the client chart; therefore, the client, if he/she requests to see the chart, will not be able to identify who made a report.

An actual Adult Protective Services or Child Protective Services report should NOT be kept in the client chart. The documentation required by the Department may be kept with the actual report as well as in the client chart.

MCWP staff is responsible for the health and welfare of all clients, regardless of any actions that may have been taken by Adult Protective Services or Child Protective Services.

Although most MCWP staff are already familiar with mandated reporting of abuse, neglect, or exploitation, the Department has not previously requested such information. The Department's sample assessment, reassessment, and CSP forms have been revised to include the collection of this information. If there is no history or recent occurrence, Waiver Agency staff must also note this in the assessments/plan. The QI/QM Guidelines also now include risk assessment and mitigation indicators and standards. Waiver Agencies are now required to develop written policies and procedures for risk assessment and mitigation.

## **SECTION 11 - RESPONSIBILITIES**

### **Waiver Agency**

The Waiver Agency shall:

- Provide fully qualified and properly degreed and/or licensed staffing. The staffing standard is 25-40 clients for each full-time equivalent NCM and SWCM. NCMs and SWCMs may have different numbers of clients. These are duplicated clients, not different clients for each case manager.
- Facilitate the goals of each client's service plan by fostering an environment of collaboration between NCM, SWCM, and other Waiver Agency staff, and capitalizing on the strengths of each discipline to provide services to each client that are timely and appropriate. Provide private office space to ensure clients feel comfortable discussing confidential information when being seen in the office setting.
- Subcontract with a sufficient number of service providers to allow the client or legal representative to choose from at least three providers for each service when possible, based on the availability of participating service providers in a given geographic area. Services such as in-home skilled nursing, in-home attendant care, homemaker services, psychotherapy, and nutritional counseling shall be subcontracted for if identified as a client need but not available to the client in the community through other funding sources.
- Make good faith efforts to secure subcontracts to provide client services with qualified providers desired by the client.
- Review service provision by and credentials of subcontractors (and their staff) at least annually, to ensure that contract requirements are met.
- Make every effort to assure meaningful access to bilingual service providers and interpreter services for clients whose ability to speak and/or understand English is limited.
- Make every effort to assure access to contact persons or organizations that can assist with communications for persons who are hearing, vision, and/or mobility impaired (in accordance with the Americans with Disabilities Act of 1990).
- Regularly participate in the meetings of the local Part B HIV Comprehensive Care Consortium or Part A Planning Councils where appropriate, for all service areas.
- Develop inter-agency and intra-agency working relationships that support the case management programs.

- Implement a QI/QM Plan as approved by the Department to continually evaluate and improve the quality of services provided by the Waiver Agency and shall:
  1. Designate a QI/QM coordinator;
  2. Obtain Department approval of Waiver Agency's QI/QM Plan, policies, and procedures. The QI/QM Plan, policies, and procedures must be submitted to the Department by January 31 of each year. At a minimum, the QI/QM Plan shall include:
    - Indicators of quality;
    - Frequency at which the indicators are monitored;
    - Standards for compliance;
    - Name and title of Waiver Agency employee(s) designated to review quality assurance (QA) findings; and
    - Name and title of Waiver Agency employee(s) designated responsible for corrective action.
  3. Submit a summary of the results of QI/QM monitoring with each progress report (even though summaries are submitted every six months, QI/QM activities should be conducted on an ongoing basis).
- Maintain current, written policies and procedures (reviewed annually) for:
  - Transportation assistance;
  - Client grievances;
  - Client enrollment, disenrollment, and denial of services;
  - Cost-avoidance (methods by which the utilization of all other resources or funding sources will be documented);
  - Criteria for admission and services to clients in residential facilities (use of residential facilities is optional; if not utilized have a policy stating so);
  - Retention and confidentiality of client records (including access, release, storage, and disposal);
  - Continuity of case management services during expected and unexpected absences of NCM and/or SWCM. In the case of absences of direct care service providers, the Waiver Agency must have a plan for back-up services developed with the subcontracted provider. Emergency plans must be in place, including efforts to contact, locate, and remove clients from their homes, in the case of natural disasters or other emergencies; and
  - Risk assessment and mitigation.
- Prepare an annual Outreach Plan targeting institutionalized populations and those disproportionately affected by HIV/AIDS as well as identifying services provided to underserved populations in the Waiver Agency's service area.

- Prepare and submit required reports to the Department in a timely manner; mid-year progress report is due July 31; annual progress report is due January 31.
- Perform Medi-Cal eligibility evaluation on each perspective client and after enrollment into MCWP, evaluate client's Medi-Cal eligibility monthly.
- Prepare and submit MCWP claims to the California Department of Health Care Services, Fiscal Intermediary in accordance with instructions provided in the Medi-Cal Provider Manual. The Department shall reimburse for correctly prepared and submitted claims received within six months following the month in which services were provided to eligible MCWP clients. Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delayed reasons allowed by regulation.
- Ensure that all provisions of HIPAA are implemented and enforced.
- Collect and report client and service data using the required standardized statewide system frequently as possible but no later than two weeks from the date services were rendered.
- Document that all staff are free of communicable TB. The annual TB screening requirements apply to all MCWP employees and volunteers who are at a site (building) where clients receive services including case management. The requirements also apply to agency staff paid for by other funds or sources who provide services to MCWP clients.
- The PD must participate in all required trainings, Webinar's, etc.

### **Core Case Management Team**

The core case management team's collective responsibilities include:

- Participation in IDTCC for each client;
- Review and revision of each client's service care plan; and
- Provision of stable, dependable, and professional case management service across institutional, community, and agency boundaries.

### **NCM**

The NCM shall:

- Assure that each client enrolled in the case management program meets medical and functional eligibility criteria;

- Perform and coordinate initial comprehensive nursing assessments and ongoing reassessments including an assessment of the client's level of care and functional status;
- Participate fully in case management activities within his/her area of expertise;
- Participate fully with the core case management team, which assures that the team is the primary service planning body and that the client or client's legal representative and family (when appropriate) is involved in the development and revisions of the service care plan;
- Monitor services and assure that only authorized services are provided, maximizing the use of all other available resources prior to the utilization MCWP services;
- Consult with the client's attending physician, primary care practitioner, and/or other medical providers as needed, to coordinate plans of treatment and advocate for the client as necessary;
- Work with the client and case management team to develop and implement a service plan for each client with review and appropriate revision based on comprehensive assessments and reassessments, case conferences, and service needs identified by the core case management team (including the client or his/her legal representative);
- Foster intra-agency and inter-agency working relationships to help accomplish goals;
- Participate in QA activities as described in the QI/QM Guidelines;
- Empower clients in decision-making for health care and service planning;
- Maintain records and collect data as required by the Department and professional standards;
- Advocate for the needs of the individual client;
- Participate in outreach activities to the entire target population, including agencies serving the homeless population,
- Assist in preparing an annual outreach plan to institutionalized and underserved populations in the community served by the Waiver Agency;
- Identify and follow up on instances of abuse, neglect, and exploitation that bring harm or create the potential for harm to clients; and

- Attend Department required trainings and Webinars.

## **SWCM**

The SWCM shall:

- Perform and coordinate initial psychosocial assessments and ongoing reassessments;
- Participate fully in case management activities within his/her area of expertise;
- Participate fully with the core case management team, which assures that the team is the primary service planning body and that the client or client's legal representative and family (when appropriate) is involved in the development and revisions of the service plan;
- Monitor services and assure that only authorized services are provided, maximizing the use of all other available resources prior to the utilization of MCWP funds;
- Consult with the client's attending physician, primary care practitioner, and/or other medical providers as needed, to coordinate plans of treatment and advocate for the client as necessary;
- Foster intra-agency and inter-agency working relationships to help accomplish goals;
- Ensure that the client's psychosocial needs are addressed in accordance with the service plan;
- Work with the client and case management team to develop and implement a service plan with review and appropriate revision based on comprehensive assessments and reassessments, case conferences, and service needs identified by the core case management team (including the client and/or his/her legal representative);
- Promote understanding of the psychosocial factors impacting persons with HIV disease or AIDS;
- Identify and assist clients in accessing benefits and entitlements, resources, and information and referral services for psychosocial needs;
- Consult with other social service providers as needed to assure continuity of care and prevent duplication of services;
- Participate in QA activities as described in the QI/QM Guidelines;

- Empower clients in decision-making for service planning;
- Maintain records and collect data as required by the Department and professional standards;
- Advocate for the needs of the individual client;
- Participate in outreach activities to the entire target population, including agencies that serve the homeless population;
- Assist in preparing an annual outreach plan for institutionalized and underserved populations in the community served by the Waiver Agency;
- Identify and follow up on instances of abuse, neglect, and exploitation that bring harm or create the potential for harm to clients; and
- Participate in conferences and trainings.

### **Waiver Agency/Core Case Management Team**

Waiver Agencies are required to maintain written policies for admission and services when a MCWP client lives in a residential facility licensed by the California Department of Social Services (CDSS), Community Care Licensing Division (CCLD). Additionally, CMS requires Waiver Agencies to establish necessary safeguards to protect the health and welfare of persons receiving services under the Waiver Agency. Information and requirements for MCWP case managers is summarized below. Also, see *Chapter 2, Section F, Residential Facilities, Client Admission, and Services* in the *Program Operations Manual (POM)* for the following information and requirements:

- Summary Description of CDSS/CCLD Residential Facilities;
- Comparison of Adult Residential Facilities, Residential Care Facilities for the Chronically Ill (RCFCI), Residential Care Facilities for the Elderly, Small Family Homes, and Foster Family Homes;
- Care and Supervision;
- Requirements that Apply to all Residential Facility Types;
- Requirements that Vary by Facility Type; and
- Residential Facilities Exempt from Licensure.

### **Provision of Basic Services by Residential Care Facility Direct Care Staff (DCS):**

Licensing requirements describe the basic services to be provided by DCS employed by

the residential facility (e.g., skilled nursing, attendant care, homemaker services, etc.). MCWP funds cannot be used as a replacement for these basic services. When MCWP funds are used to pay for “non-basic” or additional services, the client file must document the individual client’s specific need for the type and amount of services to be provided over and above those provided by the facility. Note: DCS are individuals employed by the facility that provide direct care services to the residents including, but not limited to, assistance with activities of daily living.

**Provision of Case Management:** RN case management for health and social services is a basic service under RCFCI licensing requirements. Section 87860(3) [CCR, Title 22, Division 6, Chapter 6] states: “The registered nurse may be an employee of the home health agency, the residential facility, or another organization with a contract with the residential facility.” If the residential facility does not have a NCM on staff, the MCWP provider should have a written agreement regarding the case management services available through MCWP for clients who remain eligible and need case management. This agreement should also address how the licensing requirement for RN case management services will be met if the client loses MCWP eligibility. This is to ensure that there is no pressure from the facility to maintain client enrollment if he/she is no longer eligible solely for the purpose of maintaining a stable residence.

If the residential facility does have RN case management on-site, then there must be a written agreement between the RCFCI and the Waiver Agency as to the roles and responsibilities of each NCM. The client chart must document the need for MCWP case management over and above the case management available from the facility. The MCWP case management team must be the primary case managers. Reimbursement for case management is based on comprehensive assessment, identification of service needs and the development, implementation, and periodic evaluation of a written service plan by both the NCM and SWCM.

If case management services are not needed by the client or if the client’s case management needs are met through services available at the facility, he/she should not be enrolled in MCWP. Neither of these programs should be used solely as a funding source for direct care services such as transportation, attendant care, etc.

**MCWP Staff Knowledgeable about Requirements:** MCWP staff (i.e. clients’ NCM and SWCM) should be knowledgeable as to the requirements for each facility type in which their client(s) reside and that this knowledge include:

- Basic service the residential facility is required to provide.
- Facility responsibility for providing *Care and Supervision* (see *Care and Supervision* section in the POM).
- Required facility staffing-ratios for day and night care and supervision.

- Admission and ongoing requirements including ambulatory status and TB screening.
- Allowable and prohibited medical conditions.
- General requirements for allowable conditions.
- Medications, storage of medications, self-administered medications, medication procedures, and medication documentation.
- Scheduled and controlled drugs, usage, and disposal.
- PRN (pro re nata or “as needed”) medication, usage, and disposal.
- The residential facility’s admission policy regarding persons who request a “Do Not Resuscitate Order.”
- Facility’s and adult client’s agreed plan for relocating client’s children and/or family when the adult client is hospitalized, relocated, becomes unable to meet their child’s or children’s needs, or dies.
- Identify the name of the MCWP case managers(s) who has/have responsibility to be knowledgeable about criteria for acceptance and retention of facility residents.
- Include a copy of the regulations for each facility type in which a client resides, in the central file at the Waiver Agency.

### **Attending Physician/Primary Care Practitioner**

The attending physician or primary care practitioner is responsible for:

- The medical care of the client;
- The assessment and documentation of the client’s medical status; and
- Consultation with NCM and the core case management team as needed.

### **Other Support Staff**

Other support staff may vary depending on the needs of the Waiver Agency, but basic support staff responsibilities are as follows:

### **Case Aide**

A case aide may assist the NCM and/or SWCM with practical arrangements for meeting service needs. Functions a case aide may perform include financial

assessment/reassessment, home environment assessment/reassessment, resource evaluation, transportation assistance, delivering vouchers, assisting with benefits counseling and referrals, and advocating for the client and client resources. A case aide may not perform nursing or psychosocial assessments or reassessments, or develop the initial service plan.

### **Benefits Counselor**

The benefits counselor may assist the NCM and/or SWCM in providing information, referrals, and assistance to the client in securing and maintaining benefits and entitlements.

### **Home Health Agency or Home Care Organization**

The home health agency or home care organization subcontracted to provide skilled nursing or attendant care services to clients prepares a nursing plan of care including the diagnosis, the assessment of needed care, interventions, goals, and evaluations. The subcontractor implements the nursing plan, provides supervision to their unlicensed staff, provides feedback to the core case management team, and participates in monthly case conferences (when possible). The plan of care must be provided to the Waiver Agency for inclusion in the client's MCWP file. The subcontractor must ensure that staff meets certification, education, and health requirements. When a home care organization is the subcontractor, the supervision requirements for unlicensed (certified) staff are the same as for a licensed home health agency (no less frequently than every 62 days). If the home care organization is unable to provide the supervision of the attendants, they may enter into an agreement where the Waiver Agency provides the supervision. Only Certified Home Health Aides or Certified Nursing Assistants may provide attendant care.

### **Provider of Homemaker Services**

The entity subcontracted to provide homemaker services is responsible for providing services as authorized by the MCWP NCM or SWCM. Homemaker services consist of general household activities (meal preparation, light housekeeping, and routine household care). They may only be provided by an individual who has received training in the areas of HIV/AIDS, basic infection control, and confidentiality. Services provided are in addition to, not in place of, services authorized by IHSS. Licensure is not required if the agency is providing attendant care only.

## **SECTION 12 - RECORD KEEPING**

### **Reasons for Documenting**

- To communicate client assessment, service planning, and implementation information to core case management team members;
- To meet client service record legal documentation requirements;
- To substantiate care decisions made with or on behalf of the client;
- To collect data necessary for client care and program decisions;
- To allow an assessment of the efficacy and appropriateness of funded services; and
- To document the activities of case management and related activities in a uniform, comprehensible manner.

### **Documentation Practices**

The client service record must be kept as part of the agreement with the Department, and should follow the accepted guidelines for record handling and documentation practices for health care records.

- No section/element of a form should be left blank. If a client chooses not to provide information or a case manager feels that a particular area should not be addressed at the time, or if an area was already completed by another case manager, the section/element should be noted with "N/A," "declined," "deferred," etc., by the NCM and/or SWCM.
- Each client must have a separate chart. It is optional to assign each client chart an identification number;
- Observations and conclusions documented should be objective, professional, and non-judgmental;
- Records should follow a standard format with standardized documents;
- Documentation must be legible, typewritten, computer-generated, or handwritten in ink. It must be dated and signed (with professional title);
- Waiver Agency policy should assign responsibility for recording documentation with time frames;

- Corrections should be made by drawing a single line through the entry, writing “error” and dating and initialing the entry. The use of “white-out,” rewriting pages, and destroying the original documentation or other correction methods are not acceptable; and
- Per California Health and Safety Code Section 123149 (g), “Any health care provider subject to this section, choosing to utilize an electronic record keeping system, shall develop and implement policies and procedures to include safeguards for confidentiality and unauthorized access to electronically stored patient health records, authentication by electronic signature keys, and systems maintenance.” Per the Department, if electronic records are to be printed and filed in a client chart, the original record must be signed by the appropriate case manager(s).

### **Record Handling and Storage**

- All documents should be secured in the records and protected from potential damage;
- No forms shall be destroyed or removed from the records once entered into them;
- Records should be available only to the agency staff directly responsible for filing, charting, and reviewing, and to State and Federal representatives as required by law. They should be protected from unauthorized access; computerized or electronic records must be similarly protected and have appropriate safeguards. Client records must be kept in a locked storage area, again accessible only to the agency staff directly responsible for filing, charting, and reviewing; and
- Waiver Agency policy should address the manner and length of time the documents will be stored, as well as removal from storage and destruction of records. A plan must be specified for record storage and retrieval if the organization were to close. Waiver Agency and subcontractor records must be made available for: 1) a period of three years from the date of final payment under the agreement; and 2) for such longer period, if any, as required by statute, or by any other provision of the agreement. Current State law requires adult medical records be kept at least until one year after the minor has reached the age of 18 years but in no case less than seven years.

### **Confidentiality**

- As health care providers, Waiver Agencies and staff must comply with all provisions of the Privacy Rule of HIPAA of 1996;
- Medical/health care information cannot be released verbally, in writing, or copied from records without a written consent for the release of information signed by the client (or legal representative). This consent must specify the type of information to

be released and to whom, and may be revoked at any time by the client (or legal representative);

- The Waiver Agency shall have written policies addressing the circumstances and processes by which all or part of a record may be released and to whom. Original documentation may be released only when required by court subpoena, otherwise photocopies should be provided;
- Current State and Federal law will be followed regarding client access to records;
- The Waiver Agency shall maintain signed statements of confidentiality for employees and volunteers who have access to client records;
- The Waiver Agency will protect client names and other identifying information (name, address, telephone number, date of birth, Social Security Number, driver's license number, any number, symbol or other identifying particular assigned to the client). Identifying information may only be used to provide case management and other services offered by MCWP;
- The Waiver Agency will maintain a confidential fax machine. Fax cover sheet should address the following information: who is the intended recipient, what type of information is included, and instructions for unintended recipients; and
- When using personal computers or mobile devices, protect client confidentiality and anonymity by every reasonable means, including all of the following:
  - Use password protection on desktop/laptop computers.
  - Use a Local Area Network drive that is password protected.
  - Use encryption software on all mobile devices (whether or not it contains client level data), such as, but not limited to: laptops, flash drives, CD ROMs, etc. (refer to the POM for the Department's Mobile Device Policy/Guidelines).
  - Provide a secure workstation for authorized staff with access to sensitive client information.
  - Notify Department staff immediately when a computer is stolen or repaired.

### **Contents of a Client Chart**

- Outline describing order and contents of client chart;
- Informed Consent/Agreement to Participate:
  - Client Rights and Responsibilities;
  - Grievance Policy and Procedures; and
  - Notice of Action/Right to State Fair Hearing;

- Authorization for the Exchange of Confidential Information;
- Adult Clients: Physician Certification of HIV Disease or AIDS with Current Symptoms Related to HIV Disease, AIDS, or HIV Disease/AIDS Treatment;
- Pediatric Clients: CDC Classification System for HIV in Children Under 13 Years of Age form;
- Documentation of Medi-Cal eligibility prior to enrollment and monthly thereafter;
- Initial comprehensive client assessment: physical, functional (CFA score – adults only; pediatric clients – none at this time), nutritional, health history, medication, NFLOC , psychosocial (including financial) and home within 30 days after enrollment;
- Ongoing client reassessment at least every 60 days or more often as needed: physical, functional (CFA score – adults only; pediatrics – none at this time), nutritional, medication, NFLOC (for MCWP), psychosocial (including financial) and home annually, or each time client moves;
- Resource Evaluation: policy and/or eligibility verification;
- Cost-Avoidance Documentation;
- CSP: initiated at time of enrollment and reviewed at least every 60 days and as needed;
- IDTCC documentation;
- Home Health Agency Plan of Care (for clients receiving attendant care or skilled nursing services, preferably from agency providing service); and
- Progress notes:
  - Current physical, psychosocial, and functional status and changes;
  - Education, counseling, referrals, or other direct services provided to the client;
  - Phone contact with client, caregivers, service providers, physicians, etc.;
  - Copies of correspondence, medical, and provider service records;
  - Data collection forms (ARIES); may be centrally located; and
  - Documentation of the need for the specific services delivered (may be documented on assessments/reassessments).

The Case Notes feature in ARIES may be used for documentation in place of progress notes. When this feature is used, any notes will need to be printed out and placed in client charts prior to a program compliance review.

## SECTION 13 - FORMS

Forms must not contain any blank elements or sections.

Forms can be identified as either mandatory or sample by locating the form number/revision date in the lower left corner of each document. Following the revision date will be an (M) for mandatory forms or (S) for sample forms. Forms may also be considered guidelines, identified by a (G) in the lower left corner of the document.

**Mandatory Forms** must be used “as is;” no changes may be made to these forms.

**Sample Forms** may be revised to meet an individual Waiver Agency’s needs but must contain all of the required elements within the forms. Required elements are those that make up the main section headings of the forms (e.g., client identifying information, social status, financial assessment, etc.). The elements that are within each of the main section headings are suggested elements, provided so that the use of these forms ensures comprehensiveness. If these elements are not listed on a form, it is still expected that documentation will be comprehensive, and this will be reviewed during program compliance reviews.

It is up to each provider to determine how much information will be listed within each section. Whether it is a significant amount of information (as in the sample forms in this document) or a limited amount of information, all assessment forms will be reviewed during a program compliance review to determine if the information documented is in fact comprehensive. **NOTE: the sections entitled, “Risk Assessment and Mitigation,” are an exception. These sections must remain exactly as they are in the forms of the AIDS Medi-Cal Waiver Program Protocols (elements within the sections may not be removed), as the assessment and documentation of these elements is a mandate from CMS.**

If an element is present in both of the nursing and the psychosocial assessment forms, one or both case managers may document the information. If only one case manager documents the information, the other case manager must note this in his/her assessment and make reference to the other case manager’s documentation.

Risk assessment and mitigation elements must be present in both the nursing and psychosocial assessments and reassessments. Both the NCM and SWCM must assess/reassess and document whether or not there were instances of abuse, neglect, or exploitation history upon enrollment and at least every 60 days during reassessments.

All forms can be accessed on the OA Web site at:  
<http://www.cdph.ca.gov/programs/aids/Pages/OAMCWP.aspx>.

## ELIGIBILITY FORMS

### AIDS Medi-Cal Waiver Program (MCWP) Certificate of Eligibility Physician

SECTION 1 IDENTIFYING INFORMATION	
CLIENT'S DATE OF BIRTH:	CLIENT'S SOCIAL SECURITY NUMBER:
SECTION 2 HIV DISEASE/AIDS DIAGNOSIS, OPPORTUNISTIC INFECTIONS, AND TUBERCULOSIS SCREENING	
<b>DIAGNOSIS:</b> <input type="checkbox"/> HIV ASYMPTOMATIC (INELIGIBLE FOR CMP/MCWP)      DATE OF FIRST POSITIVE TEST FOR HIV: <input type="checkbox"/> HIV SYMPTOMATIC (INDICATE ALL CURRENT SYMPTOMS BELOW)      DATE OF HIV SYMPTOMATIC DIAGNOSIS: <input type="checkbox"/> AIDS (INDICATE ALL CURRENT SYMPTOMS BELOW)      DATE OF AIDS DIAGNOSIS:	
CURRENT SYMPTOMS RELATED TO HIV DISEASE, HIV DISEASE TREATMENT, OR AIDS INCLUDE: <div style="background-color: #cccccc; height: 15px; width: 100%;"></div>	
<b>OPPORTUNISTIC INFECTIONS:</b> <input type="checkbox"/> TOXO      DATE: <input type="checkbox"/> CMV      DATE: <input type="checkbox"/> CANDIDIASIS      DATE: <input type="checkbox"/> PCP      DATE: <input type="checkbox"/> MAC      DATE: <input type="checkbox"/> KS      DATE: <input type="checkbox"/> OTHER:      DATE:	
SECTION 3 PHYSICIAN CERTIFICATION OF ELIGIBILITY	
I AM THE PHYSICIAN RESPONSIBLE FOR _____'S (CLIENT'S NAME) HIV/AIDS CARE. I CERTIFY THE ABOVE INFORMATION IS CORRECT AND BASED ON A REVIEW OF THE CLIENT'S HIV/AIDS TREATMENT NEEDS.	
PHYSICIAN SIGNATURE _____	DATE _____
PHYSICIAN NAME (PLEASE PRINT) _____	LICENSE NUMBER _____
(_____) _____	STREET ADDRESS _____
PHONE NUMBER _____	CITY _____ ZIP CODE _____
SECTION 4 CASE MANAGER INFORMATION	
CASE MANAGER NAME (PLEASE PRINT) _____	PHONE _____
DATE SENT _____	DATE RECEIVED _____

## **Eligibility and Requirements for Children under 13 Years of Age**

The CDC Classification System for HIV in Children under 13 Years of Age (MMWR September 30, 1994/Vol. 43/No. RR-12) is used to determine eligibility for children.

Pediatric clients under 13 years of age must be classified in clinical category A, B, or C. A physician must complete the form.

When a pediatric client reaches the age of 13, the CFA Score must be used for ongoing eligibility purposes. The client must continue to meet this and all other eligibility requirements for the specific program in order to continue enrollment. NOTE: NFLOC must be met or exceeded for all MCWP clients, including children. This level of care must continue to be met for ongoing MCWP eligibility. If the client is enrolled in MCWP and the CFA Score is greater than 60, the client must be disenrolled.

As MCWP does not provide “medical care related to the diagnosis or treatment of the disease,” no new Agreement to Participate, Authorization for Release of Medical Information, or any other forms are required to be signed by the client after his/her 13<sup>th</sup> birthday. The forms signed at enrollment continue to be in effect. Until a minor turns 18 years old, the parent or legal representative must sign all forms requiring the client’s signature. Whenever someone signs forms other than the client, the relationship to the client must be indicated on the form.

At the age of 18, the client must re-sign all forms, unless a conservator or legal representative has been appointed. If this is the case, the legal representative must sign all forms for continued client enrollment in MCWP.

## CDC Classification System for HIV in Children under 13 Years of Age

### CDC CLASSIFICATION SYSTEM FOR HIV IN CHILDREN UNDER 13 YEARS OF AGE

#### DIAGNOSIS CLASSIFICATION OF HIV INFECTION - DIAGNOSIS DEFINITIONS

##### Diagnosis: HIV Infected

1. A child less than 18 months of age who is known to be HIV seropositive or born to HIV-infected mother, and:
  - a. Has positive results on two separate determinations (excluding cord blood) from one or more of the following HIV detection tests: 1) HIV culture; 2) HIV polymerase chain reaction; and 3) HIV antigen (p24);  
**OR**
  - b. Meets criteria for AIDS diagnosis on the 1987 AIDS surveillance case definition (10);  
**OR**
2. A child at least 18 months of age or under 13 years of age born to an HIV-infected mother or any child infected by blood, blood products, or other known modes of transmission (e.g., sex contact) who:
  - a. Is HIV-antibody positive by repeatedly reactive enzyme immunoassay (EIA) and confirmatory test (e.g., Western blot or immunofluorescence assay (IFA));  
**OR**
  - b. Meets any of the criteria in "1.a." above.

##### Diagnosis: Perinatally Exposed (Prefix E)--A child who does not meet the HIV-Infected Diagnosis criteria who:

1. Is HIV seropositive by EIA and confirmatory test (e.g., Western blot or IFA) and is less than 18 months of age at the time of test;  
**OR**
2. Has unknown antibody status, but was born to a mother known to be infected with HIV.

##### Diagnosis: Seroreverter (SR)--A child who is born to an HIV-infected mother and who:

1. Has been documented as HIV-antibody negative (i.e., two or more negative AC tests performed at 8-18 months of age or one negative EIA test after 18 months of age);  
**AND**
2. Has had no other laboratory evidence of infection (has not had two positive viral detection tests, if performed);  
**AND**
3. Has not had an AIDS-defining condition.

CLIENT NAME:

CHART NUMBER:

### CLINICAL CATEGORIES

**Category N: Not Symptomatic**--Children who have no signs or symptoms considered to be the result of HIV infection or who have only one of the conditions listed in Category A.

**Category A: Mildly Symptomatic**--Children with two or more of the conditions listed below but none of the conditions listed in Categories B and C.

\*Lymphadenopathy ( $\geq 0.5$  cm at more than two sites: bilateral = one site) \*Parotitis \*Hepatomegaly  
\*Splenomegaly \*Dermatitis \*Recurrent or persistent upper respiratory infection, sinusitis, or otitis media

**Category B: Moderately Symptomatic**--Children who have symptomatic conditions other than those listed for Category A or C that are attributed to HIV infection. Examples of conditions in clinical Category B include but are not limited to:

\*Anemia ( $<8\text{gm/DL}$ ), neutropenia ( $<1,000/\text{mm}^3$ ), or thrombocytopenia ( $<100,000/\text{mm}^3$ ) persisting  $\geq 30$  days  
\*Bacterial meningitis, pneumonia, or sepsis (single episode Candidiasis, oropharyngeal (thrush), persisting ( $> 2$  months) in children  $> 6$  months of age \*Diarrhea, recurrent or chronic \*Hepatitis  
\*Herpes simplex virus (HSV) stomatitis, recurrent (more than two episodes within 1 year)  
\*Leiomyosarcoma \*Lymphoid interstitial pneumonia or pulmonary lymphoid hyperplasia complex  
\*Nephropathy \*Nocardiosis \* Persistent fever (lasting  $> 1$  month) \*Toxoplasmosis, onset before 1 month of age  
\*Varicella, disseminated (complicated chickenpox)

**Category C: Severely Symptomatic**--Children who have any condition listed in the 1987 surveillance case definition for acquired immunodeficiency syndrome, with the exception of LIP. Severe conditions included in clinical Category C for children infected with HIV:

\*Serious bacterial infections, multiple or recurrent (i.e., any combination of at least two culture-confirmed infections within a 2-year period) of the following types: septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media, superficial skin or mucosal abscesses, and indwelling catheter-related infections) \*Candidiasis, esophageal or pulmonary (bronchi, trachea, lungs) \*Coccidioidomycosis, disseminated (at site other than or in addition to lungs or cervical or hilar lymph nodes) \*Cryptococcosis, extrapulmonary persisting  $> 1$  month \*Cryptosporidiosis or isosporiasis with diarrhea \*Cytomegalovirus disease with onset of symptoms at age  $> 1$  month (at a site other than liver, spleen, or lymph nodes) \*Encephalopathy (at least one of the following progressive findings present for at least 2 months in the absence of a concurrent illness other than HIV infection that could explain the findings): a) failure to attain or loss of developmental milestones or loss of intellectual ability, verified by standard developmental scale or neuropsychological tests; b) impaired brain growth or acquired microcephaly demonstrated by head circumference measurements or brain atrophy demonstrated by computerized tomography or magnetic resonance imaging (serial imaging is required for children  $< 2$  years of age); c) acquired symmetric motor deficit manifested by two or more of the following: paresis, pathologic reflexes, ataxia, or gait disturbance Herpes simplex virus infection causing a mucocutaneous ulcer that persists for  $> 1$  month; or bronchitis, pneumonitis, or esophagitis for any duration affecting a child  $> 1$  month of age.  
\*Histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes) \*Kaposi's sarcoma \*Lymphoma, primary, in brain \*Lymphoma, small, noncleaved cell (Burkitt's), or immunoblastic or large cell lymphoma of B-cell or unknown immunologic phenotype \*Mycobacterium tuberculosis, disseminated or extrapulmonary \*Mycobacterium, other species or unidentified species, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes) \*Pneumocystis carinii pneumonia \*Salmonella nontyphoid) septicemia, recurrent \* Toxoplasmosis of the brain with onset at  $> 1$  month of age \*Wasting syndrome in the absence of a concurrent illness other than HIV infection that could explain the following findings: a) persistent weight loss  $> 10\%$  of baseline OR b) downward crossing of at least two of the following percentile lines on the weight-for-age chart (e.g., 95th, 75th, 50th, 25th, 5th) in a child  $\geq 1$  year of age OR c)  $< 5\text{th}$  percentile on weight-for-height chart on two consecutive measurements, 30 days apart **PLUS** a) chronic diarrhea (i.e., at least two loose stools per day for  $\geq 30$  days OR b) documented fever (for  $\geq 30$  days, intermittent or constant)

CLIENT NAME:

CHART NUMBER:

CDC Classification System for Children Under 13 Years of Age  
MCWP 6 (Rev. 5/10) (G)

Page 3 of 3

**AIDS Medi-Cal Waiver Program (MCWP)  
Nursing Facility Level of Care (NFLOC)  
Effective May 1997**

To qualify for Nursing Facility care services, the complexity of the client's medical problems is such that he or she needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Nursing Facility care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual client independence to the extent of his or her ability. Use the following description as a guide for determining appropriate placement:

1. Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis.
2. Diet may be of a special type; clients may need assistance in feeding him/herself.
3. The client may require assistance or supervision in personal care, such as in bathing or dressing.
4. The client may need encouragement in restorative measures for increasing and strengthening his or her functional capacity to work toward greater independence.
5. The client may have some degree of vision, hearing or sensory loss.
6. The client may have limitation in movement.
7. The client may be incontinent of urine and/or bowels.
8. The client may exhibit some mild confusion or depression; however, his or her behavior must be stabilized to such an extent that it poses no threat to him/herself or others.

## ENROLLMENT FORMS

### AIDS Medi-Cal Waiver Program (MCWP) Informed Consent/Agreement to Participate (English)

#### AIDS MEDI-CAL WAIVER PROGRAM (MCWP) INFORMED CONSENT/AGREEMENT TO PARTICIPATE

APPLICANT'S NAME: \_\_\_\_\_

Medi-Cal # \_\_\_\_\_

I understand that as part of my application for services under the MCWP, the Nurse Case Manager and Social Work Case Manager must evaluate my condition. My Nurse Case Manager and Social Work Case Manager will coordinate the care I receive at home. If I am eligible and choose to participate, I understand that:

1. I will participate in the process for deciding the services that I will receive and will be notified of what services I am to receive and any subsequent changes made to these services. These services will be based on need and availability of funding and that it is cost effective to provide these services. The MCWP is constructed so that I will incur no cost as a result of my participation. However, the MCWP monies will be the last source of payment to provide services; if care is available through another entity, e.g., insurance policy, then that source will be billed before the MCWP program.
2. The Nurse Case Manager and Social Work Case Manager will keep track of my progress and will develop a personalized service plan. The types and quantities of services will be determined through regular meetings with me and interdisciplinary team meetings.
3. I will be asked to provide personal information about myself including name, race, gender, health, and other pertinent information. No identifying information collected will be used against me or will be released without my consent, except as allowed by law. However, summary data based on MCWP participants (*personal identifiers deleted*) may be used by researchers for research and publication. The MCWP is committed to maintaining the highest possible level of confidentiality.
4. Information from my case record will be seen only by approved staff, consultants, and service providers, who will be serving me, or as otherwise provided by law. I understand that my case may be discussed at regular Case Conferences, consisting of MCWP staff, my physician and contractors supplying direct care services to me.
5. My participation in the MCWP is entirely voluntary and I may decide to withdraw at any time and there will be no penalties or loss of other services I am entitled to. My withdrawal will not affect the availability of medical care to me at any time. Furthermore, my doctor may withdraw me from the MCWP at any time if it's in my best interest to do so.
6. I understand that I must meet all MCWP eligibility requirements, including medical needs and condition, and that if I am hospitalized I will not receive MCWP services until my discharge. If I am hospitalized for more than 30 days, I will be disenrolled from the MCWP. I also understand that I must comply with MCWP program requirements as explained to me at enrollment.
7. I agree to cooperate fully with Agency/MCWP staff and care providers and agree to refrain from any verbal or physical hostile, abusive, or threatening behavior. I understand that failure to comply with this provision may result in termination of services.
8. I have the right to ask any questions concerning the MCWP at any time. I will be informed of any significant new information pertinent to my participation. If I have any questions concerning the MCWP program, I may contact my Nurse Case Manager or Social Work Case Manager.
9. I understand that MCWP staff are mandated reporters. I also understand that as mandated reporters they have to report situations such as elder or dependent abuse, child abuse, suicidal ideations, or homicidal ideations. The reasoning for such reports, as well as examples of such instances, has been explained to me. Furthermore, some circumstances require disclosure by law. These include when a client presents a danger to self, to others, to property, or is gravely disabled or when the client's family member(s) communicate that the client presents a danger to others.
10. I understand that there are financial caps on some of the MCWP services, including \$13,209 per client, per calendar year.
11. Client Initials \_\_\_\_\_ I acknowledge that I have received a copy of forms *Notice of Action (Denial/Discontinuance)* and *Request for a State Hearing*. I understand these forms will be mailed to me if my application is denied or if I am disenrolled from the MCWP.  
  
Client Initials \_\_\_\_\_ I acknowledge that I have received a copy of the Agency Grievance Policy  
  
Client initials \_\_\_\_\_ I acknowledge that I have received a copy of Client Rights.

I have been informed of both the home and community-based services of the MCWP and the alternative to these services and choose to receive MCWP services.

**I have read and I understand the above information concerning the program. My signature indicates my agreement to participate in the program. I will be given a copy of this consent form to refer to as needed.**

All questions I have concerning the MCWP at this time have been fully answered. If I have further questions, I should contact the MCWP Staff at: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_  
Agency Representative: \_\_\_\_\_

Date \_\_\_\_\_  
Date: \_\_\_\_\_

MCWP Informed Consent/Agreement to Participate  
MCWP 1 (Rev. 4/08) (M)

## AIDS Medi-Cal Waiver Program (MCWP) Informed Consent/Agreement to Participate (Spanish)

### AIDS Medi-Cal Waiver Program (MCWP) Consentimiento de Participación

Nombre del Cliente: \_\_\_\_\_ # de Medi-Cal \_\_\_\_\_

Entiendo que como parte de mi aplicación para recibir servicios de Manejo de Casos, el/la Enfermero/a y el manejador de asistencia social deberá evaluar mi condición. El manejador de casos de enfermero o el manejador de asistencia social trabajador/a social será responsable de coordinar servicios en mi casa. Yo entiendo que:

- 1) Yo participaré en el proceso de decidir que servicios recibiré y seré notificado de los servicios y de cualquier cambio en éstos. Estos servicios se basan en la necesidad y disponibilidad de fondos. Ningún costo está relacionado con mi participación en éste programa. Sin embargo, los costos asociados con mi cuidado se cobrarán a otras entidades como poliza de seguro medico, antes de cobrarlos al programa.
- 2) El manejador de casos de enfermería y el manejador de asistencia social mantendrá información sobre mi progreso y diseñará un programa de servicios para mí. El tipo y la cantidad de estos servicios seran determinados por medio de sesiones individuales y de juntas de el equipo acargo de mi cuidado.
- 3) Entiendo que se me haran preguntas personales que incluyen; mi nombre, raza, género, salud y otra información importante. Ninguna información adquirida sera usada en contra mia ni se dará a conocer sin antes dar mi consentimiento como lo provee la ley. Sin embargo, información general (sin ninguna clase de identificación personal) puede ser adquirida y usada en estudios o publicaciones de estos. Un certificado que obliga a los científicos que conducen estudios a mantener la confidencialidad se mantiene en archivo. El programa de AMCWP esta comprometido a mantener la mas estricta confidencialidad.
- 4) La información contenida en mi expediente sera vista solamente por el personal aprobado del programa, y otras personas que están a cargo de mi cuidado o como lo especifica la ley. Entiendo que mi caso pueda ser discutido en reuniones de casos, a las cuales asisten el personal del programa AMCWP, mi doctor y otras personas que me brindan servicios.
- 5) Mi participación en el programa de AMCWP es voluntario y yo puedo salir de el programa en cualquier momento sin represalias o pérdida de otros servicios por los cuales yo califico. Mi cuidado médico no se verá afectado por salirme del programa. Además, mi doctor puede darme de alta del programa si el/ella creé que es por mi bien.
- 6) Entiendo que necesito llenar todos los requisitos para el programa de AMCWP, los cuales incluyen necesidades y condición médica, y si llego a ser internado, yo no recibiré servicios mientras esté en el hospital. Estoy de acuerdo a seguir los reglamentos de el Programa como me lo han explicado.
- 7) Tengo el derecho de hacer preguntas de el programa de AMCWP en cualquier momento. Se me informará sobre cualquier cambio en el programa. Puedo mantenerme en contacto con mi trabajador/a de casos.
- 8) Estoy de acuerdo en cooperar con el personal de AMCWP y con los proveedores de cuidado. Consiento obstantemente de cualquier comportamiento hostil, ya sea verbal, abusivo, ó amenazante; al no cumplir con estos requisitos, mis servicios serán suspendidos.
- 9) Yo entiendo que los trabajadores profesionales de MCWP tienen la obligación de reporter situaciones de abuso de los ancianos o de personas a cargo de alguien, abuso o negligencia de niños, y amenazas de suicidio o homicidio. Las razones por las cuales éstos reportes son necesarios, incluyendo ejemplos de situaciones reportables, me han sido explicadas. Además, algunas circunstancias requieren revelación por ley. Éstos incluyen cuando un cliente presenta un peligro a sí mismo, a otros, a propiedad, o es gravemente discapacitado, o cuando los miembros de la familia del cliente comunican que el cliente presenta un peligro a otros.
- 10) Yo entiendo que existen límites de beneficio financiero para ciertos servicios de MCWP, incluso \$13,209 por cliente por año.
- 11) Iniciales de el cliente \_\_\_\_\_ Yo reconosco que hé recibido copias de las siguientes formas: **“Notificación de Acción, y Petición para una Audiencia con el Estado”**. Tambien, estas formas se me enviaron por correo si mi aplicación para servicios al AMCWP fuése negada por mal comportamiento, por haber llegado al limite del uso al Medi-Cal, ó si mis servicios son cancelados por no calificar para el programa de AMCWP.

Iniciales de el Cliente \_\_\_\_\_ Yo he recibido una copia de las Reglas de Quejas de la Agencia.

Iniciales de el Cliente \_\_\_\_\_ Yo he recibido una copia de los Derechos de el Cliente

**Certifico que he leído y entiendo la información aquí escrita sobre el programa. Con mi firma indico que estoy de acuerdo a participar en el programa. Se me proporcionará una copia de este acuerdo en el momento que lo necesite.**

Todas las preguntas sobre el programa han sido contestadas completamente. Si tengo preguntas en el futuro, llamaré a la siguiente persona al telefono: ( ) \_\_\_\_\_ - \_\_\_\_\_

Firma de el Apicante \_\_\_\_\_ Fecha \_\_\_\_\_  
Representate de la Agencia \_\_\_\_\_ Fecha \_\_\_\_\_

### Enrollment/Disenrollment Form

MEDI-CAL WAIVER PROGRAM ENROLLMENT/DISENROLLMENT FORM	
<b>TO:</b> <input style="width: 100%;" type="text" value="Waiver Enrollment Coordinator"/>	<b>NAME OF PERSON COMPLETING THIS FORM:</b> <input style="width: 100%; height: 30px;" type="text"/>
<b>FAX TO:</b> <input style="width: 100%;" type="text" value="(916) 449-5860"/>	<b>PHONE:</b> <input style="width: 100%; height: 20px;" type="text" value="( )"/>
	<b>NPI:</b> <input type="checkbox"/>
	<b>AGENCY AYD NUMBER:</b> 0 0 0 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**INSTRUCTIONS:**

**TO ENROLL A CLIENT**

1. Print the name and phone number of the agency person completing this form in the spaces provided. Enter the last three digits of the agency's AYD Number in the space provided above.
2. Complete Section I below and FAX to the enrollment coordinator at the FAX number listed above. The enrollment coordinator will process the enrollment and will call the individual named above to issue a waiver ID number or explain why enrollment cannot be processed.

**TO DISENROLL A CLIENT**

1. Complete Section II on the original enrollment form and FAX to the enrollment coordinator at the FAX number listed above. Client's Social Security Number is required.

SECTION I – ENROLLMENT INFORMATION	
<b>CLIENT'S SOCIAL SECURITY NUMBER</b> <input style="width: 100%; height: 20px;" type="text"/>	
<b>SEX (M/F)</b> <input type="checkbox"/>	<b>DATE OF BIRTH (MM/DD/YYYY)</b> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 40px;" type="text"/>
<b>ENROLLMENT BEGIN DATE (MM/DD/YYYY)</b> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 40px;" type="text"/>	
<b>RC (STATE USE ONLY)</b> <input style="width: 100%; height: 20px;" type="text" value="9"/>	
<b>LEVEL OF CARE</b> (NOTE: Nursing facility level of care or higher must be certified by the Nurse Case Manager) 1 – Nursing Facility (not hospitalized or prior hospital status unknown) 4 – Acute (hospitalized within current calendar year) <input style="width: 100%; height: 20px;" type="text"/>	
<b>RACE/ETHNICITY</b> 1 – Asian/Pacific Islander      4 – White (non-Hispanic)      9 - Unknown 2 – Black      5 – Native American 3 – Hispanic      6 – Other <input style="width: 100%; height: 20px;" type="text"/>	
<b>NURSE CASE MANAGER</b> (Print First Initial and Last Name) <input style="width: 100%; height: 20px;" type="text"/>	<b>PHONE NUMBER</b> <input style="width: 100%; height: 20px;" type="text" value="( )"/>
SECTION II – DISENROLLMENT INFORMATION	
<b>CLIENT'S WAIVER ID NUMBER</b> <input style="width: 100%; height: 20px;" type="text"/>	<b>ENROLLMENT END DATE (MM/DD/YYYY)</b> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 40px;" type="text"/>
<b>REASON FOR DISENROLLMENT</b> 01 – Death      07 – Left Service Area      11 – Transfer to CMP, Improved Health Status 02 – Annual Client Cap Exceeded      08 – Lost to Follow-Up      15 – Incarcerated 03 – Lost Medi-Cal Eligibility      09 – Transfer to CMP, Cap Exceeded      16 – Hospitalized 04 – Improved Health Status      10 – Transfer to CMP, Lost Medi-Cal Elig.      20 – Non-Compliant Client 06 – Client Choice 13 – Other, Describe <input style="width: 100%; height: 20px;" type="text"/>	
<b>FOR STATE USE ONLY</b>	
<b>Completed By:</b> <input style="width: 100%; height: 20px;" type="text"/>	<b>Date:</b> <input style="width: 100%; height: 20px;" type="text"/>
<b>Call Back Date/Time:</b> <input style="width: 100%; height: 20px;" type="text"/>	

MCWP Enrollment/Disenrollment Form  
MCWP 3 (Rev. 9/07) (M)

### Notice of Action (NOA) (English)

Page 1 of 2

**AIDS Medi-Cal Waiver Program  
NOTICE OF ACTION (NOA)  
DENIAL/REDUCTION/TERMINATION OF AIDS MEDI-CAL WAIVER BENEFITS**

Name \_\_\_\_\_ Date of Notice \_\_\_\_\_  
Address \_\_\_\_\_ Date Services Expire \_\_\_\_\_  
\_\_\_\_\_ Medi-Cal I.D. # \_\_\_\_\_  
\_\_\_\_\_ Waiver I.D. # \_\_\_\_\_

Medi-Cal regulations allow for the provision of certain AIDS Medi-Cal Waiver Program (MCWP) Home and Community-Based Services (HCBS) to persons who meet specific criteria. We have taken the following action with respect to services requested for the reasons noted:

- \_\_\_ 1. Denied your application or ended services for causes such as program noncompliance or personal safety of caregivers or agency staff, specifically \_\_\_\_\_.
- \_\_\_ 2. Denied your application or ended services because you do not meet eligibility requirements as follows:
  - You have not submitted adequate proof of Medi-Cal eligibility, your Medi-Cal eligibility cannot be verified or you are not eligible or no longer eligible for Medi-Cal.
  - Your medical condition and/or medical needs do not currently meet the Nursing Facility or higher level of care and/or your diagnosis of asymptomatic HIV or AIDS-related medical condition, does not meet eligibility requirements, or your "CFA score" (the Cognitive and Functional Ability Scale) on the evaluation form that is used was too high.
- \_\_\_ 3. Denied and/or reduced some portion of the services requested. Your medical condition and/or medical needs have improved, necessitating a change in services ordered.
- \_\_\_ 4. Continuing to provide HCBS to you is not cost effective (i.e., the estimated cost of providing you with those services exceeds cost guidelines set by the State).
- \_\_\_ 5. Cost of services provided to you has reached the \$13,209 calendar year annual cost cap. No more AIDS Medi-Cal Waiver services can be provided to you this calendar year.
- \_\_\_ 6. The services you need are fully available to you through private insurance, Medicare, Medi-Cal, or another program.
- \_\_\_ 7. You no longer desire HCBS.
- \_\_\_ 8. Other \_\_\_\_\_

This NOA is required by Code of Federal Regulations, Title 42, Chapter IV, Subpart E, and the California Code of Regulations, Title 22, Section 51014.1. You have the right to ask for a State Hearing (SH) if you disagree with any MCWP action. You only have ninety (90) days to ask for a hearing. The 90 days start the day after the MCWP gave or mailed you this notice. See page 2 for your appeal rights.

Denial or termination of AIDS MCWP benefits will not affect other medical or social services you are eligible to receive through California's Medi-Cal Program or other public benefit programs.

You may reapply for AIDS MCWP benefits at a future time if you believe you have become eligible.

Please call me for further information or if you have any questions. I may be reached at (\_\_\_\_\_) \_\_\_\_\_.

Sincerely,

\_\_\_\_\_  
Agency Representative

\_\_\_\_\_  
Agency Name

**STATE HEARING NOTICE - YOUR RIGHT TO APPEAL THE "NOTICE OF ACTION"**

State Hearing Instructions--If you do not agree with the action described, you may request a State Hearing before an Administrative Law Judge employed by the California Department of Social Services (CDSS). This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your case manager can help you request a hearing. If you decide to request a hearing, you must do so within 90 days of the date of this notice. Your benefits will only continue until the *Services Expiration Date* listed at the top of page 1 which is at least 10 days from the date of this notice. If you are currently receiving AIDS MCWP services and you request a SH before the **Date Services Expire** indicated at the top of this notice (within at least 10 days after the date of this notice), you will continue to receive services until a SH decision is made. If you are currently receiving AIDS MCWP services and you request a SH after the **Date Services Expire**, your AIDS MCWP services will stop on the **Date Services Expire**. You must verbally notify your case manager if you file an appeal within this 10-day period.

If you wish to request a SH, please complete the attached *Request for a State Hearing* form and mail it to the address listed below or call the phone number provided. You must provide all the information on the form; any information missing from the request form may delay the processing of your request. If you ask for a hearing the State Hearings Division (SHD) will set up a file. You have the right to see this file before your hearing and to get a copy of the AIDS waiver provider's written position on your case at least two days before the hearing. The SHD may give your hearing file to the California Department of Public Health and the United States Department of Health and Human Services per Welfare and Institutions Code Sections 10850 and 10950.

How to Request a State Hearing--You must either complete the attached *Request for a State Hearing* form and mail it to:

California Department of Social Services  
State Hearings Division  
MS-19-37  
744 P Street  
Sacramento, CA 95814

Or call

Toll-Free Number: (800) 952-5253  
Teletypewriter (TTD) only: (800) 952-8349

"Your Rights" Pamphlet Available--"Your Rights under California Welfare Programs" pamphlet issued by CDSS, provides useful information about State Hearings. This pamphlet will be sent to you when your hearing request is processed.

Authorized Representative--You can represent yourself at the State Hearing or be represented by a friend, attorney, or any other person; but, you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of the Public Inquiry and Response Unit (PIAR) at (800) 952-5253.

The PIAR office can also provide further information about your hearing rights. Assistance is available in languages other than English, including Spanish.

Code of Federal Regulations, Title 42, Section 431.220, Subpart E, Chapter IV, and the California Code of Regulations, Title 22, Section 51014.1, require that this **Notice of Action/State Hearing Notice** be mailed at time of denial of an application when it is determined that you are not eligible for waiver services or at time of reduction or termination of existing services. The Notice must be mailed **at least 10 calendar days** (excluding the mailing date) before the effective date of reduction or termination of services.

### Request for a State Hearing (English)

<b>REQUEST FOR A STATE HEARING</b>	
<b>Name</b>	<b>Medi-Cal I.D. Number</b>
<b>Address</b>	<b>City</b>
<p>I am requesting a State Hearing because of Medi-Cal related action by _____, an AIDS Medi-Cal Waiver agency related to the following reason(s):</p> <p><input type="checkbox"/> Denial of my application or ending of services for causes such as noncompliance or personal safety of caregivers or agency staff <b>OR</b></p> <p><input type="checkbox"/> Denial of my application or ending of services because I do not meet eligibility requirements <b>OR</b></p> <p><input type="checkbox"/> Denial and/or reduction of some portion of the service(s) requested <b>OR</b></p> <p><input type="checkbox"/> Ending of services because it is no longer cost effective to do so <b>OR</b></p> <p><input type="checkbox"/> The costs of services provided have reached the \$13,209 calendar year annual cost cap <b>OR</b></p> <p><input type="checkbox"/> Denial of my application or ending of services because services I need are fully available through private insurance, Medicare, Medi-Cal, or another program <b>OR</b></p> <p><input type="checkbox"/> I no longer desire Home and Community Based services.</p> <p><input type="checkbox"/> Other _____</p> <p><u>Describe the basis for your appeal below:</u></p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p><input type="checkbox"/> I speak a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)</p>	
Language: _____	Dialect: _____
<p><input type="checkbox"/> I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)</p> <p>Name: _____ Phone Number: _____</p> <p>Street Address: _____</p> <p>City: _____ State _____ Zip Code _____</p>	
<b>Signature:</b> _____	<b>Date:</b> _____
<p>Mail to: California Department of Social Services State Hearings Division MS-19-37 744 P Street Sacramento, CA 95814 Toll-Free Number: (800) 952-5253 Teletypewriter (TTD) only: (800) 952-8349</p>	
<p>The AIDS Medi-Cal Waiver Program is administered by the Community Based Care Section, Office of AIDS, Department of Public Health, MS 7700, P.O. Box 997426, Sacramento, CA 95899-7426, (916) 449-5900.</p>	

Request for a State Hearing  
MCWP 4 Attachment (Rev. 6/08) (M)

## Notice of Action (NOA) (Spanish)

**Programa de Exención para Personas con el Síndrome de Inmunodeficiencia Adquirida (SIDA)  
bajo el Programa de Asistencia Médica de California (Medi-Cal)  
NOTIFICACION DE ACCION (NOA)**

**NEGACION/REDUCCION/DESCONTINUACION DE LOS BENEFICIOS DE ESTE PROGRAMA**

Nombre _____	Fecha de la notificación _____
Dirección _____	Medi-Cal - # de identificación _____
_____	Exención - # de identificación _____
_____	Fecha en que los servicios se discontinuarán _____

Los reglamentos de Medi-Cal permiten que se proporcionen ciertos servicios de casa y servicios basados en la comunidad (HCBS) a través del Programa de Exención bajo el Programa de Medi-Cal (MCWP) para Personas con SIDA si estas personas cumplen con los requisitos específicos. En relación a los servicios que se solicitaron, hemos tomado la siguiente acción debido a las razones indicadas:

- \_\_\_ 1. Negamos su solicitud o discontinuamos sus servicios debido a motivos tales como la falta de cumplimiento con los requisitos del programa o problemas en relación a la seguridad personal de los proveedores de cuidado o del personal de la agencia/oficina, específicamente \_\_\_\_\_.
  
- \_\_\_ 2. Negamos su solicitud o discontinuamos sus servicios debido a que usted no cumple con los requisitos de elegibilidad como se indica a continuación:
  - Usted no ha presentado las pruebas adecuadas de elegibilidad para Medi-Cal, su elegibilidad para Medi-Cal no se puede verificar, o no es o ha dejado de ser elegible para Medi-Cal.
  
  - Actualmente, su condición médica y/o sus necesidades médicas no cumplen con los requisitos para el cuidado en un establecimiento de cuidado médico continuo no intenso o a un nivel más alto y/o el diagnóstico de que usted tiene el virus de inmunodeficiencia humana (VIH) o SIDA sin presentar síntomas no cumple con los requisitos de elegibilidad, o su clasificación en la evaluación que se utiliza (la tabla de habilidad cognoscitiva y habilidad para funcionar) fue demasiado baja.
  
- \_\_\_ 3. Negamos y/o reducimos una porción de los servicios que se solicitaron. Su condición médica y/o sus necesidades médicas han mejorado lo cual ocasionó un cambio en los servicios que se ordenaron.
  
- \_\_\_ 4. El continuar proporcionándole los servicios HCBS ya no es lo más económico (es decir, el costo calculado para proporcionarle a usted esos servicios es más que las normas de costo establecidas por el Estado).
  
- \_\_\_ 5. El costo de los servicios que se le han proporcionado ha alcanzado los \$13,209 que es lo máximo permitido anualmente para un año civil. Para este año civil, ya no puede recibir más servicios bajo el MCWP para Personas con SIDA.
  
- \_\_\_ 6. Los servicios que usted necesita están completamente disponibles a través de su seguro privado, Medicare (seguro médico federal), Medi-Cal, u otro programa.
  
- \_\_\_ 7. Usted ya no quiere los servicios HCBS.
  
- \_\_\_ 8. Otra razón: \_\_\_\_\_

Esta notificación de acción es un requisito del Código de Ordenamientos Federales, Título 42, Capítulo IV, Subparte E, y el Código de Ordenamientos de California, Título 22, Sección 51014.1. Usted tiene derecho a solicitar una audiencia con el estado (SH) si usted no está de acuerdo con alguna acción en relación al MCWP. Tiene solamente noventa (90) días para solicitar una audiencia. Los 90 días empezaron a contar al siguiente día de cuando el MCWP le dio o le envió por correo esta notificación. Para los derechos que tiene para apelar, vea la página 2.

La negación o discontinuación de los beneficios del MCWP para Personas con SIDA no afectará otros servicios médicos o sociales para los cuales usted es elegible bajo el Programa de Medi-Cal u otros programas de beneficios públicos.

En el futuro, puede volver a solicitar los beneficios del MCWP para Personas con SIDA si usted cree que ya es elegible.

Para más información o si tiene alguna pregunta, por favor llámeme. Mi número de teléfono es ( ) \_\_\_\_\_.

Atentamente.

\_\_\_\_\_  
Representante de la agencia/oficina

\_\_\_\_\_  
Nombre de la agencia/oficina

MCWP Notice of Action (NOA)  
MCWP 4 Spanish (Rev. 8/06) (M)

**NOTIFICACION DE UNA AUDIENCIA CON EL ESTADO - SU DERECHO A APELAR LA "NOTIFICACION DE ACCION"**

Instrucciones en relación a una audiencia con el estado--Si usted no está de acuerdo con la acción descrita, usted puede solicitar una audiencia con el estado ante un juez de leyes administrativas empleado por el Departamento de Servicios Sociales de California (CDSS). Esta audiencia se llevará a cabo en una manera informal para asegurar que todas las personas presentes puedan hablar libremente. La persona encargada de su caso puede ayudarle a solicitar una audiencia. Si usted decide solicitar una audiencia, tiene que hacerlo antes de que pasen 90 días a partir de la fecha de esta notificación. Sus beneficios solamente continuarán hasta la "**Fecha en que los beneficios se descontinuarán**" que aparece en la parte de arriba de la página 1, la cual es al menos 10 días después de la fecha de esta notificación. Si actualmente está recibiendo servicios bajo el MCWP para Personas con SIDA y usted solicita una audiencia con el estado antes de la "**Fecha en que los beneficios se descontinuarán**" anotada en la parte de arriba de esta notificación (al menos 10 días después de la fecha de esta notificación), usted continuará recibiendo los servicios hasta que se emita la decisión de la audiencia con el estado. Si actualmente está recibiendo servicios bajo el MCWP para Personas con SIDA y usted solicita una audiencia con el estado después de la "**Fecha en que los beneficios se descontinuarán**", los servicios se descontinuarán en dicha fecha. Si usted presenta una apelación antes que se termine el periodo de 10 días, tiene que notificarle verbalmente al trabajador encargado de su caso.

Si desea solicitar una audiencia con el estado, por favor complete el formulario de "Petición para una audiencia con el estado" adjunto y envíelo por correo a la dirección que aparece abajo o llame al número de teléfono que se proporciona. Usted tiene que proporcionar toda la información en el formulario; cualquier información que falte en el formulario pudiera atrasar la tramitación de su petición para una audiencia con el estado. Si usted solicita una audiencia, la División de Audiencias Administrativas preparará un expediente. Al menos dos días antes de su audiencia, usted tiene derecho a ver su expediente y a recibir una copia escrita de la declaración de posición sobre su caso del proveedor de la exención para las personas con SIDA. De acuerdo a lo estipulado en las Secciones 10850 y 10950 del Código de Bienestar Público e Instituciones, la División de Audiencias Administrativas puede darle su expediente de la audiencia al Departamento de Servicios de Salud de California y al Departamento de Servicios de Salud y Servicios Humanos de los Estados Unidos.

**Cómo solicitar una audiencia con el estado**—Usted puede completar el formulario de "Petición para una audiencia con el estado" adjunto y enviarlo por correo al Departamento de Servicios Sociales de California (CDSS) a la siguiente dirección:

California Department of Social Services  
State Hearings Division  
MS-19-37  
744 P Street  
Sacramento, CA 95814

o puede llamar al  
Número de teléfono gratuito: (800) 952-5253  
Teletipo (TTY) solamente: (800) 952-8349

Folleto disponible acerca de sus derechos--El folleto "Sus derechos bajo los programas de asistencia pública de California" publicado por el CDSS le proporciona información útil acerca de las audiencias con el estado. Le enviarán este folleto una vez que se tramite su petición para una audiencia.

Representante autorizado--En la audiencia con el estado, se puede representar a sí mismo o puede ser representado por un amigo, abogado, o cualquier otra persona; pero, usted tiene que hacer los arreglos para tener a un representante. Puede obtener ayuda para localizar asesoramiento legal sin costo llamando al número de teléfono gratuito de la Oficina de Preguntas y Respuestas al Público (PIAR) al (800) 952-5253.

La Oficina de PIAR también le puede proporcionar más información acerca de sus derechos en relación a una audiencia. Esta información se proporciona en varios idiomas aparte del inglés, incluyendo el español.

La Sección 431.220 del Código de Ordenamientos Federales, Título 42, Capítulo IV, Subparte E, y la Sección 51014.1 del Código de Ordenamientos de California, Título 22, estipulan que esta **Notificación de acción/Notificación de una audiencia con el estado** se tiene que enviar por correo cuando se niegue una solicitud debido a que se determinó que usted ya no es elegible para los servicios bajo una exención o cuando se reduzcan o descontinúen los servicios actuales. La notificación se tiene que enviar por correo **al menos 10 días consecutivos** (excluyendo la fecha en que se envió) antes de la fecha en que entre en vigor la reducción o descontinuación de los servicios.

MCWP Notice of Action (NOA)  
MCWP 4 Spanish (Rev. 8/06) (M)

### Request for a State Hearing (Spanish)

PETICION PARA UNA AUDIENCIA CON EL ESTADO	
Nombre	Número de identificación de Medi-Cal
Dirección	Ciudad
<p>Estoy solicitando una audiencia con el estado debido a una acción relacionada a Medi-Cal que tomó _____, una agencia/oficina que proporciona exenciones para personas con SIDA para el Programa de Medi-Cal. El motivo (o motivos) aparece a continuación:</p> <ul style="list-style-type: none"> <li>• Negación de mi solicitud o discontinuación de los servicios debido a motivos tales como la falta de cumplimiento con los requisitos del programa o problemas en relación a la seguridad personal de los proveedores de cuidado o del personal de la agencia/oficina, <u>o</u></li> <li>• Negación de mi solicitud o discontinuación de los servicios debido a que no cumplo con los requisitos de elegibilidad, <u>o</u></li> <li>• Negación y/o reducción de una porción de los servicios solicitados, <u>o</u></li> <li>• Discontinuación de los servicios debido a que el proporcionar los servicios ya no es lo más económico o porque el costo de los servicios proporcionados ha alcanzado los \$13,209 que es lo máximo permitido anualmente para un año civil.</li> <li>• Negación de mi solicitud o discontinuación de los servicios debido a que los servicios que necesito están completamente disponibles a través de un seguro privado, Medicare (seguro médico federal), Medi-Cal, u otro programa o debido a que yo ya no quiero los servicios de casa y basados en la comunidad.</li> <li>• Otro motivo: _____</li> </ul> <p><u>Describe a continuación en que se basa su apelación:</u></p> <p>_____</p> <p>_____</p> <p>_____</p>	
<ul style="list-style-type: none"> <li>• Hablo otro idioma que no es el inglés y necesito un intérprete para mi audiencia. (El Estado le proporcionará un intérprete sin costo para usted.)</li> </ul>	
Idioma:	Dialecto:
<ul style="list-style-type: none"> <li>• Quiero que la persona cuyo nombre aparece a continuación me represente en esta audiencia. Otorgo el permiso para que esta persona vea mis expedientes o asista a la audiencia en mi nombre. (Esta persona puede ser un amigo o pariente pero no puede ser su intérprete.)</li> </ul> <p>Nombre: _____ Número de teléfono: _____</p> <p>Domicilio: _____</p> <p>Ciudad: _____ Estado _____ Código postal _____</p>	
Firma:	
<p>Envíe por correo a: California Department of Social Services State Hearings Division MS-19-37 744 P Street Sacramento, CA 95814 Número de teléfono gratuito: (800) 952-5253 Teletipo (TTY) solamente: (800) 952-8349</p>	
<p>El Programa de Exención para Personas con SIDA bajo el Programa de Medi-Cal es administrado por la Sección del Cuidado Basado en la Comunidad en la Oficina del SIDA en el Departamento de Servicios de Salud; la dirección y número de teléfono son: <i>AIDS Medi-Cal Waiver Program, Community Based Care Section, Office of AIDS, Department of Health Services, MS 7700, P.O. Box 997426, Sacramento, CA 95899-7426, (916) 449-5900.</i></p>	

## Authorization to Exchange Confidential Information

Waiver Agency staff shall NOT disclose or receive medical information regarding a client without first obtaining a written *Authorization for the Exchange of Confidential Information*, except for the purpose of care or treatment. This authorization must be completed **on or within 15 days prior to enrollment**, and updated and renewed as needed. Authorizations for exchange of confidential information are subject to [California Civil Code \(CCC\), Part 2, Section 56](#). It is suggested that Waiver Agencies consult their agency legal counsel with any questions not specifically addressed in the CCC. The *Authorization for Exchange of Confidential Information* shall include the following elements (CCC, Part 2, Section 56.11):

- It must be clearly separate from any other language on the same page and executed by a signature that serves no other purpose than to execute the authorization.
- It must be signed and dated by the patient or the legal representative of the patient. [Note: additional information regarding who may sign the authorization and under what circumstances is included in CCC, Part 2, Section 56.11 (c).]
- The specific uses and limitations on the types of confidential information to be disclosed must be stated.
- The name or functions of the health care provider that may disclose the information must be stated.
- The name or functions of the persons or entities that are authorized to receive the information must be stated.
- It must state the specific uses and limitations on the use of the confidential information by those authorized to receive it.
- A *specific* date after which the provider is no longer authorized to disclose the information must be stated. (Note: the length of time an authorization may be valid is to be determined by the Waiver Agency; however, many Waiver Agencies use two years.)
- The form must advise the person signing the authorization of the right to receive a copy of the authorization.
- The form must state that an individual may cancel or modify the authorization at any time (CCC, Part 2, Section 56.15).

Note: the cancellation or modification of any authorization shall be effective only after the provider of health care actually receives written notice of the cancellation and modification.

As health care providers, Waiver Agencies must comply with all provisions of the Privacy Rule of HIPAA of 1996.

## Authorization to Exchange Confidential Information (English Form)

### AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

Client Name \_\_\_\_\_ Chart Number \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider Name/ \_\_\_\_\_  
Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the above-named healthcare provider to furnish and/or receive pertinent medical (**specifically, records relating to my HIV/AIDS status**) and social services records and documents relating to my medical history, my mental and physical condition, services rendered and all treatment provided to me, to:

Program Name/ \_\_\_\_\_  
Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that as part of my application for services through \_\_\_\_\_, my medical condition must be evaluated to determine eligibility for case management and provide ongoing case management and related services. Information released pursuant to this authorization will be used solely for the purpose of administering this program.

Additionally, I hereby authorize \_\_\_\_\_ to fax information to the State Office of AIDS.

This authorization is **effective today**, and shall remain in effect until such time as I revoke it in writing or until **two years from the date signed**.

I understand that I have a right to receive a copy of this authorization.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Client/Legal Representative)

If signed by other than the client, indicate relationship

\_\_\_\_\_

### Authorization to Exchange Confidential Information (Spanish Form)

#### AUTORIZACIÓN PARA COMPARTIR INFORMACIÓN CONFIDENCIAL

Nombre del Cliente: \_\_\_\_\_ Número del Archivo: \_\_\_\_\_

Número de Seguro Social: \_\_\_\_\_ Fecha de Nacimiento: \_\_\_\_\_

Nombre y Dirección  
Del Proveedor Médico  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yo, \_\_\_\_\_, por medio de la presente, autorizo al proveedor de salud arriba mencionado a presentar información pertinente a mis servicios médicos y sociales, al igual que documentos relacionados con mi historial médico, mi condición física y mental, servicios y todos los tratamientos provistos hacia mi persona, a:

Nombre y Dirección  
Del Programa  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Específicamente, yo autorizo a compartir mi historial médico relacionado con mi estado de VIH/SIDA. Iniciales del cliente: \_\_\_\_\_.**

Yo entiendo que, como parte del proceso de mi solicitud para servicios a través de \_\_\_\_\_, mi condición médica debe de ser evaluada para determinar mi elegibilidad para manejo de casos y servicios relacionados. La información revelada por ésta autorización será utilizada solamente con el propósito de administración del programa. También le autorizo a \_\_\_\_\_ que mande información por fax a la Oficina Del SIDA Del Estado.

Esta autorización es **efectiva hoy mismo** y se mantendrá vigente hasta la fecha en que yo mismo la revoque por escrito, ó **dos años después de la fecha de hoy**.

Yo entiendo que tengo el derecho a recibir una copia de ésta autorización.

**Firma** \_\_\_\_\_ **Fecha** \_\_\_\_\_  
(Cliente / Representante Legal)

**Si ha sido firmado por otra persona, indique la relación** \_\_\_\_\_

## Client Rights in Case Management (English)

### AIDS MEDI-CAL WAIVER PROGRAM (MCWP) CLIENT RIGHTS IN CASE MANAGEMENT

Case Management should observe the following rights for all clients:

- ✓ The right to be given a fair and comprehensive assessment of his or her health, functional, psychosocial and cognitive ability.
- ✓ The right to have access to needed health and social services for which he or she is eligible.
- ✓ The right to be treated with respect and dignity.
- ✓ The right to self-determination, including the opportunity to participate in developing one's plan for services.
- ✓ The right to be notified of any changes of services, termination of service, or discharge from the program.
- ✓ The right to withdraw from the case management program any time.
- ✓ The right to a grievance procedure in the event that the client feels his or her rights have been violated, or perceives discrimination or inappropriate treatment.

I have explained the MCWP and the involvement requested of the client. I have explained the rights of the client for case management services. I have answered questions about the MCWP asked by the client, or by a responsible concerned persons on behalf of the client, and I have provided a copy of this form to the client.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Client Rights in Case Management (Spanish)

### Derechos del Cliente en el Manejo de Casos

El Manejo de Casos asegurará los siguientes derechos de los clientes registrados en el programa.

- ✓ El derecho de tener un asesoramiento integral de salud, habilidades funcionales, psicológicas y cognitivas.
- ✓ El derecho de tener acceso a servicios médicos y sociales por los cuales esta elegible.
- ✓ El derecho de ser tratado con respeto y dignidad.
- ✓ El derecho de auto-determinación, incluyendo tener la oportunidad de participar en el desarrollo de el plan de servicio.
- ✓ El derecho de ser notificado de cualquier cambio en servicios, terminación de servicios o suspensión del programa.
- ✓ El derecho de terminar mi participación en el programa de manejo de casos en cualquier momento.
- ✓ El derecho a un Procedimiento de Quejas en caso que piense que mis derechos hayan sido violados, o en caso de discriminación o de haber recibido mal tratamiento.

Los derechos de los clientes han sido explicados. Le he explicado al cliente sus derechos sobre los servicios de manejo de casos. He respondido a las preguntas sobre MCWP que ha hecho el cliente, y/o la persona al cuidado del cliente. El cliente ha recibido una copia de esta forma.

Mi firma asegura que he recibido una copia de esta forma.

\_\_\_\_\_  
Firma de el Cliente

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma de el Trabajador

\_\_\_\_\_  
Fecha

## ASSESSMENT FORMS

### Initial Nursing Assessment

AIDS Medi-Cal Waiver Program (MCWP) Initial Nursing Assessment	
SECTION 1 IDENTIFYING INFORMATION	
<b>HIV STATUS/DATE OF DIAGNOSIS:</b>	<b>MODE OF TRANSMISSION:</b>
<b>ADDRESS:</b> STREET _____ CITY _____ ZIP CODE _____	<b>DATE OF ASSESSMENT:</b>
MAIL OK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>PHONE:</b> IS IT OK TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>LOCATION OF ASSESSMENT:</b>
<b>CLIENT SSN:</b>	<b>GENDER:</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER <input type="checkbox"/> FEMALE-TO-MALE <input type="checkbox"/> MALE-TO-FEMALE
<b>DOB:</b>	<b>AGE:</b>
<b>SEXUAL ORIENTATION:</b> <input type="checkbox"/> HOMOSEXUAL <input type="checkbox"/> HETEROSEXUAL <input type="checkbox"/> BISEXUAL <input type="checkbox"/> UNKNOWN	<b>RELATIONSHIP STATUS:</b> <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> SIGNIFICANT OTHER NAME:
<b>PRIMARY LANGUAGE:</b>	<b>RACE:</b> <b>ETHNICITY:</b> <b>CULTURAL ISSUES:</b>
<b>RELIGIOUS/SPIRITUAL PREFERENCE:</b>	
<b>EMERGENCY CONTACT:</b>	
<b>PRIMARY:</b> NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>SECONDARY:</b> NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>WHAT OTHER AGENCIES ARE ASSISTING YOU?</b>	
<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>

Initial Nursing Assessment  
MCWP 4 (Rev. 5/10) (S)

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**AIDS Medi-Cal Waiver Program (MCWP)  
Initial Nursing  
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**SECTION 2  
HEALTH HISTORY**

<b>MEDICAL HISTORY OBTAINED FROM:</b>			
<input type="checkbox"/> CLIENT			
<input type="checkbox"/> OTHER (SPECIFY):			
<b>HIV DISEASE HISTORY:</b>		<b>AIDS DIAGNOSIS DATE:</b>	
HIV+ DIAGNOSIS DATE:		MOST RECENT VIRAL LOAD:	
MOST RECENT CD4 COUNT:		LOWEST VIRAL LOAD:	
LOWEST CD4 COUNT:		HIGHEST VIRAL LOAD:	
HIGHEST CD4 COUNT:			
<b>TUBERCULOSIS HISTORY:</b>		<b>ALLERGIES:</b>	
LATEST TST RESULTS:	DATE:	<input type="checkbox"/> NO KNOWN ALLERGIES	
LATEST CXR RESULTS:	DATE:	<input type="checkbox"/> MEDICATION	
PROPHYLACTIC TREATMENT:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> FOOD	
		<input type="checkbox"/> ENVIRONMENT	
		COMMENTS:	
<b>HISTORY OF THE FOLLOWING: (CHECK ALL THAT APPLY)</b>		<b>OTHER HEALTH HISTORY: (CHECK ALL THAT APPLY)</b>	
<input type="checkbox"/> AIDS DEMENTIA	<input type="checkbox"/> KAPOSI'S SARCOMA	<input type="checkbox"/> ALCOHOL USE	<input type="checkbox"/> GI
<input type="checkbox"/> BACTERIAL PNEUMONIA	<input type="checkbox"/> ISOSPORIASIS	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HTN
<input type="checkbox"/> CANDIDIASIS (ESOPHAGEAL, ORAL, VAGINAL)	<input type="checkbox"/> LYMPHOMA	<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> MENTAL HEALTH
<input type="checkbox"/> CERVICAL CANCER	<input type="checkbox"/> HERPES	<input type="checkbox"/> CANCER	<input type="checkbox"/> RENAL
<input type="checkbox"/> CRYPTOCOCCAL INFECTION	<input type="checkbox"/> MAC	<input type="checkbox"/> CARDIAC	<input type="checkbox"/> RESPIRATORY
<input type="checkbox"/> COCCI	<input type="checkbox"/> PCP	<input type="checkbox"/> COPD	<input type="checkbox"/> TOBACCO USE (PPD)
<input type="checkbox"/> CMV	<input type="checkbox"/> TOXOPLASMOSIS	<input type="checkbox"/> DIABETES	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> CMV RETINITIS	<input type="checkbox"/> STD'S	<input type="checkbox"/> ELEVATED CHOLESTEROL	<input type="checkbox"/> OTHER
<input type="checkbox"/> ENCEPHALITIS	<input type="checkbox"/> WASTING	<input type="checkbox"/> RECREATIONAL DRUG USE	
<input type="checkbox"/> HISTOPLASMOSIS	<input type="checkbox"/> TUBERCULOSIS	COMMENTS:	
<input type="checkbox"/> HEPATITIS A, B, C	<input type="checkbox"/> OTHER:		
COMMENTS:			
<b>CHILDHOOD DISEASES/IMMUNIZATION HISTORY:</b>			
<b>DISEASE:</b>	<b>AGE OR YEAR INFECTED:</b>	<b>OR</b>	<b>YEAR IMMUNIZED:</b>
<b>CHICKEN POX:</b>			<b>CHECK IF NEITHER:</b>
			<input type="checkbox"/>
<b>MUMPS:</b>			<input type="checkbox"/>
<b>MEASLES:</b>			<input type="checkbox"/>
<b>RUBELLA:</b>			<input type="checkbox"/>
<b>TETANUS:</b>			<input type="checkbox"/>
<b>FLU:</b>			<input type="checkbox"/>
<b>PNEUMONIA:</b>			<input type="checkbox"/>
<b>HEPATITIS A:</b>			<input type="checkbox"/>
<b>HEPATITIS B:</b>			<input type="checkbox"/>
<b>HIB:</b>			<input type="checkbox"/>
<b>OTHER:</b>			<input type="checkbox"/>
<b>RECENT HIV RELATED EMERGENCY ROOM VISITS/HOSPITALIZATIONS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>REASON:</b>		<b>DATE:</b>	
<b>LOCATIONS:</b>		<b>LENGTH OF STAY:</b>	
<b>COMMENTS:</b>			

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
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SECTION 3 SEXUAL HISTORY			
<b>FEMALE:</b> SEXUALLY ACTIVE: <input type="checkbox"/> YES <input type="checkbox"/> NO  USES SAFE SEX PRACTICES: (REQUIRES DISCUSSION WITH CLIENT) <input type="checkbox"/> YES <input type="checkbox"/> NO  BIRTH CONTROL: METHOD: <input type="checkbox"/> YES <input type="checkbox"/> NO  LAST MENSTRUAL PERIOD:                      DATE:  CURRENTLY PREGNANT: <input type="checkbox"/> YES <input type="checkbox"/> NO PLANS TO CONTINUE PREGNANCY <input type="checkbox"/> YES <input type="checkbox"/> NO PLANS TO TERMINATE PREGNANCY <input type="checkbox"/> YES <input type="checkbox"/> NO UNDECIDED <input type="checkbox"/> YES <input type="checkbox"/> NO  NUMBER OF PREGNANCIES: NUMBER OF LIVE BIRTHS: NO LIVE BIRTHS:  UNDERSTANDS TREATMENT OPTIONS FOR VERTICAL TRANSMISSION RISK REDUCTION <input type="checkbox"/> YES <input type="checkbox"/> NO  DATE OF LAST PAP: RESULTS OF LAST PAP: <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL HISTORY OF ABNORMAL PAP <input type="checkbox"/> YES <input type="checkbox"/> NO  PERFORMS SBE MONTHLY: <input type="checkbox"/> YES <input type="checkbox"/> NO  DATE OF LAST MAMMOGRAM: RESULTS OF MAMMOGRAM: <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL  VAGINAL BURNING, ITCHING, DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>MALE:</b> SEXUALLY ACTIVE: <input type="checkbox"/> YES <input type="checkbox"/> NO  USES SAFE SEX PRACTICES: (REQUIRES DISCUSSION WITH CLIENT) <input type="checkbox"/> YES <input type="checkbox"/> NO  PROSTATE DISORDER: <input type="checkbox"/> YES <input type="checkbox"/> NO  LAST RECTAL/PROSTATE EXAM: RESULTS OF RECTAL/PROSTATE EXAM: <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL  LAST PSA TEST: RESULTS OF PSA TEST: <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL  PERFORMS SELF TESTICULAR EXAM MONTHLY: <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:		

SECTION 4 SERVICE PROVIDERS	
<b>PRIMARY MEDICAL PROVIDER:</b> NAME: STREET ADDRESS: CITY AND ZIP CODE PHONE NUMBER:	<b>PHARMACY:</b> NAME: STREET ADDRESS: CITY AND ZIP CODE PHONE NUMBER:
<b>DENTIST:</b> NAME: STREET ADDRESS: CITY AND ZIP CODE PHONE NUMBER:	<b>OTHER PROVIDERS:</b> NAME: STREET ADDRESS: CITY AND ZIP CODE PHONE NUMBER:

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Initial Nursing  
Assessment**

**SECTION 5  
SYSTEMS REVIEW**

<b>GENERAL APPEARANCE:</b>	
<b>CHIEF COMPLAINT:</b>	<b>CLIENT'S PERCEPTION OF ILLNESS:</b>
<b>VITAL SIGNS AS INDICATED:</b> TEMPERATURE: BLOOD PRESSURE:	<b>PULSE:</b> <b>RESPIRATIONS:</b>
<b>HEAD AND NECK:</b> (CHECK ALL THAT APPLY) <input type="checkbox"/> NO PROBLEMS IDENTIFIED <input type="checkbox"/> HEADACHES <input type="checkbox"/> MASSES/NODES COMMENTS/SEVERITY/FREQUENCY:	<b>EYES:</b> (CHECK ALL THAT APPLY) <input type="checkbox"/> NO PROBLEMS IDENTIFIED <input type="checkbox"/> VISUAL CHANGE <input type="checkbox"/> FLOATERS <input type="checkbox"/> ITCHING/DISCHARGE <input type="checkbox"/> REDNESS <input type="checkbox"/> GLASSES/CONTACTS <input type="checkbox"/> BLIND R/L <input type="checkbox"/> BLURRED VISION <input type="checkbox"/> LIGHT FLASHES <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> PERRLA COMMENTS/SEVERITY/FREQUENCY:
<b>EARS/NOSE:</b> (CHECK ALL THAT APPLY) <input type="checkbox"/> NO PROBLEMS IDENTIFIED <input type="checkbox"/> TINNITUS <input type="checkbox"/> DEAF R/L <input type="checkbox"/> HARD OF HEARING R/L <input type="checkbox"/> DRAINAGE <input type="checkbox"/> REDNESS COMMENTS/SEVERITY/FREQUENCY:	<b>MOUTH/THROAT:</b> (CHECK ALL THAT APPLY) <input type="checkbox"/> NO PROBLEMS IDENTIFIED <input type="checkbox"/> BLEEDING GUMS <input type="checkbox"/> ORAL LESIONS <input type="checkbox"/> CANDIDIASIS <input type="checkbox"/> DIFFICULTY SWALLOWING <input type="checkbox"/> WHITE PLAQUES <input type="checkbox"/> VESICLE <input type="checkbox"/> HOARSENESS COMMENTS/SEVERITY/FREQUENCY:

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
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Assessment**

**SECTION 5  
SYSTEMS REVIEW (CONT'D)**

**CARDIAC/CIRCULATORY:** (CHECK ALL THAT APPLY)

- NO PROBLEMS IDENTIFIED
- RATE/RHYTHM
- ORTHOPNEA
- DYSPNEA ON EXERTION
- PAROXYSMAL NOCTURNAL DYSPNEA
- CHEST PAIN (DESCRIBE)
- EDEMA
- PERIPHERAL PULSES
- ASCITES
- LIPID PANEL

COMMENTS/SEVERITY/FREQUENCY:

**SKIN:** (CHECK ALL THAT APPLY)

- NO PROBLEMS IDENTIFIED
- WARM
- DRY
- MOIST
- COLOR
- POOR TURGOR
- LESIONS (LOCATION, SIZE, DRAINAGE)
- KS LESIONS
- VESICLES
- BRUISING
- ITCHING
- RASH
- NUMBNESS
- TINGLING
- PETECHIAE

COMMENTS/SEVERITY/FREQUENCY:

**RESPIRATORY:** (CHECK ALL THAT APPLY)

- NO PROBLEMS IDENTIFIED
- RATE/RHYTHM
- APNEA
- DYSPNEA AT REST
- TACHYPNEA
- BREATH SOUNDS (DESCRIBE)
- NON-PRODUCTIVE COUGH
- PRODUCTIVE COUGH
- SOB AT REST
- DYSPNEA ON EXERTION
- OXYGEN
- CYANOSIS

COMMENTS/SEVERITY/FREQUENCY:

**GASTROINTESTINAL:** (CHECK ALL THAT APPLY)

- NO PROBLEMS IDENTIFIED
- ABDOMINAL DISTENTION
- CONSTIPATION
- CRAMPING
- BLOODY STOOLS
- FLATULENCE
- DIARRHEA
- NAUSEA/VOMITING
- HEARTBURN
- INCONTINENCE

COMMENTS/SEVERITY/FREQUENCY:

CLIENT NAME:

CHART NUMBER:

**AIDS Medi-Cal Waiver Program (MCWP)  
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**SECTION 5  
SYSTEMS REVIEW (CONT'D)**

<p><b>GENITOURINARY:</b> (CHECK ALL THAT APPLY)</p> <p><input type="checkbox"/> NO PROBLEMS IDENTIFIED</p> <p><input type="checkbox"/> FREQUENCY</p> <p><input type="checkbox"/> URGENCY</p> <p><input type="checkbox"/> DYSURIA</p> <p><input type="checkbox"/> HEMATURIA</p> <p><input type="checkbox"/> LESION</p> <p><input type="checkbox"/> BURNING</p> <p><input type="checkbox"/> INCONTINENCE</p> <p><input type="checkbox"/> INFLAMMATION</p> <p><input type="checkbox"/> DISCHARGE/DRAINAGE</p> <p>FEMALE:</p> <p><input type="checkbox"/> CANDIDIASIS</p> <p><input type="checkbox"/> VAGINAL DISCHARGE</p> <p><input type="checkbox"/> DYSMENORRHEA</p> <p><input type="checkbox"/> ABNORMAL BLEEDING</p> <p>COMMENTS/SEVERITY/FREQUENCY:</p>	<p><b>ENDOCRINE:</b> (CHECK ALL THAT APPLY)</p> <p><input type="checkbox"/> NO PROBLEMS IDENTIFIED</p> <p><input type="checkbox"/> FATIGUE</p> <p><input type="checkbox"/> IRRITABILITY</p> <p><input type="checkbox"/> MENTAL STATUS CHANGES</p> <p><input type="checkbox"/> WEIGHT CHANGE</p> <p><input type="checkbox"/> OBESITY</p> <p><input type="checkbox"/> BLOD SUGAR LEVELS</p> <p>COMMENTS/SEVERITY/FREQUENCY:</p>
<p><b>CENTRAL NERVOUS SYSTEM:</b> (CHECK ALL THAT APPLY)</p> <p><input type="checkbox"/> NO PROBLEMS IDENTIFIED</p> <p><input type="checkbox"/> NEUROPATHY</p> <p><input type="checkbox"/> SEIZURES</p> <p><input type="checkbox"/> BEHAVIORAL CHANGES</p> <p><input type="checkbox"/> DELUSIONS</p> <p><input type="checkbox"/> APHASIA</p> <p><input type="checkbox"/> FINE MOTOR CHANGES</p> <p><input type="checkbox"/> TREMORS</p> <p><input type="checkbox"/> SYNCOPE</p> <p><input type="checkbox"/> MEMORY LOSS</p> <p><input type="checkbox"/> IMPAIRED DECISION MAKING</p> <p><input type="checkbox"/> HALLUCINATIONS</p> <p><input type="checkbox"/> ATAXIA</p> <p><input type="checkbox"/> GROSS MOTOR CHANGE</p> <p><input type="checkbox"/> SLURRED SPEECH</p> <p><input type="checkbox"/> VERTIGO</p> <p>COMMENTS/SEVERITY/FREQUENCY:</p>	<p><b>MUSCULOSKELETAL:</b> (CHECK ALL THAT APPLY)</p> <p><input type="checkbox"/> NO PROBLEMS IDENTIFIED</p> <p><input type="checkbox"/> MYALGIA</p> <p><input type="checkbox"/> ATAXIA</p> <p><input type="checkbox"/> PAIN</p> <p><input type="checkbox"/> DEFORMITY (DESCRIBE)</p> <p><input type="checkbox"/> PARAPLEGIC</p> <p><input type="checkbox"/> SWELLING</p> <p><input type="checkbox"/> STIFFNESS</p> <p><input type="checkbox"/> HEMIPLEGIC</p> <p>COMMENTS/SEVERITY/FREQUENCY:</p>
<p><b>PAIN:</b> (CHECK ALL THAT APPLY)</p> <p><input type="checkbox"/> NO PROBLEMS IDENTIFIED</p> <p><b>TYPE:</b></p> <p><input type="checkbox"/> ACUTE</p> <p><input type="checkbox"/> AT REST</p> <p><input type="checkbox"/> CONSTANT</p> <p><input type="checkbox"/> CHRONIC</p> <p><input type="checkbox"/> SPORADIC</p> <p><input type="checkbox"/> WITH MOVEMENT</p> <p><b>QUALITY:</b></p> <p><input type="checkbox"/> ACHING</p> <p><input type="checkbox"/> THROBBING</p> <p><input type="checkbox"/> BURNING</p> <p><input type="checkbox"/> DULL</p> <p><input type="checkbox"/> SHARP</p> <p><input type="checkbox"/> PRESSURE</p> <p><input type="checkbox"/> SHOOTING</p> <p>COMMENTS/SEVERITY/FREQUENCY:</p>	<p><b>MENTAL STATUS:</b> (CHECK ALL THAT APPLY)</p> <p><input type="checkbox"/> NO PROBLEMS IDENTIFIED</p> <p><input type="checkbox"/> ALERT</p> <p><input type="checkbox"/> ORIENTED:</p> <p><input type="checkbox"/> OTHER (SPECIFY):</p> <p><b>MOOD:</b></p> <p><b>AFFECT:</b></p> <p>COMMENTS/SEVERITY/FREQUENCY:</p>

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
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**SECTION 6  
NUTRITION (CONT'D)**

<b>NUTRITIONAL SUPPLEMENTS:</b> (CHECK ALL THAT APPLY)		
<input type="checkbox"/> NONE	<input type="checkbox"/> ENSURE/BOOST	
<input type="checkbox"/> VITAMINS/MINERALS	<input type="checkbox"/> OTHER (SPECIFY):	
<input type="checkbox"/> HERBS/OTHER		
COMMENTS:		
<b>ALTERNATIVE NUTRITION:</b>		
<input type="checkbox"/> TPN	<input type="checkbox"/> LIPIDS	<input type="checkbox"/> TUBE FEEDING
COMMENTS:		
<b>OTHER BARRIERS TO ACHIEVING OPTIMAL NUTRITIONAL STATUS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		
COMMENTS:		
<b>DOES CLIENT NEED ASSISTANCE WITH MEALS (MEALS ON WHEELS, ATTENDANT CARE, ETC.):</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		
COMMENTS:		
<b>NUTRITIONAL EDUCATION PROVIDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		
COMMENTS:		
<b>NUTRITIONAL REFERRAL NEEDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		
COMMENTS:		
<b>NUTRITIONAL SUMMARY/PLAN:</b>		

**SECTION 7  
MEDICATION ADHERENCE**

<b>IS THE CLIENT ON MEDICATIONS (HAART OR OTHER):</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, REFER TO MEDICATION SHEET	
<b>CLIENT UNDERSTANDS MEDICATION REGIMEN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
COMMENTS:	
<b>CLIENT ADHERES TO MEDICATION REGIMEN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
COMMENTS:	
<b>CLIENT'S ABILITY TO TAKE MEDICATIONS (HAART OR OTHER):</b>	
DID THE CLIENT MISS ANY DOSES YESTERDAY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DID THE CLIENT MISS ANY DOSES THE DAY BEFORE YESTERDAY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> CLIENT IS ABLE TO INDEPENDENTLY TAKE CORRECT MEDICATION(S) & DOSE AT CORRECT TIMES
	<input type="checkbox"/> CLIENT IS ABLE TO TAKE CORRECT MEDICATION(S) & DOSES AT CORRECT TIMES WITH SUPERVISION OR ASSISTANCE
	<input type="checkbox"/> CLIENT IS UNABLE TO TAKE MEDICATION(S) UNLESS ADMINISTERED BY SOMEONE ELSE
	<input type="checkbox"/> UNABLE TO ASSESS CLIENT'S ABILITY TO TAKE MEDICATIONS
COMMENTS:	

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
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**SECTION 7  
MEDICATION ADHERENCE (CONT'D)**

**ADHERENCE BARRIERS:**

- |                                                            |                                                                              |
|------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> NO PROBLEMS/BARRIERS              | <input type="checkbox"/> DIFFICULTY SWALLOWING MEDICATION                    |
| <input type="checkbox"/> MEDICATION REGIMEN IS TOO COMPLEX | <input type="checkbox"/> MISUNDERSTANDING REGARDING MEDICATION EFFECTIVENESS |
| <input type="checkbox"/> SCHEDULING PROBLEMS               | <input type="checkbox"/> NO SOCIAL SUPPORT                                   |
| <input type="checkbox"/> MENTAL STATUS CHANGES             | <input type="checkbox"/> NEEDS ASSISTANCE WITH ADL'S                         |
| <input type="checkbox"/> ALCOHOL/DRUG USE/ABUSE            | <input type="checkbox"/> PROBLEMS OBTAINING MEDICATION OR REFILLS            |
| <input type="checkbox"/> DEPRESSION                        | <input type="checkbox"/> CULTURAL BELIEFS                                    |
| <input type="checkbox"/> MEDICATION SIDE EFFECTS           | <input type="checkbox"/> LACK OF REFRIGERATION, SAFE STORAGE                 |
| <input type="checkbox"/> LANGUAGE/CULTURAL BARRIERS        | <input type="checkbox"/> CURRENT SUBSTANCE USE                               |

COMMENTS:

**IS THE CLIENT EXPERIENCING ANY OF THE FOLLOWING MEDICATION SIDE EFFECTS:**

- |                                     |                                      |                                      |                                          |                               |
|-------------------------------------|--------------------------------------|--------------------------------------|------------------------------------------|-------------------------------|
| <input type="checkbox"/> ANOREXIA   | <input type="checkbox"/> DIARRHEA    | <input type="checkbox"/> DIZZINESS   | <input type="checkbox"/> FATIGUE         | <input type="checkbox"/> RASH |
| <input type="checkbox"/> NEUROPATHY | <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> WEIGHT GAIN | <input type="checkbox"/> NAUSEA/VOMITING |                               |

HAS THE MEDICAL PROVIDER BEEN NOTIFIED:  YES  NO

COMMENTS:

**COMPLIMENTARY ALTERNATIVE THERAPIES:**

- |                                      |                                     |
|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> ACUPUNCTURE | <input type="checkbox"/> HOMEOPATHY |
| <input type="checkbox"/> ACUPRESSURE | <input type="checkbox"/> HYPNOSIS   |
| <input type="checkbox"/> BIOFEEDBACK | <input type="checkbox"/> MASSAGE    |
| <input type="checkbox"/> HERBAL      | <input type="checkbox"/> OTHER:     |

COMMENTS:

**IV ACCESS/NAME AND LOCATION:**

- |                                      |           |                                   |           |
|--------------------------------------|-----------|-----------------------------------|-----------|
| <input type="checkbox"/> PICC        | LOCATION: | <input type="checkbox"/> GROSHONG | LOCATION: |
| <input type="checkbox"/> PORT-A-CATH | LOCATION: | <input type="checkbox"/> HICKMAN  | LOCATION: |

INFUSION COMPANY:

COMMENTS:

**SECTION 8  
RISK FACTORS FOR HIV TRANSMISSION**

**NEEDLE SHARING:**  YES  NO **SEX WORK:**  YES  NO

COMMENTS:

COMMENTS:

**UNPROTECTED SEX WITH MEN:**  YES  NO

COMMENTS:

**UNPROTECTED SEX WITH WOMEN:**  YES  NO

COMMENTS:

**SEX WITH IDU:**  YES  NO

COMMENTS:

**SEX WITH HIV+ INDIVIDUAL:**  YES  NO

COMMENTS:

**DISCUSSION OF CURRENT HARM REDUCTION PRACTICES:**  YES  NO

COMMENTS:

**CLIENT NAME:**

**CHART NUMBER:**

**AIDS Medi-Cal Waiver Program (MCWP)  
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SECTION 9 RISK ASSESSMENT AND MITIGATION	
<b>DOES THE CLIENT HAVE ANY HISTORY OF INSTANCES OF ABUSE, NEGLECT, OR EXPLOITATION?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES AND IF KNOWN, TYPE OF ABUSE:	<input type="checkbox"/> PHYSICAL <input type="checkbox"/> ISOLATION <input type="checkbox"/> VERBAL <input type="checkbox"/> NEGLECT BY SELF OR OTHER
	<input type="checkbox"/> FINANCIAL <input type="checkbox"/> ABANDONMENT <input type="checkbox"/> SEXUAL <input type="checkbox"/> EMOTIONAL
IDENTIFYING INSTANCE(S):	
REPORT MADE TO: <input type="checkbox"/> APS <input type="checkbox"/> CPS <input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> LONG TERM CARE OMBUDSMAN	
OUTCOME:	
COMMENTS:	

SECTION 10 SUMMARY/CONCLUSIONS

SECTION 11 PLAN

SECTION 12 CERTIFICATION	
<b>CLIENT MEETS THE MINIMUM NURSING FACILITY LEVEL OF CARE CRITERIA:</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____
NURSE CASE MANAGER SIGNATURE/CREDENTIALS	DATE

<b>CLIENT NAME:</b> _____	<b>CHART NUMBER:</b> _____
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### Medication Sheet

**AIDS Medi-Cal Waiver Program (MCWP) Client  
MEDICATION SHEET**

Start Date	Stop Date	Generic Name	Brand Name	Dose	Scheduled times
<b>Nucleoside Analog Reverse Transcriptase Inhibitors (NRTI's)</b>					
		Abacavir	Ziagen		
		Abacavir / Lamivudine (Ziagen + 3TC)	Epizcom		
		Zidovudine/Lamivudine/Abacavir (AZT + 3Tc + Abacovir)	Trizivir		
		Zidovudine/Lamivudine (AZT + 3TC)	Combivir		
		Didanosine (ddl)	Videx		
		Emtricitabine (FTC)	Emtriva		
		Lamivudine (3TC)	Epivir		
		Stavudine (d4T)	Zerit		
		Tenofovir	Viread		
		Tenofovir / Emtricitabine (Viread + Emtriva)	Truvada		
		Zalcitabine (ddC)	Hivid		
		Zidovudine (AZT or ZDV)	Retrovir		
<b>Protease Inhibitors (PI's)</b>					
		Amprenavir (APV)	Agenerase		
		Atazanavir	Reyataz		
		Fosamprenavir	Lexiva		
		Indinavir (IDV)	Crixivan		
		Lopinavir	Kaletra		
		Nelfinavir (NFV)	Viracept		
		Ritonavir (RTV)	Norvir		
		Saquinavir (SQV)	Fortovase		
<b>Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI's)</b>					
		Delavirdine	Rescriptor		
		Efavirenz	Sustiva		
		Nevirapine	Viramune		
<b>HIV-1 Entry Inhibitors</b>					
		Fuzeon (T-20)	Enfuvirtide		
<b>Allergies to Medications:</b>					

NURSE CASE MANAGER SIGNATURE/CREDENTIALS	DATE:

CLIENT NAME:	CHART NUMBER:
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## CFA Scale for Persons with HIV Disease/AIDS - Definitions

### 1. NUTRITION

<u>INDEPENDENT</u> - Able to do all meal planning, shopping, and preparation.	11
<u>MINIMAL ASSISTANCE</u> - Knowledge deficit or needs assistance with planning or shopping.	7
<u>MODERATE ASSISTANCE</u> - Home-delivered meals, needs assistance with meal preparation, or physiological impairment such as nausea, vomiting, weight loss or malnourishment.	5
<u>CONSIDERABLE ASSISTANCE</u> - Alternative or artificial therapy including tube feedings or must be fed by others.	3
<u>TOTALLY DEPENDENT</u> – Intravenous fluids or TPN only or no intake.	1

### 2. HYGIENE

<u>INDEPENDENT</u> – Able to perform personal hygiene and dressing without assistance.	11
<u>MINIMAL ASSISTANCE</u> – Tire easily, needs adaptive devices, and/or supervision.	7
<u>MODERATE ASSISTANCE</u> – Able to perform personal hygiene and dressing with assistance of one person.	5
<u>CONSIDERABLE ASSISTANCE</u> – Assistance with entire bath and dressing. Cannot stand independently.	3
<u>TOTALLY DEPENDENT</u> – Bed bath only. Does not or should not be dressed.	1

### 3. EXCRETION

<u>INDEPENDENT</u> – Fully continent. Up to bathroom alone. Able to complete all toileting functions without assistance.	11
<u>MINIMAL ASSISTANCE</u> – Continent with assistance. Tires easily.	7
<u>MODERATE ASSISTANCE</u> – Stress or occasional incontinence. May need some assistance or adaptive device.	5
<u>CONSIDERABLE ASSISTANCE</u> - Frequent incontinence. Needs adaptive devices and assistance.	3
<u>TOTALLY DEPENDENT</u> - No bowel or bladder control. Needs maximum assistance.	1

#### 4. ACTIVITY

<u>INDEPENDENT</u> - No physical limitations.	11
<u>MINIMAL ASSISTANCE</u> – Ambulates independently but requires frequent rest and/or adaptive devices. Tires easily.	7
<u>MODERATE ASSISTANCE</u> - Unable to ambulate without assistance and/or adaptive devices. Unsteady gait.	5
<u>CONSIDERABLE ASSISTANCE</u> - Unable to ambulate or falls frequently.	3
<u>TOTALLY DEPENDENT</u> - Bedridden. Unable to move self in bed. Cannot transfer self.	1

#### 5. TREATMENTS/MEDICATIONS

<u>INDEPENDENT</u> - No or self-administered medications. Able to access medical services without assistance.	11
<u>MINIMAL ASSISTANCE</u> - Self-administers medications/treatments and requires intermittent instruction and observation. May need reminder to take medications.	7
<u>MODERATE ASSISTANCE</u> - Administration requires supervision and/or assistance.	5
<u>CONSIDERABLE ASSISTANCE</u> - Frequent administration of medications/treatments with maximum assistance.	3
<u>TOTALLY DEPENDENT</u> - No self-administration. Comfort measures only.	1

#### 6. TEACHING

<u>INDEPENDENT</u> - Able to obtain and understand information independently.	11
<u>MINIMAL ASSISTANCE</u> - Knowledge deficit. Guidance needed in accessing information and resources.	7
<u>MODERATE ASSISTANCE</u> - Moderate teaching required with ongoing reinforcement.	5
<u>CONSIDERABLE ASSISTANCE</u> - Detailed in-depth teaching required. Communication barriers/sensory defects.	3
<u>TOTALLY DEPENDENT</u> - Unresponsive.	1

#### 7. SUPPORT SYSTEMS

<u>INDEPENDENT</u> - Independently accesses available support systems.	11
<u>MINIMAL ASSISTANCE</u> - Guidance needed in accessing available support systems.	7
<u>MODERATE ASSISTANCE</u> - Some support systems in place. Occasional intervention.	5
<u>CONSIDERABLE ASSISTANCE</u> - Limited resources available. Ongoing assistance required accessing support systems. More than one HIV-infected household member.	3
<u>TOTALLY DEPENDENT</u> - No identifiable support systems.	1

**8. MENTAL STATUS**

<u>INDEPENDENT</u> - Alert and oriented.	11
<u>MINIMAL ASSISTANCE</u> - Deficit in concentration, thought process, memory and/or insight.	7
<u>MODERATE ASSISTANCE</u> - Substantial deficit in concentration, thought process, memory and/or insight requiring supervision and/or assistance. Safety risk.	5
<u>CONSIDERABLE ASSISTANCE</u> - Responses minimal. Disabling dementia or other psychiatric diagnosis.	3
<u>TOTALLY DEPENDENT</u> - Unresponsive.	1

**9. BEHAVIOR**

<u>INDEPENDENT</u> - Self-directed, cooperative, active in decision-making.	11
<u>MINIMAL ASSISTANCE</u> - Socially appropriate. May require encouragement to initiate interactions but follows through.	7
<u>MODERATE ASSISTANCE</u> - Passive, resistant, or poor compliance. Requires continuous encouragement to follow through.	5
<u>CONSIDERABLE ASSISTANCE</u> - Non-compliant. Unpredictable, socially inappropriate.	3
<u>TOTALLY DEPENDENT</u> – Unresponsive.	1

### CFA Scale Rating Form

Cognitive and Functional Ability Scale (CFA) Rating Form						
AREAS ASSESSED	DATE:					
	INITIALS:					
<b>1. NUTRITION</b> INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
<b>2. HYGIENE</b> INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
<b>3. EXCRETION</b> INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
<b>4. ACTIVITY</b> INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
<b>5. TREATMENT/MEDICATION</b> INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
<b>6. TEACHING</b> INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
<b>7. SUPPORT SYSTEMS</b> INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
<b>8. MENTAL STATUS</b> INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
<b>9. BEHAVIOR</b> INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
<b>TOTAL RATING</b>						
<b>NFLOC OR HIGHER? (MCWP ONLY)</b>	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

  

NURSE CASE MANAGER SIGNATURE/CREDENTIALS	INITIALS:	DATE:
SOCIAL WORK CASE MANAGER SIGNATURE/CREDENTIALS	INITIALS:	DATE:

  

CLIENT NAME:	CHART NUMBER:
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Cognitive and Functional Ability Scale  
MCWP 5 (Rev. 5/10) (S)

## Initial Psychosocial Assessment

AIDS Medi-Cal Waiver Program (MCWP) Initial Psychosocial Assessment	
SECTION 1 CLIENT IDENTIFYING INFORMATION	
<b>DATE OF ASSESSMENT:</b>	<b>LOCATION OF ASSESSMENT:</b> <input type="checkbox"/> CLIENT HOME <input type="checkbox"/> CASE MANAGER OFFICE <input type="checkbox"/> MEDICAL OFFICE <input type="checkbox"/> OTHER:
<b>ADDRESS:</b> STREET _____ CITY _____ ZIP CODE _____ MAIL OK? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>PHONE:</b> _____ OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS: _____
<b>DATE OF HIV DIAGNOSIS:</b> _____ <b>DATE OF AIDS DIAGNOSIS:</b> _____	<b>MODE OF TRANSMISSION:</b> <input type="checkbox"/> SEXUAL CONTACT <input type="checkbox"/> IV DRUG USE <input type="checkbox"/> BIRTH <input type="checkbox"/> BREAST FEEDING
<b>UNDERSTANDING OF HIV/AIDS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS: _____	<b>PREVIOUS EXPERIENCE(S) WITH HEALTH CARE SYSTEM:</b> <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR COMMENTS: _____
<b>GENDER:</b> <input type="checkbox"/> MALE <input type="checkbox"/> OTHER <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> TRANSGENDER <input type="checkbox"/> FEMALE-TO-MALE <input type="checkbox"/> MALE-TO-FEMALE <input type="checkbox"/> DECLINED TO STATE	
<b>CLIENT SSN:</b> _____	<b>DOB:</b> _____
<b>AGE:</b> _____	
<b>SEXUAL ORIENTATION:</b> <input type="checkbox"/> HOMOSEXUAL <input type="checkbox"/> HETEROSEXUAL <input type="checkbox"/> BISEXUAL <input type="checkbox"/> DECLINED TO STATE	<b>RELATIONSHIP STATUS/NAME:</b> <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> DIVORCED <input type="checkbox"/> SIGNIFICANT OTHER <input type="checkbox"/> WIDOWED AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT AWARE OF RELATIONSHIP'S STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>PRIMARY LANGUAGE:</b> <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER	<b>RACE:</b> White <b>ETHNICITY:</b> African American Black    Laotian <b>CULTURAL ISSUES:</b>
<b>RELIGIOUS/SPIRITUAL PREFERENCE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS: _____	<b>PRIMARY MEDICAL PROVIDER:</b> NAME: _____ ADDRESS: _____ PHONE: _____
<b>EMERGENCY CONTACT:</b> <b>PRIMARY:</b> NAME: _____ RELATIONSHIP: _____ PHONE: _____ AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>SECONDARY:</b> NAME: _____ RELATIONSHIP: _____ PHONE: _____ AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>OTHER SERVICE PROVIDERS:</b> _____    AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>CLIENT NAME:</b> _____	
<b>CHART NUMBER:</b> _____	

**AIDS Medi-Cal Waiver Program (MCWP)  
Initial Psychosocial  
Assessment**

SECTION 2 LEGAL INFORMATION	
<b>HISTORY OF ARRESTS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN: WHERE: REASON:	<b>HISTORY OF INCARCERATIONS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN: WHERE: REASON:
<b>ON PAROLE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>ON PROBATION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>DPOA FOR HEALTHCARE COMPLETED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> WANTS DECLINES: HEALTHCARE AGENT NAME: HEALTHCARE AGENT PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>DPOA FOR FINANCIAL COMPLETED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> WANTS DECLINES: FINANCIAL AGENT NAME: FINANCIAL AGENT PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>WILL COMPLETED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>ATTORNEY:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: ADDRESS: PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>CONSERVATOR/GUARDIAN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>REPRESENTATIVE PAYEE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>CODE STATUS:</b> DNR: <input type="checkbox"/> YES <input type="checkbox"/> NO FULL: <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>FUNERAL ARRANGEMENTS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>GUARDIAN OF MINOR CHILDREN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>PROTECTIVE SERVICES INVOLVED :</b> APS: <input type="checkbox"/> YES <input type="checkbox"/> NO CPS: <input type="checkbox"/> YES <input type="checkbox"/> NO AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>LEGAL ASSISTANCE/REFERRAL NEEDED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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SECTION 3 RISK ASSESSMENT AND MITIGATION									
<p><b>DOES THE CLIENT HAVE ANY HISTORY OF INSTANCES OF ABUSE, NEGLECT, OR EXPLOITATION?</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF YES AND IF KNOWN, TYPE OF ABUSE:</p> <table style="width:100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> PHYSICAL</td> <td style="width: 50%; border: none;"><input type="checkbox"/> FINANCIAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> ISOLATION</td> <td style="border: none;"><input type="checkbox"/> ABANDONMENT</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> VERBAL</td> <td style="border: none;"><input type="checkbox"/> SEXUAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> NEGLECT BY SELF OR OTHER</td> <td style="border: none;"><input type="checkbox"/> EMOTIONAL</td> </tr> </table> <p>IDENTIFYING INSTANCE(S):                  REPORT MADE TO: <input type="checkbox"/> APS <input type="checkbox"/> CPS <input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> LONG TERM CARE OMBUDSMAN                  OUTCOME:                  COMMENTS:</p>		<input type="checkbox"/> PHYSICAL	<input type="checkbox"/> FINANCIAL	<input type="checkbox"/> ISOLATION	<input type="checkbox"/> ABANDONMENT	<input type="checkbox"/> VERBAL	<input type="checkbox"/> SEXUAL	<input type="checkbox"/> NEGLECT BY SELF OR OTHER	<input type="checkbox"/> EMOTIONAL
<input type="checkbox"/> PHYSICAL	<input type="checkbox"/> FINANCIAL								
<input type="checkbox"/> ISOLATION	<input type="checkbox"/> ABANDONMENT								
<input type="checkbox"/> VERBAL	<input type="checkbox"/> SEXUAL								
<input type="checkbox"/> NEGLECT BY SELF OR OTHER	<input type="checkbox"/> EMOTIONAL								

SECTION 4 SOCIAL STATUS																																					
<p><b>PRIMARY CAREGIVER:</b>                  NAME: _____ AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO                  RELATIONSHIP: _____ OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO                  PHONE: _____ CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>																																					
<p><b>FAMILY OF ORIGIN:</b>                  MEMBERS: _____                  DYNAMICS: _____                  AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO                  CLIENT-SIGNED CONSENT FOR COMMUNICATION:  <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p><b>CHILDREN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO                  STATUS: _____                  LOCATION: _____                  COMMENTS: _____                  AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO                  CLIENT-SIGNED CONSENT FOR COMMUNICATION:  <input type="checkbox"/> YES <input type="checkbox"/> NO</p>																																				
<p><b>SUPPORT SYSTEM:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width: 25%;">FAMILY:</td> <td style="width: 25%;">AWARE OF STATUS:</td> <td style="width: 25%;">IMPACT OF DIAGNOSIS:</td> </tr> <tr> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>CHILDREN:</td> <td>AWARE OF STATUS:</td> <td>IMPACT OF DIAGNOSIS:</td> </tr> <tr> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>FRIENDS:</td> <td>AWARE OF STATUS:</td> <td>IMPACT OF DIAGNOSIS:</td> </tr> <tr> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>NEIGHBORS:</td> <td>AWARE OF STATUS:</td> <td>IMPACT OF DIAGNOSIS:</td> </tr> <tr> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>GROUPS:</td> <td>AWARE OF STATUS:</td> <td>IMPACT OF DIAGNOSIS:</td> </tr> <tr> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>ORGANIZATIONS:</td> <td>AWARE OF STATUS:</td> <td>IMPACT OF DIAGNOSIS:</td> </tr> <tr> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> </table> <p>CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO                  COMMENTS:</p>		FAMILY:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	CHILDREN:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	FRIENDS:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	NEIGHBORS:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	GROUPS:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	ORGANIZATIONS:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
FAMILY:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:																																			
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO																																			
CHILDREN:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:																																			
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO																																			
FRIENDS:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:																																			
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO																																			
NEIGHBORS:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:																																			
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO																																			
GROUPS:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:																																			
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO																																			
ORGANIZATIONS:	AWARE OF STATUS:	IMPACT OF DIAGNOSIS:																																			
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO																																			
<p><b>EDUCATION:</b>  <input type="checkbox"/> 8<sup>TH</sup> GRADE OR LESS <input type="checkbox"/> SOME HIGH SCHOOL  <input type="checkbox"/> FINISHED HIGH SCHOOL <input type="checkbox"/> GED  <input type="checkbox"/> SOME COLLEGE <input type="checkbox"/> FINISHED COLLEGE</p>	<p><b>DOES CLIENT HAVE PETS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO                  COMMENTS: _____</p> <p><b>HOBBIES/INTERESTS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO                  COMMENTS: _____</p>																																				
<p><b>LIVING SITUATION:</b>                  NAME OF PERSON(S) LIVING WITH: _____                  AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO                  OK TO LEAVE SPECIFIC MESSAGE: <input type="checkbox"/> YES <input type="checkbox"/> NO                  CLIENT-SIGNED CONSENT FOR COMMUNICATION:  <input type="checkbox"/> YES <input type="checkbox"/> NO                  COMMENTS:</p>	<p><b>LIVING ENVIRONMENT ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO                  COMMENTS: _____</p>																																				
<p><b>SUPPORT/REFERRAL NEEDED FOR CHILD CARE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO                  COMMENTS:</p>																																					

<b>CLIENT NAME:</b> _____	<b>CHART NUMBER:</b> _____
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SECTION 5 MENTAL HEALTH/EMOTIONAL STATUS	
<b>FAMILY HISTORY OF MENTAL HEALTH ISSUE(S):</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>CLIENT MENTAL HEALTH HISTORY:</b> <input type="checkbox"/> NO <input type="checkbox"/> YES, ACTIVE PROBLEM WITHIN LAST 3 MONTHS <input type="checkbox"/> YES, NOT ACTIVE PROBLEM WITHIN LAST 3 MONTHS
<b>EMOTIONAL STATE AT TIME OF DIAGNOSIS:</b>	<b>CURRENT EMOTIONAL STATE REGARDING DIAGNOSIS:</b>
<b>CURRENT PSYCHIATRIST:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>CURRENT PSYCHIATRIC MEDICATIONS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO MEDS: IF TAKING, ADHERENT: <input type="checkbox"/> YES <input type="checkbox"/> NO MONITORING NEEDED: <input type="checkbox"/> YES <input type="checkbox"/> NO BARRIERS TO ADHERENCE:  <b>CURRENT PSYCHIATRIC DIAGNOSIS:</b>
<b>CURRENT TREATMENT STATUS:</b> <input type="checkbox"/> NOT APPLICABLE <input type="checkbox"/> IN TREATMENT <input type="checkbox"/> WAITING LIST FOR TREATMENT <input type="checkbox"/> REFUSED TREATMENT <input type="checkbox"/> COMPLETED TREATMENT <input type="checkbox"/> PRE-TREATMENT PROCESS <input type="checkbox"/> DROPPED OUT OF TREATMENT <input type="checkbox"/> NO ACTIVE TREATMENT <input type="checkbox"/> RESUMED TREATMENT <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN	
<b>COPING STRATEGIES:</b>	<b>STRENGTHS:</b> <b>WEAKNESSES:</b>
<b>CURRENT THERAPIST:</b> AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>ANXIETY ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>DEPRESSION ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>AIDS RELATED DEMENTIA ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>DEATH AND DYING ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>BODY IMAGE ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>DISCLOSURE ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>CONFIDENTIALITY ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>PARTNER NOTIFICATION ISSUES:</b> COMMENTS:
<b>THERAPIST/SUPPORT GROUP/OTHER MENTAL HEALTH SUPPORT/REFERRAL NEEDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>MENTAL HEALTH EVALUATION WARRANTED:</b> <input type="checkbox"/> YES <input type="checkbox"/> COMMENTS:	

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**SECTION 6  
CURRENT MENTAL STATUS EXAMINATION (MSE)**

<b>APPEARANCE:</b>		
GROOMING: <input type="checkbox"/> NEAT/CLEAN	<input type="checkbox"/> DISHEVELED/DIRTY	<b>EYE CONTACT:</b>
HYGIENE: <input type="checkbox"/> CLEAN	<input type="checkbox"/> MALODOROUS	<input type="checkbox"/> APPROPRIATE
AGE: <input type="checkbox"/> LOOKS OLDER THAN AGE	<input type="checkbox"/> LOOKS YOUNGER THAN AGE	<input type="checkbox"/> MINIMAL ERRATIC
OTHER:		<input type="checkbox"/> NONE
<b>BEHAVIOR/MOTOR ACTIVITY:</b>		
<input type="checkbox"/> RELAXED	<input type="checkbox"/> THREATENING	<input type="checkbox"/> APPROPRIATE TO SITUATION
<input type="checkbox"/> RESTLESS	<input type="checkbox"/> CATATONIC	<input type="checkbox"/> INAPPROPRIATE TO SITUATION
<input type="checkbox"/> PACING	<input type="checkbox"/> POSTURING	<input type="checkbox"/> OTHER:
<input type="checkbox"/> SEDATE	<input type="checkbox"/> TREMORS/TICS	
<b>ATTITUDE:</b>		
<input type="checkbox"/> CALM	<input type="checkbox"/> EVASIVE	<input type="checkbox"/> MANIPULATIVE
<input type="checkbox"/> PLEASANT	<input type="checkbox"/> GUARDED	<input type="checkbox"/> WITHDRAWN
<input type="checkbox"/> COOPERATIVE	<input type="checkbox"/> SUSPICIOUS	<input type="checkbox"/> HOSTILE
<input type="checkbox"/> RESISTANT	<input type="checkbox"/> DEMANDING	<input type="checkbox"/> OTHER
<input type="checkbox"/> DEFENSIVE		
<b>SPEECH:</b>		
<input type="checkbox"/> SLOW	<input type="checkbox"/> SLURRED	<input type="checkbox"/> INCREASED QUANTITY
<input type="checkbox"/> RAPID	<input type="checkbox"/> SOFT	<input type="checkbox"/> DECREASED QUANTITY
<input type="checkbox"/> CLEAR	<input type="checkbox"/> LOUD	<input type="checkbox"/> OTHER:
<input type="checkbox"/> MUMBLED		
<b>MOOD:</b>		
<input type="checkbox"/> NORMAL	<input type="checkbox"/> AGITATED	<input type="checkbox"/> FEARFUL
<input type="checkbox"/> EUPHORIC	<input type="checkbox"/> ANXIOUS	<input type="checkbox"/> ELATED
<input type="checkbox"/> ELEVATED	<input type="checkbox"/> APATHETIC	<input type="checkbox"/> SAD
<input type="checkbox"/> DEPRESSED	<input type="checkbox"/> PLEASANT	<input type="checkbox"/> OTHER:
<input type="checkbox"/> ANGRY	<input type="checkbox"/> UNPLEASANT	
<input type="checkbox"/> IRRITABLE	<input type="checkbox"/> NEUTRAL	
<b>AFFECT:</b>		
<input type="checkbox"/> BROAD	<input type="checkbox"/> FLAT	<input type="checkbox"/> INAPPROPRIATE TO SITUATION
<input type="checkbox"/> RESTRICTED	<input type="checkbox"/> LABILE	<input type="checkbox"/> OTHER:
<input type="checkbox"/> BLUNTED	<input type="checkbox"/> APPROPRIATE TO SITUATION	
<b>ORIENTATION:</b>		<b>ATTENTION:</b>
<input type="checkbox"/> PERSON	<input type="checkbox"/> TIME	<input type="checkbox"/> NORMAL
<input type="checkbox"/> PLACE	<input type="checkbox"/> SITUATION	<input type="checkbox"/> HYPER
		<input type="checkbox"/> VIGILANT
		<input type="checkbox"/> DISTRACTIBLE
<b>CONCENTRATION:</b>		<b>MEMORY:</b>
<input type="checkbox"/> GOOD		IMMEDIATE: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR
<input type="checkbox"/> FAIR		RECENT: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR
<input type="checkbox"/> POOR		REMOTE: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR
<b>THOUGHT CONTENT:</b>		
<input type="checkbox"/> IDEAS OF REFERENCE	<input type="checkbox"/> DELUSIONS	<input type="checkbox"/> HYPOCHONDRIACHAL
<input type="checkbox"/> GRANDIOSITY	<input type="checkbox"/> DEPERSONALIZATION	<input type="checkbox"/> RELIGIOUSLY PREOCCUPIED
<input type="checkbox"/> PHOBIAS	<input type="checkbox"/> SUICIDAL IDEATIONS	<input type="checkbox"/> SEXUALLY PREOCCUPIED
<input type="checkbox"/> OBSESSIONS/COMPULSIONS	<input type="checkbox"/> HOMICIDAL IDEATIONS	<input type="checkbox"/> OTHER:

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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SECTION 7 SUBSTANCE USE/ABUSE INFORMATION	
<b>FAMILY HISTORY OF SUBSTANCE USE/ABUSE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	
<b>CLIENT HISTORY OF SUBSTANCE USE/ABUSE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>SUBSTANCES(S) OF CHOICE:</b> <input type="checkbox"/> ALCOHOL <input type="checkbox"/> CAFFEINE <input type="checkbox"/> CANNABIS <input type="checkbox"/> NICOTINE <input type="checkbox"/> HEROIN <input type="checkbox"/> INHALANTS <input type="checkbox"/> CRACK/COCAINE <input type="checkbox"/> GHB/ECSTACY/KETAMINE <input type="checkbox"/> CRANK/METH/SPEED <input type="checkbox"/> HALLUCINOGENS <input type="checkbox"/> PRESCRIPTIONS <input type="checkbox"/> OTHER
<b>TREATMENT HISTORY:</b> INPATIENT: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE(S): OUTPATIENT: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE(S):	<b>CURRENT TREATMENT STATUS:</b> INPATIENT: <input type="checkbox"/> YES <input type="checkbox"/> NO OUTPATIENT: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>CURRENT USE/ABUSE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>SUBSTANCES(S) OF CHOICE:</b> <input type="checkbox"/> ALCOHOL <input type="checkbox"/> CAFFEINE <input type="checkbox"/> CANNABIS <input type="checkbox"/> NICOTINE <input type="checkbox"/> HEROIN <input type="checkbox"/> INHALANTS <input type="checkbox"/> CRACK/COCAINE <input type="checkbox"/> GHB/ECSTACY/KETAMINE <input type="checkbox"/> CRANK/METH/SPEED <input type="checkbox"/> HALLUCINOGENS <input type="checkbox"/> PRESCRIPTIONS <input type="checkbox"/> OTHER
<b>UNDERSTANDING OF HARM REDUCTION PRACTICES</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>IF ACTIVELY USING, PRACTICING HARM REDUCTION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>DETOX OR TREATMENT PROGRAM NEEDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	
<b>REFERRAL TO AA, OUTPATIENT TREATMENT NEEDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	

SECTION 8 RISK FACTORS FOR HIV TRANSMISSION	
<b>NEEDLE SHARING:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>SEX WORK:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>UNPROTECTED SEX WITH MEN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>UNPROTECTED SEX WITH WOMEN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>SEX WITH IDU:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>SEX WITH HIV+ INDIVIDUAL:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>UNDERSTANDING OF HARM REDUCTION PRACTICES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>PRACTICING HARM REDUCTION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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SECTION 9 FOOD/HOUSING/TRANSPORTATION		
<b>CLIENT CURRENTLY RECEIVES:</b>		
<b>FOOD:</b> <input type="checkbox"/> FOOD BANK <input type="checkbox"/> FOOD VOUCHERS <input type="checkbox"/> MEALS ON WHEELS <input type="checkbox"/> OTHER	<b>HOUSING:</b> <input type="checkbox"/> HOPWA <input type="checkbox"/> SECTION 8 <input type="checkbox"/> OTHER	<b>TRANSPORTATION:</b> <input type="checkbox"/> BUS <input type="checkbox"/> TAXI <input type="checkbox"/> OTHER
<b>FOOD/HOUSING/TRANSPORTATION ASSISTANCE/REFERRAL NEEDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>COMMENTS:</b>		

SECTION 10 PRACTICAL SUPPORT		
<b>ACTIVITIES OF DAILY LIVING:</b>		
	<b>HOW ARE NEEDS MET/BY WHOM:</b>	<b>ASSISTANCE REQUIRED:</b>
MEALS		SEE SECTION 9
TRANSPORTATION		SEE SECTION 9
PERSONAL CARE		<input type="checkbox"/> YES <input type="checkbox"/> NO
HOUSEKEEPING		<input type="checkbox"/> YES <input type="checkbox"/> NO
MOBILITY		<input type="checkbox"/> YES <input type="checkbox"/> NO
MEDICATIONS		<input type="checkbox"/> YES <input type="checkbox"/> NO
LAUNDRY		<input type="checkbox"/> YES <input type="checkbox"/> NO
SHOPPING		<input type="checkbox"/> YES <input type="checkbox"/> NO
APPOINTMENTS		<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>ATTENDANT CARE:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>IHSS:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>HOSPICE:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>LIFELINE:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>CHILDCARE:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>ADULT DAY CARE:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>MEDICATION MANAGEMENT:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>OTHER:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Initial Psychosocial  
Assessment**

SECTION 11 FINANCIAL ASSESSMENT		
<b>EMPLOYMENT/OCCUPATION HISTORY:</b> COMMENTS:	<b>CURRENT EMPLOYMENT/OCCUPATION STATUS:</b> <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> DISABLED <input type="checkbox"/> UNEMPLOYED-LOOKING FOR WORK <input type="checkbox"/> UNEMPLOYED-NOT LOOKING FOR WORK	
<b>IF EMPLOYED, AWARE OF STATUS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>CLIENT-SIGNED CONSENT FOR COMMUNICATION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>OK TO LEAVE SPECIFIC MESSAGE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>WORK HOURS:</b>		
<b>INCOME SOURCE:</b> <input type="checkbox"/> SSI    \$ <input type="checkbox"/> SSDI    \$ <input type="checkbox"/> GA    \$	<input type="checkbox"/> TANF    \$ <input type="checkbox"/> UNEMPLOYMENT    \$ <input type="checkbox"/> FOOD STAMPS    \$	<input type="checkbox"/> WIC    \$ <input type="checkbox"/> SECTION 8    \$ <input type="checkbox"/> OTHER    \$
<b>MONTHLY EXPENSES:</b>		
HOUSING (RENT/MORTGAGE):    \$ UTILITIES (GAS & ELECTRIC):    \$ TELEPHONE:    \$ FOOD:    \$ TRANSPORTATION:    \$ MEDICAL:    \$ AUTO (LOAN & INSURANCE):    \$	CABLE    \$ CLOTHING:    \$ ENTERTAINMENT:    \$ TOBACCO:    \$ ALCOHOL:    \$ MISCELLANEOUS/OTHER:    \$	
<b>NET INCOME:</b> INCOME \$    -    EXPENSES \$    =    NET INCOME \$ COMMENTS:		
<b>FINANCIAL/BENEFITS ASSISTANCE/COUNSELING/REFERRAL NEEDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Initial Psychosocial  
Assessment**

**SECTION 12  
SUMMARY/CONCLUSIONS**

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**SECTION 13  
PLAN**

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**SECTION 14  
SIGNATURE**

_____	_____	_____
SOCIAL WORK CASE MANAGER	CREDENTIALS	DATE

CLIENT NAME:	CHART NUMBER:
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**AIDS Medi-Cal Waiver Program (MCWP)  
Home Environment  
Assessment/Reassessment**

SECTION 5 PETS				
NUMBER OF PETS:	TYPES:	ADEQUATE	INADEQUATE	N/A
PET(S) ARE CLEAN AND APPEAR HEALTHY AND SPACE IS CLEAN		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6 GENERAL ASSESSMENTS
GENERAL CONDITION OF LIVING AREA: (CLUTTER, LOOSE RUGS, WORN ELECTRICAL CORDS, WALKUP, STATE OF REPAIR, SANITATION AND SAFETY)
GENERAL COMMENTS/NEED FOR HOME MODIFICATIONS/ADAPTIVE DEVICES:
IF ELEMENT IDENTIFIED AS INADEQUATE, INTERVENTION PROVIDED (NOTE: ADDRESS IF INADEQUATE SITUATION WARRANTS OR RESULTS IN REPORTING AN INSTANCE OF ABUSE, NEGLECT, OR EXPLOITATION. IF SO, PROVIDE APPROPRIATE DOCUMENTATION IN REASSESSMENT):

SECTION 7 CERTIFICATION		
CASE MANAGER _____	CREDENTIALS _____	DATE _____

CLIENT NAME:	CHART NUMBER:
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## REASSESSMENTS

### Nursing Reassessment

AIDS Medi-Cal Waiver Program (MCWP) Nursing Reassessment	
<b>SECTION 1 IDENTIFYING INFORMATION</b>	
<b>HIV STATUS/DATE OF DIAGNOSIS:</b>	<b>MODE OF TRANSMISSION:</b>
<b>ADDRESS:</b> (IF CHANGED IN PAST 60 DAYS) STREET CITY ZIP CODE  MAIL OK? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>DATE OF REASSESSMENT:</b>
<b>PHONE:</b> IS IT OK TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>LOCATION OF REASSESSMENT:</b>
<b>RELATIONSHIP STATUS (IF CHANGED IN PAST 60 DAYS):</b> <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> DIVORCED <input type="checkbox"/> SIGNIFICANT OTHER <input type="checkbox"/> WIDOWED NAME:	
<b>EMERGENCY CONTACT (IF CHANGED IN PAST 60 DAYS):</b>	
<b>PRIMARY:</b> NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>SECONDARY:</b> NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>WHAT OTHER AGENCIES ARE ASSISTING YOU?</b>	
<b>SECTION 2 CURRENT HEALTH STATUS</b>	
<b>HIV DISEASE STATUS:</b> <input type="checkbox"/> PER CLIENT <input type="checkbox"/> PER OTHER	
<b>MOST RECENT CD4 COUNT:</b>	<b>MOST RECENT VIRAL LOAD:</b>
<b>CURRENT/ANNUAL TUBERCULOSIS STATUS:</b> LATEST TST RESULTS: DATE: LATEST CXR RESULTS: DATE: PROPHYLACTIC TREATMENT: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>ALLERGIES (IF CHANGES IN PAST 60 DAYS):</b> <input type="checkbox"/> NO KNOWN ALLERGIES <input type="checkbox"/> MEDICATION <input type="checkbox"/> FOOD <input type="checkbox"/> ENVIRONMENT COMMENTS:
<b>RECENT HIV RELATED EMERGENCY ROOM VISITS/HOSPITALIZATIONS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
REASON: LOCATIONS: COMMENTS:	DATE: LENGTH OF STAY:
<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
Nursing Reassessment MCWP 10 (Rev. 5/10) (S)	
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**AIDS Medi-Cal Waiver Program (MCWP)  
Nursing  
Reassessment**

SECTION 3 SEXUAL ACTIVITY IN PAST 60 DAYS			
<b>FEMALE:</b> SEXUALLY ACTIVE: <input type="checkbox"/> YES <input type="checkbox"/> NO  USES SAFE SEX PRACTICES: <input type="checkbox"/> YES <input type="checkbox"/> NO (REQUIRES DISCUSSION WITH CLIENT)  BIRTH CONTROL: <input type="checkbox"/> YES <input type="checkbox"/> NO METHOD:  LAST MENSTRUAL PERIOD:      DATE:  CURRENTLY PREGNANT: <input type="checkbox"/> YES <input type="checkbox"/> NO PLANS TO CONTINUE PREGNANCY <input type="checkbox"/> YES <input type="checkbox"/> NO PLANS TO TERMINATE PREGNANCY <input type="checkbox"/> YES <input type="checkbox"/> NO UNDECIDED <input type="checkbox"/> YES <input type="checkbox"/> NO  UNDERSTANDS TREATMENT OPTIONS <input type="checkbox"/> YES <input type="checkbox"/> NO FOR VERTICAL TRANSMISSION RISK REDUCTION  DATE OF LAST PAP: <input type="checkbox"/> NORMAL RESULTS OF LAST PAP: <input type="checkbox"/> ABNORMAL  PERFORMS SBE MONTHLY: <input type="checkbox"/> YES <input type="checkbox"/> NO  DATE OF LAST MAMMOGRAM: <input type="checkbox"/> NORMAL RESULTS OF MAMMOGRAM: <input type="checkbox"/> ABNORMAL  VAGINAL BURNING, ITCHING, <input type="checkbox"/> YES <input type="checkbox"/> NO DISCHARGE COMMENTS:	<b>MALE:</b> SEXUALLY ACTIVE: <input type="checkbox"/> YES <input type="checkbox"/> NO  USES SAFE SEX PRACTICES: <input type="checkbox"/> YES <input type="checkbox"/> NO (REQUIRES DISCUSSION WITH CLIENT)  PROSTATE DISORDER: <input type="checkbox"/> YES <input type="checkbox"/> NO  LAST RECTAL/PROSTATE EXAM: <input type="checkbox"/> NORMAL RESULTS OF RECTAL/PROSTATE EXAM: <input type="checkbox"/> ABNORMAL  LAST PSA TEST: <input type="checkbox"/> NORMAL RESULTS OF PSA TEST: <input type="checkbox"/> ABNORMAL  PERFORMS SELF TESTICULAR <input type="checkbox"/> YES <input type="checkbox"/> NO EXAM MONTHLY: COMMENTS:		

SECTION 4 SERVICE PROVIDERS	
<b>PRIMARY MEDICAL PROVIDER:</b> CHANGES: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE INFORMATION BELOW: NAME: STREET ADDRESS: CITY AND ZIP CODE PHONE NUMBER:	<b>PHARMACY:</b> CHANGES: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE INFORMATION BELOW: NAME: STREET ADDRESS: CITY AND ZIP CODE PHONE NUMBER:
<b>DENTIST:</b> CHANGES: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE INFORMATION BELOW: NAME: STREET ADDRESS: CITY AND ZIP CODE PHONE NUMBER:	<b>OTHER PROVIDERS:</b> CHANGES: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE INFORMATION BELOW: NAME: STREET ADDRESS: CITY AND ZIP CODE PHONE NUMBER:

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Nursing  
Reassessment**

SECTION 5 SYSTEMS REVIEW OF PAST 60 DAYS	
GENERAL APPEARANCE:	
CHIEF COMPLAINT:	CLIENT'S PERCEPTION OF ILLNESS:
VITAL SIGNS AS INDICATED: TEMPERATURE: PULSE: BLOOD PRESSURE: RESPIRATIONS:	
<b>HEAD AND NECK: (CHECK ALL THAT APPLY)</b> <input type="checkbox"/> NO PROBLEMS IDENTIFIED <input type="checkbox"/> HEADACHES <input type="checkbox"/> MASSES/NODES COMMENTS/SEVERITY/FREQUENCY:	<b>EYES: (CHECK ALL THAT APPLY)</b> <input type="checkbox"/> NO PROBLEMS IDENTIFIED <input type="checkbox"/> VISUAL CHANGE <input type="checkbox"/> FLOATERS <input type="checkbox"/> ITCHING/DISCHARGE <input type="checkbox"/> REDNESS <input type="checkbox"/> GLASSES/CONTACTS <input type="checkbox"/> BLIND R/L <input type="checkbox"/> BLURRED VISION <input type="checkbox"/> LIGHT FLASHES <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> PERRLA COMMENTS/SEVERITY/FREQUENCY:

CLIENT NAME:	CHART NUMBER:
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**AIDS Medi-Cal Waiver Program (MCWP)  
Nursing  
Reassessment**

**SECTION 5  
SYSTEMS REVIEW OF PAST 60 DAYS (CONT'D)**

**EARS/NOSE:** (CHECK ALL THAT APPLY)

- NO PROBLEMS IDENTIFIED
- TINNITUS
- DEAF R/L
- HARD OF HEARING R/L
- DRAINAGE
- REDNESS

COMMENTS/SEVERITY/FREQUENCY:

**MOUTH/THROAT:** (CHECK ALL THAT APPLY)

- NO PROBLEMS IDENTIFIED
- BLEEDING GUMS
- ORAL LESIONS
- CANDIDIASIS
- DIFFICULTY SWALLOWING
- WHITE PLAQUES
- VESICLE
- HOARSENESS

COMMENTS/SEVERITY/FREQUENCY:

**CARDIAC/CIRCULATORY:** (CHECK ALL THAT APPLY)

- NO PROBLEMS IDENTIFIED
- RATE/RHYTHM
- ORTHOPNEA
- DYSPNEA ON EXERTION
- PAROXYSMAL NOCTURNAL DYSPNEA
- CHEST PAIN (DESCRIBE)
- EDEMA
- PERIPHERAL PULSES
- ASCITES
- LIPID PANELS

COMMENTS/SEVERITY/FREQUENCY:

**SKIN:** (CHECK ALL THAT APPLY)

- NO PROBLEMS IDENTIFIED
- WARM
- DRY
- MOIST
- COLOR
- POOR TURGOR
- LESIONS (LOCATION, SIZE, DRAINAGE)
- KS LESIONS
- VESICLES
- BRUISING
- ITCHING
- RASH
- NUMBNESS
- TINGLING
- PETECHIAE

COMMENTS/SEVERITY/FREQUENCY:

CLIENT NAME:

CHART NUMBER:

**AIDS Medi-Cal Waiver Program (MCWP)  
Nursing  
Reassessment**

**SECTION 5  
SYSTEMS REVIEW OF PAST 60 DAYS (CONT'D)**

**RESPIRATORY: (CHECK ALL THAT APPLY)**

- NO PROBLEMS IDENTIFIED
- RATE/RHYTHM
- APNEA
- DYSPNEA AT REST
- TACHYPNEA
- BREATH SOUNDS (DESCRIBE)
- NON-PRODUCTIVE COUGH
- PRODUCTIVE COUGH
- SOB AT REST
- DYSPNEA ON EXERTION
- OXYGEN
- CYANOSIS

COMMENTS/SEVERITY/FREQUENCY:

**GASTROINTESTINAL: (CHECK ALL THAT APPLY)**

- NO PROBLEMS IDENTIFIED
- ABDOMINAL DISTENTION
- CONSTIPATION
- CRAMPING
- BLOODY STOOLS
- FLATULENCE
- DIARRHEA
- NAUSEA/VOMITING
- HEARTBURN
- INCONTINENCE

COMMENTS/SEVERITY/FREQUENCY:

**GENITOURINARY: (CHECK ALL THAT APPLY)**

- NO PROBLEMS IDENTIFIED
- FREQUENCY
- URGENCY
- DYSURIA
- HEMATURIA
- LESION
- BURNING
- INCONTINENCE
- INFLAMMATION
- DISCHARGE/DRAINAGE

**FEMALE:**

- CANDIDIASIS
- VAGINAL DISCHARGE
- DYSMENORRHEA
- ABNORMAL BLEEDING

COMMENTS/SEVERITY/FREQUENCY:

**ENDOCRINE: (CHECK ALL THAT APPLY)**

- NO PROBLEMS IDENTIFIED
- FATIGUE
- IRRITABILITY
- MENTAL STATUS CHANGES
- WEIGHT CHANGE
- OBESITY
- BLOOD SUGAR LEVELS

COMMENTS/SEVERITY/FREQUENCY:

CLIENT NAME:

CHART NUMBER:

**AIDS Medi-Cal Waiver Program (MCWP)  
Nursing  
Reassessment**

**SECTION 5  
SYSTEMS REVIEW OF PAST 60 DAYS (CONT'D)**

<p><b>CENTRAL NERVOUS SYSTEM:</b> (CHECK ALL THAT APPLY)</p> <input type="checkbox"/> NO PROBLEMS IDENTIFIED <input type="checkbox"/> NEUROPATHY <input type="checkbox"/> SEIZURES <input type="checkbox"/> BEHAVIORAL CHANGES <input type="checkbox"/> DELUSIONS <input type="checkbox"/> APHASIA <input type="checkbox"/> FINE MOTOR CHANGES <input type="checkbox"/> TREMORS <input type="checkbox"/> SYNCOPE <input type="checkbox"/> MEMORY LOSS <input type="checkbox"/> IMPAIRED DECISION MAKING <input type="checkbox"/> HALLUCINATIONS <input type="checkbox"/> ATAXIA <input type="checkbox"/> GROSS MOTOR CHANGE <input type="checkbox"/> SLURRED SPEECH <input type="checkbox"/> VERTIGO COMMENTS/SEVERITY/FREQUENCY:	<p><b>MUSCULOSKELETAL:</b> (CHECK ALL THAT APPLY)</p> <input type="checkbox"/> NO PROBLEMS IDENTIFIED <input type="checkbox"/> MYALGIA <input type="checkbox"/> ATAXIA <input type="checkbox"/> PAIN <input type="checkbox"/> DEFORMITY (DESCRIBE) <input type="checkbox"/> PARAPLEGIC <input type="checkbox"/> SWELLING <input type="checkbox"/> STIFFNESS <input type="checkbox"/> HEMIPLEGIC COMMENTS/SEVERITY/FREQUENCY:
<p><b>PAIN:</b> (CHECK ALL THAT APPLY)</p> <input type="checkbox"/> NO PROBLEMS IDENTIFIED <b>TYPE:</b> <input type="checkbox"/> ACUTE <input type="checkbox"/> AT REST <input type="checkbox"/> CONSTANT <input type="checkbox"/> CHRONIC <input type="checkbox"/> SPORADIC <input type="checkbox"/> WITH MOVEMENT  <b>QUALITY:</b> <input type="checkbox"/> ACHING <input type="checkbox"/> THROBBING <input type="checkbox"/> BURNING <input type="checkbox"/> DULL <input type="checkbox"/> SHARP <input type="checkbox"/> PRESSURE <input type="checkbox"/> SHOOTING  COMMENTS/SEVERITY/FREQUENCY:	<p><b>MENTAL STATUS:</b> (CHECK ALL THAT APPLY)</p> <input type="checkbox"/> NO PROBLEMS IDENTIFIED <input type="checkbox"/> ALERT <input type="checkbox"/> ORIENTED: <input type="checkbox"/> OTHER (SPECIFY):  <b>MOOD:</b> AFFECT:  COMMENTS/SEVERITY/FREQUENCY:

**SECTION 6  
NUTRITION IN PAST 60 DAYS**

<p><b>PRESENT HEIGHT:</b></p>	<p><b>CURRENT WEIGHT:</b></p>
<p>WEIGHT GAIN IN PAST 60 DAYS:    <input type="checkbox"/> YES    <input type="checkbox"/> NO                  WEIGHT LOSS IN PAST 60 DAYS:    <input type="checkbox"/> YES    <input type="checkbox"/> NO                  COMMENTS:</p>	
<p><b>APPETITE:</b>  <input type="checkbox"/> EXCELLENT  <input type="checkbox"/> GOOD  <input type="checkbox"/> FAIR  <input type="checkbox"/> POOR                  CHANGES IN THE PAST 60 DAYS:    <input type="checkbox"/> YES    <input type="checkbox"/> NO                  COMMENTS:</p>	<p><b>ACTIVITY LEVEL:</b>  <input type="checkbox"/> VERY ACTIVE  <input type="checkbox"/> MODERATELY ACTIVE  <input type="checkbox"/> MILDLY ACTIVE  <input type="checkbox"/> MOSTLY SEDENTARY                  CHANGES IN THE PAST 60 DAYS:    <input type="checkbox"/> YES    <input type="checkbox"/> NO                  COMMENTS:</p>

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Nursing  
Reassessment**

SECTION 6 NUTRITION IN PAST 60 DAYS (CONT'D)	
<b>NEW FOOD ALLERGIES:</b> LIST:	<b>PRESCRIBED SPECIAL DIET:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MACROBIOTIC <span style="margin-left: 150px;"><input type="checkbox"/> DIABETIC</span> <input type="checkbox"/> VEGETARIAN <span style="margin-left: 150px;"><input type="checkbox"/> LOW FAT</span> <input type="checkbox"/> IMMUNE BOOSTING <span style="margin-left: 150px;"><input type="checkbox"/> LOW CHOLESTEROL</span> <input type="checkbox"/> LOW SODIUM <span style="margin-left: 150px;"><input type="checkbox"/> LOW PROTEIN</span> FOLLOWING: <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>PHYSIOLOGICAL ISSUES AFFECTING NUTRITION: (CHECK ALL THAT APPLY)</b> <input type="checkbox"/> NONE <span style="margin-left: 100px;"><input type="checkbox"/> CONSTIPATION</span> <span style="margin-left: 100px;"><input type="checkbox"/> DRY MOUTH</span> <input type="checkbox"/> CHEWING <span style="margin-left: 100px;"><input type="checkbox"/> DIARRHEA</span> <span style="margin-left: 100px;"><input type="checkbox"/> TASTE PERCEPTION</span> <input type="checkbox"/> SWALLOWING <span style="margin-left: 100px;"><input type="checkbox"/> ABDOMINAL CRAMPING/BLOATING</span> <span style="margin-left: 100px;"><input type="checkbox"/> APPETITE CHANGES</span> <input type="checkbox"/> NAUSEA <span style="margin-left: 100px;"><input type="checkbox"/> HEARTBURN/INDIGESTION</span> <span style="margin-left: 100px;"><input type="checkbox"/> OTHER (SPECIFY):</span> <input type="checkbox"/> VOMITING COMMENTS:	
<b>MEDICAL ISSUES AFFECTING NUTRITION: (CHECK ALL THAT APPLY)</b> <input type="checkbox"/> NONE <span style="margin-left: 100px;"><input type="checkbox"/> MOUTH SORES/GUM INFECTIONS</span> <span style="margin-left: 100px;"><input type="checkbox"/> OTHER (SPECIFY):</span> <input type="checkbox"/> ULCER/STOMACH PROBLEMS <span style="margin-left: 100px;"><input type="checkbox"/> FATIGUE</span> <input type="checkbox"/> HEART DISEASE/HYPERTENSION <span style="margin-left: 100px;"><input type="checkbox"/> FEVER</span> <input type="checkbox"/> DIABETES COMMENTS:	
<b>PSYCHOSOCIAL ISSUES AFFECTING NUTRITION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	
<b>PHYSICAL ISSUES AFFECTING NUTRITION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	
<b>FINANCIAL ISSUES AFFECTING NUTRITION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	
<b>NUTRITIONAL SUPPLEMENTS: (CHECK ALL THAT APPLY)</b> <input type="checkbox"/> VITAMINS/MINERALS <span style="margin-left: 100px;"><input type="checkbox"/> ENSURE/BOOST</span> <input type="checkbox"/> HERBS/OTHER <span style="margin-left: 100px;"><input type="checkbox"/> OTHER (SPECIFY):</span> COMMENTS:	
<b>ALTERNATIVE NUTRITION:</b> <input type="checkbox"/> TPN <span style="margin-left: 150px;"><input type="checkbox"/> LIPIDS</span> <span style="margin-left: 150px;"><input type="checkbox"/> TUBE FEEDING</span> COMMENTS:	
<b>OTHER BARRIERS TO ACHIEVING OPTIMAL NUTRITIONAL STATUS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	
<b>DOES CLIENT NEED ASSISTANCE WITH MEALS (MEALS ON WHEELS, ATTENDANT CARE, ETC.):</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	
<b>NUTRITIONAL EDUCATION PROVIDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	
<b>NUTRITIONAL REFERRAL NEEDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Nursing  
Reassessment**

<b>NUTRITIONAL SUMMARY/PLAN:</b>				
<b>SECTION 7 MEDICATION ADHERENCE IN PAST 60 DAYS</b>				
<b>ANY CHANGES IN MEDICATION REGIMEN (HAART OR OTHER):</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, REFER TO MEDICATION SHEET				
<b>CLIENT UNDERSTANDS MEDICATION REGIMEN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:				
<b>CLIENT ADHERES TO MEDICATION REGIMEN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:				
<b>CLIENT'S ABILITY TO TAKE MEDICATIONS (HAART OR OTHER):</b>				
DID THE CLIENT MISS ANY DOSES YESTERDAY? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CLIENT IS ABLE TO INDEPENDENTLY TAKE CORRECT MEDICATION(S) & DOSE AT CORRECT TIMES			
DID THE CLIENT MISS ANY DOSES THE DAY BEFORE YESTERDAY? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CLIENT IS ABLE TO TAKE CORRECT MEDICATION(S) & DOSES AT CORRECT TIMES WITH SUPERVISION OR ASSISTANCE			
	<input type="checkbox"/> CLIENT IS UNABLE TO TAKE MEDICATION(S) UNLESS ADMINISTERED BY SOMEONE ELSE			
	<input type="checkbox"/> UNABLE TO ASSESS CLIENT'S ABILITY TO TAKE MEDICATIONS			
COMMENTS:				
<b>ADHERENCE BARRIERS:</b>				
<input type="checkbox"/> NO PROBLEMS/BARRIERS	<input type="checkbox"/> MISUNDERSTANDING REGARDING MEDICATION EFFECTIVENESS			
<input type="checkbox"/> MEDICATION REGIMEN IS TOO COMPLEX	<input type="checkbox"/> NO SOCIAL SUPPORT			
<input type="checkbox"/> SCHEDULING PROBLEMS	<input type="checkbox"/> NEEDS ASSISTANCE WITH ADL'S			
<input type="checkbox"/> MENTAL STATUS CHANGES	<input type="checkbox"/> PROBLEMS OBTAINING MEDICATION OR REFILLS			
<input type="checkbox"/> ALCOHOL/DRUG USE/ABUSE	<input type="checkbox"/> CULTURAL BELIEFS			
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> LACK OF REFRIGERATION, SAFE STORAGE			
<input type="checkbox"/> MEDICATION SIDE EFFECTS	<input type="checkbox"/> CURRENT SUBSTANCE USE			
<input type="checkbox"/> LANGUAGE/CULTURAL BARRIERS				
<input type="checkbox"/> DIFFICULTY SWALLOWING MEDICATION				
COMMENTS:				
<b>IS THE CLIENT EXPERIENCING ANY OF THE FOLLOWING MEDICATION SIDE EFFECTS:</b>				
<input type="checkbox"/> ANOREXIA	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> RASH
<input type="checkbox"/> NEUROPATHY	<input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> WEIGHT GAIN	<input type="checkbox"/> NAUSEA/VOMITING	
HAS THE MEDICAL PROVIDER BEEN NOTIFIED: <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE:	TIME:	
COMMENTS:				
<b>COMPLIMENTARY ALTERNATIVE THERAPIES:</b>				
<input type="checkbox"/> ACUPUNCTURE	<input type="checkbox"/> HOMEOPATHY			
<input type="checkbox"/> ACUPRESSURE	<input type="checkbox"/> HYPNOSIS			
<input type="checkbox"/> BIOFEEDBACK	<input type="checkbox"/> MASSAGE			
<input type="checkbox"/> HERBAL	<input type="checkbox"/> OTHER:			
COMMENTS:				

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Nursing  
Reassessment**

<b>IV ACCESS/NAME AND LOCATION:</b>	<b>LOCATION:</b>	<b>LOCATION:</b>	<b>LOCATION:</b>
<input type="checkbox"/> PICC	<input type="checkbox"/> GROSHONG	<input type="checkbox"/> HICKMAN	<input type="checkbox"/> LOCATION:
<input type="checkbox"/> PORT-A-CATH	<input type="checkbox"/> LOCATION:		<input type="checkbox"/> LOCATION:
INFUSION COMPANY:			
COMMENTS:			

<b>SECTION 8 RISK FACTORS FOR HIV TRANSMISSION</b>	
<b>NEEDLE SHARING:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>SEX WORK:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>UNPROTECTED SEX WITH MEN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>UNPROTECTED SEX WITH WOMEN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>SEX WITH IDU:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>SEX WITH HIV+ INDIVIDUAL:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>DISCUSSION OF CURRENT HARM REDUCTION PRACTICES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	

<b>SECTION 9 RISK ASSESSMENT AND MITIGATION</b>
<b>WERE THERE ANY INSTANCES OF ABUSE, NEGLECT, OR EXPLOITATION OF THE CLIENT IN PAST 60 DAYS?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, TYPE OF ABUSE: <input type="checkbox"/> PHYSICAL <input type="checkbox"/> ISOLATION <input type="checkbox"/> FINANCIAL <input type="checkbox"/> ABANDONMENT <input type="checkbox"/> SEXUAL <input type="checkbox"/> VERBAL <input type="checkbox"/> NEGLECT BY SELF OR OTHER <input type="checkbox"/> EMOTIONAL
IDENTIFYING INSTANCE(S):
REPORT MADE TO: <input type="checkbox"/> APS <input type="checkbox"/> CPS <input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> LONG TERM CARE OMBUDSMAN
OUTCOME:
COMMENTS:

<b>SECTION 10 SUMMARY/FOLLOW UP ON PREVIOUSLY IDENTIFIED CONCERNS</b>

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Nursing  
Reassessment**

**SECTION 11  
PLAN/IDENTIFICATION OF POTENTIAL PROBLEMS OR CONCERNS**

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**SECTION 12  
DOCUMENTATION OF SERVICE PLAN REVIEW WITH CLIENT**

SERVICE PLAN WAS REVIEWED WITH CLIENT DURING THIS REASSESSMENT

COMMENTS:

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**SECTION 13  
CERTIFICATION**

CLIENT MEETS THE MINIMUM NURSING FACILITY LEVEL OF CARE CRITERIA:  YES  NO

\_\_\_\_\_  
NURSE CASE MANAGER SIGNATURE/CREDENTIALS

\_\_\_\_\_  
DATE

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CLIENT NAME:

CHART NUMBER:

Nursing Reassessment  
MCWP 10 (Rev. 5/10) (S)

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## Psychosocial Reassessment

<b>AIDS Medi-Cal Waiver Program (MCWP) Psychosocial Reassessment</b>			
<b>SECTION 1 CLIENT IDENTIFYING INFORMATION</b>			
<b>DATE OF REASSESSMENT:</b>  	<b>LOCATION OF REASSESSMENT:</b> <input type="checkbox"/> CLIENT HOME <input type="checkbox"/> CASE MANAGER OFFICE <input type="checkbox"/> MEDICAL OFFICE <input type="checkbox"/> OTHER:		
<b>ADDRESS IF CHANGED IN THE PAST 60 DAYS:</b> STREET: CITY:                      ZIP CODE: MAIL OK? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>PHONE:</b> OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:		
<b>RELATIONSHIP STATUS/NAME IF CHANGED IN PAST 60 DAYS:</b> <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> DIVORCED <input type="checkbox"/> SIGNIFICANT OTHER <input type="checkbox"/> WIDOWED AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO    CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT AWARE OF RELATIONSHIP'S STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>PRIMARY MEDICAL PROVIDER:</b> NAME: ADDRESS: PHONE:			
<b>EMERGENCY CONTACT:</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <b>PRIMARY:</b>            NAME:            RELATIONSHIP:            PHONE:            AWARE OF STATUS:                      <input type="checkbox"/> YES <input type="checkbox"/> NO            OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO            CLIENT-SIGNED CONSENT FOR COMMUNICATION:  <input type="checkbox"/> YES <input type="checkbox"/> NO         </td> <td style="width: 50%; border: none; vertical-align: top;"> <b>SECONDARY:</b>            NAME:            RELATIONSHIP:            PHONE:            AWARE OF STATUS:                      <input type="checkbox"/> YES <input type="checkbox"/> NO            OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO            CLIENT-SIGNED CONSENT FOR COMMUNICATION:  <input type="checkbox"/> YES <input type="checkbox"/> NO         </td> </tr> </table>		<b>PRIMARY:</b> NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>SECONDARY:</b> NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>PRIMARY:</b> NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>SECONDARY:</b> NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>OTHER SERVICE PROVIDERS:</b> AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO			

  
  

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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Psychosocial Reassessment  
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**AIDS Medi-Cal Waiver Program (MCWP)  
Psychosocial  
Reassessment**

SECTION 2 LEGAL INFORMATION IN PAST 60 DAYS	
<b>ARRESTS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN: WHERE: REASON:	<b>INCARCERATIONS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN: WHERE: REASON:
<b>ON PAROLE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>ON PROBATION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>DPOA FOR HEALTHCARE COMPLETED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> WANTS DECLINES: HEALTHCARE AGENT NAME: HEALTHCARE AGENT PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>DPOA FOR FINANCIAL COMPLETED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> WANTS DECLINES: FINANCIAL AGENT NAME: FINANCIAL AGENT PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>WILL COMPLETED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>ATTORNEY:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>CONSERVATOR/GUARDIAN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>REPRESENTATIVE PAYEE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>CODE STATUS:</b> DNR: <input type="checkbox"/> YES <input type="checkbox"/> NO FULL: <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>FUNERAL ARRANGEMENTS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>GUARDIAN OF MINOR CHILDREN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A NAME: ADDRESS: PHONE: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>PROTECTIVE SERVICES INVOLVED :</b> APS: <input type="checkbox"/> YES <input type="checkbox"/> NO CPS: <input type="checkbox"/> YES <input type="checkbox"/> NO AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>LEGAL ASSISTANCE/REFERRAL NEEDED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Psychosocial  
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SECTION 3 RISK ASSESSMENT AND MITIGATION IN PAST 60 DAYS	
WERE THERE ANY INSTANCES OF ABUSE, NEGLECT, OR EXPLOITATION OF THE CLIENT IN PAST 60 DAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, TYPE OF ABUSE:	<input type="checkbox"/> PHYSICAL <input type="checkbox"/> ISOLATION <input type="checkbox"/> FINANCIAL <input type="checkbox"/> NEGLECT BY SELF OR OTHER <input type="checkbox"/> ABANDONMENT <input type="checkbox"/> SEXUAL <input type="checkbox"/> VERBAL <input type="checkbox"/> EMOTIONAL
IDENTIFYING INSTANCE(S): REPORT MADE TO: <input type="checkbox"/> APS <input type="checkbox"/> CPS <input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> LONG TERM CARE OMBUDSMAN OUTCOME: COMMENTS:	

SECTION 4 SOCIAL STATUS IF CHANGED IN PAST 60 DAYS																			
<b>PRIMARY CAREGIVER:</b> NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO																			
<b>SUPPORT SYSTEM:</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">FAMILY: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td style="width: 33%;">AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td style="width: 33%;">IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>CHILDREN: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>FRIENDS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>NEIGHBORS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>GROUPS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>ORGANIZATIONS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> </table> CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:		FAMILY: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO	CHILDREN: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO	FRIENDS: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO	NEIGHBORS: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO	GROUPS: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO	ORGANIZATIONS: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO
FAMILY: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO																	
CHILDREN: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO																	
FRIENDS: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO																	
NEIGHBORS: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO																	
GROUPS: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO																	
ORGANIZATIONS: <input type="checkbox"/> YES <input type="checkbox"/> NO	AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IMPACT OF DIAGNOSIS: <input type="checkbox"/> YES <input type="checkbox"/> NO																	
DOES CLIENT HAVE PETS: <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:																			
NEW HOBBIES/INTERESTS: <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:																			
<b>LIVING SITUATION:</b> NAME OF PERSON(S) LIVING WITH: AWARE OF STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE SPECIFIC MESSAGE: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>LIVING ENVIRONMENT ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:																		
<b>ADDITIONAL SUPPORT/REFERRAL NEEDED FOR CHILD CARE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:																			

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Psychosocial  
Reassessment**

SECTION 5 MENTAL HEALTH/EMOTIONAL STATUS IN PAST 60 DAYS	
<b>CURRENT TREATMENT STATUS:</b> <input type="checkbox"/> NOT APPLICABLE <input type="checkbox"/> IN TREATMENT <input type="checkbox"/> WAITING LIST FOR TREATMENT <input type="checkbox"/> REFUSED TREATMENT <input type="checkbox"/> COMPLETED TREATMENT <input type="checkbox"/> PRE-TREATMENT PROCESS <input type="checkbox"/> DROPPED OUT OF TREATMENT <input type="checkbox"/> NO ACTIVE TREATMENT <input type="checkbox"/> RESUMED TREATMENT <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN	
<b>CURRENT PSYCHIATRIST:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>CURRENT PSYCHIATRIC MEDICATIONS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO MEDS: IF TAKING, ADHERENT: <input type="checkbox"/> YES <input type="checkbox"/> NO MONITORING NEEDED: <input type="checkbox"/> YES <input type="checkbox"/> NO BARRIERS TO ADHERENCE:  <b>CURRENT PSYCHIATRIC DIAGNOSIS:</b>
<b>CURRENT EMOTIONAL STATE REGARDING DIAGNOSIS:</b>	
<b>NEW COPING STRATEGIES:</b>	<b>CURRENT STRENGTHS:</b>  <b>CURRENT WEAKNESSES:</b>
<b>CURRENT THERAPIST:</b> AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>CURRENT SUPPORT GROUP:</b> AWARE OF STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO CLIENT-SIGNED CONSENT FOR COMMUNICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>ANXIETY ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>DEPRESSION ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>AIDS RELATED DEMENTIA ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>DEATH AND DYING ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>BODY IMAGE ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>DISCLOSURE ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>CONFIDENTIALITY ISSUES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>PARTNER NOTIFICATION ISSUES:</b> COMMENTS:
<b>THERAPIST/SUPPORT GROUP/OTHER MENTAL HEALTH SUPPORT/REFERRAL NEEDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>MENTAL HEALTH EVALUATION WARRANTED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
Psychosocial  
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SECTION 7 SUBSTANCE USE/ABUSE IN PAST 60 DAYS	
<b>CURRENT USE/ABUSE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>SUBSTANCES(S) OF CHOICE:</b> <input type="checkbox"/> ALCOHOL <input type="checkbox"/> CAFFEINE <input type="checkbox"/> CANNABIS <input type="checkbox"/> NICOTINE <input type="checkbox"/> HEROIN <input type="checkbox"/> INHALANTS <input type="checkbox"/> CRACK/COCAINE <input type="checkbox"/> GHB/ECSTASY/KETAMINE <input type="checkbox"/> CRANK/METH/SPEED <input type="checkbox"/> HALLUCINOGENS <input type="checkbox"/> PRESCRIPTIONS <input type="checkbox"/> OTHER
<b>CURRENT TREATMENT STATUS:</b> INPATIENT: <input type="checkbox"/> YES <input type="checkbox"/> NO OUTPATIENT: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>IF ACTIVELY USING, PRACTICING HARM REDUCTION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>IN NEED OF DETOX OR TREATMENT PROGRAM:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	
<b>REFERRAL TO AA, OUTPATIENT:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	

SECTION 8 RISK FACTORS FOR HIV TRANSMISSION IN PAST 60 DAYS	
<b>NEEDLE SHARING:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>SEX WORK:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>UNPROTECTED SEX WITH WOMEN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>UNPROTECTED SEX WITH MEN:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>SEX WITH HIV+ INDIVIDUAL:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>SEX WITH IDU:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>UNDERSTANDING OF HARM REDUCTION PRACTICES:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>PRACTICING HARM REDUCTION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
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SECTION 9 CURRENT FOOD/HOUSING/TRANSPORTATION RESOURCES/NEEDS		
<b>CLIENT CURRENTLY RECEIVES:</b>		
<b>FOOD:</b> <input type="checkbox"/> FOOD BANK <input type="checkbox"/> FOOD VOUCHERS <input type="checkbox"/> MEALS ON WHEELS <input type="checkbox"/> OTHER	<b>HOUSING:</b> <input type="checkbox"/> HOPWA <input type="checkbox"/> SECTION 8 <input type="checkbox"/> OTHER	<b>TRANSPORTATION:</b> <input type="checkbox"/> BUS <input type="checkbox"/> TAXI <input type="checkbox"/> OTHER
<b>FOOD/HOUSING/TRANSPORTATION ASSISTANCE/REFERRAL NEEDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>COMMENTS:</b>		

SECTION 10 CURRENT PRACTICAL SUPPORT		
<b>ACTIVITIES OF DAILY LIVING:</b>		
MEALS TRANSPORTATION PERSONAL CARE HOUSEKEEPING MOBILITY MEDICATIONS LAUNDRY SHOPPING APPOINTMENTS	<b>HOW ARE NEEDS MET/BY WHOM:</b>	<b>ASSISTANCE REQUIRED:</b> SEE SECTION 9 SEE SECTION 9 <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>ATTENDANT CARE:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>IHSS:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>HOSPICE:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>LIFELINE:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>CHILDCARE:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>ADULT DAY CARE:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>MEDICATION MANAGEMENT:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		
<b>OTHER:</b>	<input type="checkbox"/> RECEIVING <input type="checkbox"/> NEEDED <input type="checkbox"/> REFERRED <input type="checkbox"/> N/A	
<b>COMMENTS:</b>		

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
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SECTION 11 FINANCIAL REASSESSMENT OF PAST 60 DAYS			
<b>CURRENT EMPLOYMENT/OCCUPATION STATUS:</b> <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> DISABLED <input type="checkbox"/> UNEMPLOYED-LOOKING FOR WORK <input type="checkbox"/> UNEMPLOYED-NOT LOOKING FOR WORK		<b>IF EMPLOYED, AWARE OF STATUS:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>CLIENT-SIGNED CONSENT FOR COMMUNICATION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>OK TO LEAVE SPECIFIC MESSAGE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>WORK HOURS:</b>	
<b>INCOME SOURCE:</b> <input type="checkbox"/> SSI        \$ <input type="checkbox"/> SSDI       \$ <input type="checkbox"/> GA         \$		<input type="checkbox"/> TANF                \$ <input type="checkbox"/> UNEMPLOYMENT    \$ <input type="checkbox"/> FOOD STAMPS      \$	
<input type="checkbox"/> WIC                    \$ <input type="checkbox"/> SECTION 8          \$ <input type="checkbox"/> OTHER                \$			
<b>MONTHLY EXPENSES:</b>			
HOUSING (RENT & MORTGAGE):	\$	CABLE	\$
UTILITIES (GAS & ELECTRIC):	\$	CLOTHING:	\$
TELEPHONE:	\$	ENTERTAINMENT:	\$
FOOD:	\$	TOBACCO:	\$
TRANSPORTATION:	\$	ALCOHOL:	\$
MEDICAL:	\$	MISCELLANEOUS/OTHER:	\$
AUTO (LOAN & INSURANCE)	\$		
<b>NET INCOME:</b> INCOME \$        - EXPENSES \$        = NET INCOME \$			
COMMENTS:			
<b>FINANCIAL/BENEFITS ASSISTANCE/COUNSELING/REFERRAL NEEDED:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			

<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
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**AIDS Medi-Cal Waiver Program (MCWP)  
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Reassessment**

**SECTION 12  
SUMMARY/FOLLOW UP ON PREVIOUSLY IDENTIFIED CONCERNS**

**SECTION 13  
PLAN/IDENTIFICATION OF POTENTIAL PROBLEMS OR CONCERNS**

**SECTION 14  
SIGNATURE**

\_\_\_\_\_  
SOCIAL WORK CASE MANAGER

\_\_\_\_\_  
CREDENTIALS

\_\_\_\_\_  
DATE

**SECTION 15  
DOCUMENTATION OF SERVICE PLAN REVIEW WITH CLIENT**

SERVICE PLAN WAS REVIEWED WITH CLIENT DURING THIS REASSESSMENT  
COMMENTS:

CLIENT NAME:

CHART NUMBER:

## **COST-AVOIDANCE INSTRUCTIONS**

Cost avoidance is the process used to ensure that all available resources are screened for and accessed prior to utilization of MCWP funds when arranging client services.

### **Clients with Private Health Insurance (e.g., Kaiser, Healthnet, Blue Cross, etc.)**

For MCWP, there is a federal third-party liability/cost-avoidance requirement that applies to clients with private insurance. Certain procedures must be in place for MCWP to assure that all other sources of funding are exhausted before using program funds. This includes:

- Screening clients for other health coverage and/or private insurance payment sources for services;
- Seeking reimbursement from all other funding sources prior to billing MCWP;
- Accessing all other potential resources for services prior to using MCWP funds (see *B* in this section below);
- Advocating on behalf of the client to access other resources and services; and
- Maintaining appropriate documentation in the client record.

Waiver Agency procedures must address all items and be in the same order as the following list:

1. As part of the eligibility/intake process, a full resource evaluation is completed to obtain information concerning the client's healthcare coverage. This information is documented in the case record.
2. The NCM/SWCM contacts known payers of health care for the client to verify eligibility for coverage and to determine third-party responsibility for payment of services to the client.
3. If it is determined that the client has health insurance coverage other than Medicare and/or Medi-Cal, the NCM/SWCM verifies the benefits available under the client's health plan, including services covered under Medi-Cal and MCWP. The NCM/SWCM verifies and documents coverage limitations and exclusions, and negotiates with the insurance company case worker to assure maximum coverage is made. In cases where the insurance company is reluctant to cover services that appear to be eligible for coverage, the NCM/SWCM advocates on behalf of the client to access these services.
4. For services covered by the insurer, the NCM/SWCM finds out from the insurance company case worker, which service providers are authorized to provide the requested services and facilitates referral to the appropriate service provider. The service provider arranges for payment from the insurance company for covered services.

5. Subcontractors are required to bill all other payer sources prior to billing MCWP. This includes Medicare, Medi-Cal, and/or private insurance. Services cannot be billed to MCWP until all other payer sources have been exhausted.
6. If the client has Medicare and/or Medi-Cal, the MCWP Waiver Agency or subcontractor bills:
  - a. Medicare for all Medicare-covered services;
  - b. Medi-Cal for all Medi-Cal only covered services, utilizing the Treatment Authorization Request (TAR) process, if necessary;
  - c. HIV Care Program (HCP) for all HCP only covered services and services denied by primary payers; and
  - d. Medi-Cal for all MCWP only covered services and services denied by primary payers.
7. When there is a third-party payer, the NCM/SWCM provides the following billing information to the service provider:
  - a. Primary payer, case worker name, address, and telephone number;
  - b. Client group and policy number;
  - c. Coverage requirements and limitations; and
  - d. Prior authorization requirements, if any.
8. If there is a change in the service delivery pattern (e.g., increase in attendant care from four hours, three days/week to eight hours, seven days/week), the new orders will be documented and provided to the service provider. Contact will be made with the insurance company case worker to attempt to negotiate further coverage, as applicable.
9. The NCM/SWCM documents the lack or limitations of coverage in the case record. The subcontractor is instructed to forward a copy of the Explanation of Benefits, or other such documentation, with any bill submitted to MCWP if the client has other health coverage. (Documentation may be kept in the client chart, fiscal office, or other designated area.)
10. The Waiver Agency monitors the subcontractor's invoices to verify that services billed have prior authorization from the NCM and verifies that payment has been denied by other health coverage, when applicable.

11. Cost-avoidance activities must be documented in a standardized format in the client record, following the Waiver Agency's policy and procedures whenever program funds are used to pay for services to clients (excluding case management). This documentation must include:
  - a. A full resource evaluation including a list of all known payers of health care, and group and member number. (This should be included on the resource evaluation form);
  - b. For payers other than Medicare or Medi-Cal, the name and telephone number of the contact person/representative. (This may be included with the above information);
  - c. A record of contact made with the representative noted in item 4 above. (This should not be in progress notes. A separate log for documenting cost these contacts should be developed.);
  - d. For clients with private insurance policies, coverage limitations, and exclusions, any negotiation regarding coverage, and prior authorization requested. (This may be included with the record of contact);
  - e. Contact with service provider(s) regarding requirement to bill to private insurance or Medicare, and submit a TAR to Medi-Cal. (This may be included with the record of contact);
  - f. Written authorization by the case manager to use MCWP funds if no other funding source is available (e.g., private health insurance, Medi-Cal, Ryan White Care Act funds, county funds, etc.); and
  - g. If billing MCWP, a copy of the request for service provider(s) to forward a copy of the denial of service must be maintained in the client record or program file. (This may be included with the record of contact).

Cost avoidance also refers to accessing all other potential resources for services prior to using MCWP funds for services such as food vouchers, gas vouchers, taxi vouchers, bus passes, housing, utilities, etc. The NCM, SWCM, or other MCWP staff (e.g., case aide, benefits counselor) must document these instances of cost avoidance in the client chart each time they occur. Documentation should cover what agencies/resources were accessed, what services were requested, and why services could not be provided. This can be done either in progress notes or on a form designated for this purpose.

**Clients with or without Private Health Insurance (e.g., Medi-Cal, Medi-Cal Managed Care, Medicare, etc.)**

All other potential resources must be accessed prior to using MCWP funds, including attendant care, homemaker services, skilled nursing, food vouchers, gas vouchers, taxi

vouchers, bus passes, housing, utilities, etc. The NCM, SWCM, or other MCWP staff (e.g., case aide, benefits counselor) must document these instances of cost avoidance each time they occur. Documentation may be kept in the client chart or in a central location. Documentation should include what agencies were accessed, what services were requested, and why services could not be provided. This can be done either in progress notes or on a form designated for this purpose.

Certain situations may warrant a one-time-only documentation of cost-avoidance activities. If it has been determined that a direct care service cannot be paid for by any other funds in a given area, then it is acceptable to document one-time only that as a result, the direct care service will have to be paid for, on an ongoing basis, by MCWP funds.

For the purpose of developing a cost-avoidance policy and procedures, list the actual steps a case manager would take when providing a service to a client that will be paid for with MCWP funds.



## CASE CONFERENCES

### IDTCC Form

AIDS Medi-Cal Waiver Program (MCWP) Interdisciplinary Team Case Conference (IDTCC)	
<b>SECTION 1 SERVICE PLAN</b>	
<b>SERVICE PLAN REVIEWED:</b> (OPTIONAL) <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>CHANGES:</b> <input type="checkbox"/> YES, SEE SERVICE PLAN <input type="checkbox"/> NO
<b>SECTION 2 REVIEW OF CLIENT'S CURRENT STATUS, CHANGES, SERVICE PLAN</b>	
<b>MEDICAL:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>PSYCHOSOCIAL:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>HOUSING:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:	<b>FINANCIAL:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO COMMENTS:
<b>SECTION 3 TRANSITION PLANNING/GOALS</b>	
<b>SECTION 4 COMMENTS</b>	
<b>SECTION 5 PARTICIPANTS (INITIALS/CREDENTIALS)</b>	
<input type="checkbox"/> NURSE CASE MANAGER	_____ _____ _____
<input type="checkbox"/> SOCIAL WORK CASE MANAGER	_____ _____ _____
<input type="checkbox"/> OTHER SERVICE PROVIDERS: LIST:	_____ _____ _____
<input type="checkbox"/> PROJECT DIRECTOR <input type="checkbox"/> CLIENT/CLIENT LEGAL REPRESENTATIVE <input type="checkbox"/> ATTENDING PHYSICIAN <input type="checkbox"/> PRIMARY CARE PRACTITIONER <input type="checkbox"/> SIGNIFICANT OTHER <input type="checkbox"/> CAREGIVER	_____ _____ _____ _____
<b>SECTION 6 SIGNATURE</b>	
_____ CASE MANAGER	_____ CREDENTIALS:
_____ DATE:	
<b>CLIENT NAME:</b>	<b>CHART NUMBER:</b>
Interdisciplinary Team Case Conference (IDTCC) MCWP 13 (Rev. 5/10) (S)	
Page 1 of 1	



Standardized CSP

STANDARDIZED COMPREHENSIVE SERVICE PLAN					
DATE PROBLEM/NEED IDENTIFIED	PROBLEM/NEED	GOAL(S)	INTERVENTION(S): TYPE OF SERVICE/SERVICE PROVIDER/ QUANTITY/FREQUENCY/DURATION	P S C	START OF SERVICE
<p><b>LONG TERM GOAL(S):</b></p> <ol style="list-style-type: none"> <li>Client to remain at home in lieu of institutionalization</li> <li>Client to receive assistance in accessing and coordinating all necessary community resources.</li> <li>Client knowledgeable re: illness, disease process, medications, treatments, and timely reporting of signs &amp; symptoms</li> <li>Client's legal documents completed</li> </ol>					
	Compromised Immune Status	<ul style="list-style-type: none"> <li>Maintain Optimal Health Status.</li> <li>Advocate for self Report s/s of OIs to MD</li> </ul>	<input type="checkbox"/> See Primary Medical Provider; At Least Quarterly & PRN for one year  <input type="checkbox"/> RN/SW Case Management; Reassessment At Least q 60 Days and Contact Between Reassessments as Deemed Appropriate by Case Managers		
	Specialized Medical Care (e.g. specialty care for CMV, TB, DM, etc.) RT:	<input type="checkbox"/> Will Receive Specialty Care as Indicated.	<input type="checkbox"/> Specialty Care by Dr. _____ Quarterly & PRN for 6 months  <input type="checkbox"/> Specialty Care by Dr. _____ Quarterly & PRN for 6 months  <input type="checkbox"/> Specialty Care by Dr. _____ Quarterly & PRN for 6 months  <input type="checkbox"/> Other: _____; q _____ for 6 mos		
	Dental Care	<input type="checkbox"/> Access to Regular Dental Care.	<input type="checkbox"/> Private Dentist; q 6 Months & PRN for one year  <input type="checkbox"/> Other: _____; q _____ for _____		
<b>DATE/INITIAL/SIEVAL CODE</b>					

  

RN Case Manager: Signature / Initials SW Case Manager: Signature / Initials	Payment Source Codes Medi-Cal Waiver (MCW) _____ Private/3rd Party _____ HCP _____ Medi-Cal _____ Medicare _____ Multiple (see progress notes) _____ Other (see progress notes) _____ Care Title /Ill _____ HOPWA _____	Evaluation Codes Referral Initiated _____ Referral Refused _____ Services Refused/Cont. to Adv. _____ Services Initiated _____ Services Continued _____ Services Discontinued _____ Services Not Delivered _____ Goal Achieved _____
--------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

M.D. sent copy/notified of contents of initial plan? YES  Date: \_\_\_\_\_  
 Initial Service Plan Discussed with Client? YES

CLIENT NAME: \_\_\_\_\_ CHART NUMBER: \_\_\_\_\_

Standardized Comprehensive Service Plan  
MCWP 14 (a) (Rev. 5/10) (S)

DATE PROBLEM IDENTIFIED	PROBLEM/NEED	GOALS	INTERVENTION(S): TYPE OF SERVICE/SERVICE PROVIDER/ QUANTITY/FREQUENCY/DURATION	PSC	START OF SERVICE
	Weight Maintenance	<input type="checkbox"/> Have Access to Adequate Nutritional Resources. <input type="checkbox"/> Maintain Optimum Weight for Height	<input type="checkbox"/> Meals on Wheels--Hot Meals; Daily for 60 days <input type="checkbox"/> _____ Food Bank; q _____ for 60 days <input type="checkbox"/> Nutritional Supplements; See Attachment A <input type="checkbox"/> Food Vouchers \$ _____; q _____ for 6 mos <input type="checkbox"/> Other: _____; q _____ for 6 mos <input type="checkbox"/> Ongoing assessment by NCM		
	Requires Assistance with Activities of Daily Living/Self-Care Deficit	<input type="checkbox"/> Domestic & Personal Care Needs Will Be Met.	<input type="checkbox"/> Attendant Care (See Attachment A) <input type="checkbox"/> IHSS: _____ Hours; q Month for 60 days <input type="checkbox"/> Volunteer, <input type="checkbox"/> Family Member, <input type="checkbox"/> S/O to Provide Care; _____ hrs, q _____ for 60 days <input type="checkbox"/> Other: _____; q _____ for 60 days <input type="checkbox"/> Ongoing assessment by NCM		
	Complicated Medication Regime	<input type="checkbox"/> Will Have Access to Prescribed Medications <input type="checkbox"/> Adherence to Medication Regimen.	<input type="checkbox"/> Medication Adherence Education/Monitoring by _____; q 30-60 days for one year <input type="checkbox"/> Pharmacy: _____ <input type="checkbox"/> Weekly Delivery by Medication Service (See Attachment A) <input type="checkbox"/> ADAP Services q. month (Recertification q year due _____) <input type="checkbox"/> Other: _____; q _____		

CLIENT NAME: \_\_\_\_\_

CHART NUMBER: \_\_\_\_\_

Standardized Comprehensive Service Plan  
MCWP 14 (a) (Rev. 5/10) (S)

Page 2 of 7

DATE PROBLEM IDENTIFIED	PROBLEM/NEED	GOALS	INTERVENTION(S): TYPE OF SERVICE/SERVICE PROVIDER/ QUANTITY/FREQUENCY/DURATION	PSC	START OF SERVICE	DATE/INITIALS/EVAL CODE
	Mobility	<input type="checkbox"/> Achievement of Maximum Safe Mobility within Physical Limitations	<input type="checkbox"/> Durable Medical Equipment Provided (See Attachment A) <input type="checkbox"/> PT; _____ Hours/Week (See Attachment A) <input type="checkbox"/> OT; _____ Hours/Week (See Attachment A) <input type="checkbox"/> Alterations Made to Living Space (See Attachment A) <input type="checkbox"/> Other: _____; q _____ for _____ <input type="checkbox"/> Ongoing assessment by NCM			
	Skilled Nursing Needs	<input type="checkbox"/> Skilled Nursing Needs To Be Met per MD or RNCM Orders.	<input type="checkbox"/> Skilled Nursing Visit per orders (See Attachment A) <input type="checkbox"/> In Home Hospice (See Attachment A) <input type="checkbox"/> Residential Hospice (See Attachment A) <input type="checkbox"/> SN Facility (See Attachment A) <input type="checkbox"/> Other: _____; q _____ for _____ <input type="checkbox"/> Ongoing assessment by NCM			
	Pain Management	<input type="checkbox"/> Access to Assistance for Pain Control. <input type="checkbox"/> Pain Level will Decrease	<input type="checkbox"/> Pain Management Clinic per MD orders (See Attachment A) <input type="checkbox"/> Acupuncture / Therapeutic Massage (circle one or both) (See Attachment A) <input type="checkbox"/> PT; _____ Hours per Week (See Attachment A) <input type="checkbox"/> OT; _____ Hours per Week (See Attachment A) <input type="checkbox"/> Other: _____; q _____ for _____ <input type="checkbox"/> Ongoing assessment by NCM			

CLIENT NAME: \_\_\_\_\_ CHART NUMBER: \_\_\_\_\_

DATE PROBLEM IDENTIFIED	PROBLEM/NEED	GOALS	INTERVENTION(S): TYPE OF SERVICE/SERVICE PROVIDER/ QUANTITY/FREQUENCY/DURATION	PSC	START OF SERVICE	DATE/INITIALS/EVAL CODE
	Potential Spread of HIV	<input type="checkbox"/> Reduce risk of disease transmission	<input type="checkbox"/> Gloves <input type="checkbox"/> Probe Covers <input type="checkbox"/> Condoms <input type="checkbox"/> Sharps <input type="checkbox"/> Partner Notification (See Attachment A) <input type="checkbox"/> Ongoing assessment by NCM/SWCM			
	Immunizations	<input type="checkbox"/> Will obtain Immunizations PRN	<input type="checkbox"/> PPD Date Last Test: _____ <input type="checkbox"/> Flu Date Last Immun: _____ <input type="checkbox"/> Hep B Date Immun: _____ <input type="checkbox"/> Series Complete <input type="checkbox"/> Booster Given <input type="checkbox"/> Pneumonia Date Immun: _____ <input type="checkbox"/> Other: _____ Date Immun: _____ <input type="checkbox"/> Ongoing assessment by NCM			
	Substance Abuse	<input type="checkbox"/> Will Reduce Risk Associated with Substance Use.	<input type="checkbox"/> Inpatient Tx (See Attachment A) <input type="checkbox"/> Group Home (See Attachment A) <input type="checkbox"/> Outpatient Tx (See Attachment A) <input type="checkbox"/> 12 Step Groups _____; q week for 60 days <input type="checkbox"/> Detox (See Attachment A) <input type="checkbox"/> RN/SWCM Educator/Encourage Access to Tx/ Recovery Resources q 30-60 Days and PRN for one year <input type="checkbox"/> Other: _____; q _____ for _____			

CLIENT NAME: \_\_\_\_\_ CHART NUMBER: \_\_\_\_\_

Standardized Comprehensive Service Plan  
MCWP-14 (a) (Rev. 5/10) (S)

DATE PROBLEM IDENTIFIED	PROBLEM/NEED	GOALS	INTERVENTION(S): TYPE OF SERVICE/SERVICE PROVIDER/ QUANTITY/FREQUENCY/DURATION	PSC	START OF SERVICE	DATE/INITIALS/EVAL CODE
	Assistance with Pet Care	<input type="checkbox"/> Decrease Risk of Infections R/T Pet Care <input type="checkbox"/> Assistance with Pet Adoption-Out <input type="checkbox"/> Pet will remain in home	<input type="checkbox"/> Family/Neighbor to provide pet care; _____ q _____ and PRN for _____ <input type="checkbox"/> Volunteer; _____ q _____ and PRN for _____ <input type="checkbox"/> Animal Rescue/Adoption Service Initial Contact and PRN (one time only) <input type="checkbox"/> Other: _____; q _____ for _____			
	Mental Health	<input type="checkbox"/> Will Maintain Optimum Mental Health.	<input type="checkbox"/> Subcontracted Therapist; _____ Sessions q Week <input type="checkbox"/> LCSW <input type="checkbox"/> MFCC <input type="checkbox"/> PhD <input type="checkbox"/> PsyD for _____ <input type="checkbox"/> Psychiatrist; q _____ for _____ <input type="checkbox"/> Other Outpatient Psychotherapy; _____ Sessions q Week: <input type="checkbox"/> LCSW <input type="checkbox"/> MFCC <input type="checkbox"/> PhD <input type="checkbox"/> PsyD (See Attachment A) <input type="checkbox"/> Support Group; _____ q _____ for _____ <input type="checkbox"/> Buddy Program for 6 months <input type="checkbox"/> Other: _____; q _____ for _____ <input type="checkbox"/> Ongoing assessment by SWCM			
	Transportation	<input type="checkbox"/> Will Access Non-Emergency Medical, Social, & Community Resources.	<input type="checkbox"/> One Bus Pass; q Month for 6 months <input type="checkbox"/> Taxi Voucher NTE \$ _____ q _____ for 60days <input type="checkbox"/> Other: _____; q _____ for _____ <input type="checkbox"/> Ongoing assessment by NCM/SWCM			

CLIENT NAME: \_\_\_\_\_ CHART NUMBER: \_\_\_\_\_ Page 5 of 7

Standardized Comprehensive Service Plan  
MCWP 14 (a) (Rev. 5/10) (S)

DATE PROBLEM IDENTIFIED	PROBLEM/NEED	GOALS	INTERVENTION(S): TYPE OF SERVICE/SERVICE PROVIDER/ QUANTITY/FREQUENCY/DURATION	PSC	START OF SERVICE	DATE/INITIALS/EVAL CODE
	Housing	<input type="checkbox"/> Will Remain in Safe & Affordable Housing.	<input type="checkbox"/> Section 8 _____ q month for one year <input type="checkbox"/> HOPWA grant \$ _____ q _____ for 6 mos <input type="checkbox"/> Residential/assisted living, at: _____ for 6 mos <input type="checkbox"/> Motel Voucher: _____ Days (up to _____ Days) <input type="checkbox"/> Other: _____; q _____ for _____ <input type="checkbox"/> Ongoing assessment by NCM/SWCM			
	Legal	<input type="checkbox"/> Will Obtain Information, Referral, and/or Advocacy to Complete Legal Documents <input type="checkbox"/> Will Resolve Outstanding Legal Issues <input type="checkbox"/> Will Resolve Immigration Issues	<input type="checkbox"/> SWCM to provide info/assistance in completing Legal Documents q 30-60 Days and PRN (See Reassessments/Progress Notes) for one year <input type="checkbox"/> Legal Referral Panel; (See Attachment A) <input type="checkbox"/> Private Attorney (See Attachment A) <input type="checkbox"/> Other: _____; q _____ for _____ <input type="checkbox"/> Ongoing assessment by SWCM			
	Benefits	<input type="checkbox"/> Will Access Public/Private Benefits per Eligibility.	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> CMSP <input type="checkbox"/> Private Insurance (See Resource Evaluation) <input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Financial counseling <input type="checkbox"/> Other: _____ <input type="checkbox"/> Ongoing assessment by SWCM			

CLIENT NAME: \_\_\_\_\_ CHART NUMBER: \_\_\_\_\_ Page 6 of 7



## **QI/QM GUIDELINES AND REQUIREMENTS**

### **Guidelines**

The following QI/QM guidelines were developed with the assistance of Statewide AIDS Project Directors, NCMs, and SWCMs. The purpose of these guidelines is to assure that every Waiver Agency provides coordinated quality care in a cost-effective and culturally sensitive manner. The QI/QM guidelines should be used to develop each Waiver Agency's individual QI/QM Plan. The information obtained from some of the QI/QM activities provides agency staff with information they can utilize to evaluate and improve their programs.

The client medical record review guidelines have a standard of compliance set at 100 percent. This compliance standard was established at this level because these are program requirements. We recognize Waiver Agencies may not find this standard an immediate realistic goal. Therefore, we recommend that Waiver Agencies evaluate their current baseline compliance and establish incremental threshold goals with the understanding that they are working toward complete compliance.

The QI/QM Plan is to be submitted to the Office of AIDS annually, by July 31 of each fiscal year. The QI/QM summaries (and corrective action plans, if needed) are to be submitted with the semi-annual progress reports. Even though they are only reported semi-annually, QI/QM activities must be conducted on an ongoing basis during the reporting period.

## Requirements

### QUALITY IMPROVEMENT/QUALITY MANAGEMENT (QI/QM) GUIDELINES

<b>REQUIREMENT 1</b> <b>Case Management Program (Written)</b> <b>Policies &amp; Procedures</b>	
Indicators	Standards
<ol style="list-style-type: none"> <li>1. Food, housing, transportation, and utilities</li> <li>2. Client grievance</li> <li>3. Enrollment/Disenrollment, denial of services</li> <li>4. Cost avoidance</li> <li>5. Criteria for admission and services to clients in a residential facility</li> <li>6. Retention and confidentiality of client records</li> <li>7. Continuity of case management services during expected and unexpected absence of the case management staff</li> <li>8. Risk Assessment and Mitigation</li> </ol>	<p>Projects must develop policies and procedures (P &amp; P's) for all the required P &amp; P's listed in the indicator column. The P &amp; P's must be reviewed and approved by the Department's consultants.</p> <p>Once consultant approval has been obtained, the PD is required to:</p> <ol style="list-style-type: none"> <li>1. Notify and fax or send the consultants any significant revisions made to the required P &amp; P's <i>within 30 calendar days</i> of the revision, for approval</li> <li>2. Annually review, and update if necessary, the required P &amp; P's.</li> </ol>

<b>REQUIREMENT 2</b> <b>Outreach Plan</b> Outreach to institutionalized population(s) and those disproportionately affected by HIV/AIDS either by incidence or mortality	
Indicators	Standards
<p>The plan at a minimum contains: identification of target population(s), linkages with community resources and agencies for purposes of outreach and referrals; and a description of planned outreach activities, strategies, and materials.</p> <p>Outreach activities</p> <p>Client linguistic/cultural needs</p>	<ol style="list-style-type: none"> <li>1. A brief concise summary addressing the minimum outreach elements should be kept on file at the project. The PD should:                         <ol style="list-style-type: none"> <li>a. annually review the plan, and update it as necessary</li> <li>b. notify the consultants of any significant changes made to the plan</li> </ol> </li> <li>2. Outreach activities target appropriate community and cultural groups.</li> <li>3. Evidence of Project outreach activities                         <ol style="list-style-type: none"> <li>a. Description of outreach activities reported on PR</li> <li>b. Referrals and outreach with community resources, agencies and institutions.</li> <li>c. Literacy/language appropriate brochures or flyers targeting cultural groups and other at-risk populations are accessible to clients.</li> </ol> </li> <li>4. Project demonstrates attempts to meet linguistic/cultural needs of monolingual clients. (i.e. bilingual staff recruited, interpreter services available, written information in targeted cultural group language available at the project in client accessible areas.)</li> </ol>

**QUALITY IMPROVEMENT/QUALITY MANAGEMENT (QI/QM) GUIDELINES**

**REQUIREMENT 3**

**Client Medical Record Review**

All items to be included in client record review conducted by QI/QM committee annually.  
(quarterly for indicators found to have a 75% or less compliance rating)

Committee may assign one or more of its members to conduct the review.

For each NCM and each SWCM, select records to review. Include any waiver client records that have exceeded the annual capitation rate in the annual review.

*A minimum of six client records per project site must be reviewed annually.*

<b>Indicators</b>	<b>Standards</b>
1. Initial Nursing and Psychosocial Assessment	1. 100% of records contain a NCM and SWCM initial assessment of all required components. a. NCM initial assessment must be performed on the date of or within 15 days prior to enrollment. Includes CFA (with SWCM collaboration), and for MCWP, NFLOC certification. b. SWCM initial assessment must be performed between 15 days prior to and 15 days after enrollment.
2. Initial contact with clients	2. 100% of records contain initial client contact by agency staff within 5 days of referral.
3. M.D./Primary Care Practitioner signed diagnosis certification	3. 100% of records contain signed certification of client diagnosis obtained between 45 days prior to and 45 days after enrollment. a. MD must sign the form and document current symptoms. For waiver clients, this document must be received prior to billing for service
4. Client insurance/resource evaluation	4. 100% of records contain insurance eligibility and resource evaluation determined at the time of enrollment and at least every 60 days. MCWP charts indicate verification of Medi-Cal status prior to enrollment and at the beginning of each month thereafter.
5. SWCM/NCM face-to-face reassessment every 60 days	5. 100% of records contain: a. Documented comprehensive face-to-face reassessment at least every 60 days by NCM and SWCM. b. Problems identified and documented by the SWCM/NCM are followed up and attempts are made to link to appropriate interventions until resolution or documented client refusal for further intervention(s).
6. Comprehensive Service Plan (CSP)/ IDT Case Conference	6. 100% of records contain: a. A CSP individualized to reflect service provision consistent with NCM and SWCM documentation of client need. b. Documentation of client review and approval of initial CSP indicated by client signature on CSP and NCM/SWCM documentation of client approval in client record at least every 60 days. c. Documentation of IDT case conference and identification of conference participants at least every 60 days. d. Documentation of SWCM and NCM CSP review at least every 60 days and documentation of service change(s) or continuation consistent with NCM/SWCM documentation of client needs.
7. Facilitating access to medical care	7. 100% of records document case manager interventions to facilitate access to health care, psychosocial, and other services
8. Cost avoidance	8. 100% of records contain documented evidence of cost avoidance activities prior to using MCWP funds for services.
9. Client informed consent	9. 100% of records contain client signed informed consent/agreement to participate on or within 15 days prior to the date of enrollment.
10. Client authorization for exchange of confidential information	10. 100% of records contain client signed authorization to exchange confidential information on or within 15 days prior to the date of enrollment.

**QUALITY IMPROVEMENT/QUALITY MANAGEMENT (QI/QM) GUIDELINES**

<b>REQUIREMENT 3</b>	
<b>Client Medical Record Review (Cont'd)</b>	
<b>Indicators</b>	<b>Standards</b>
<p>11. Clients rights and responsibilities</p> <p>Grievance procedure</p> <p>Notice of Action (NOA)/Right to State Fair Hearing</p> <p>12. Disenrollment, decrease, discontinuation, or denial of service criteria</p>	<p>11. 100% of records contain:</p> <p>a. Client signed acknowledgement of receipt of rights and responsibilities dated on or within 15 days prior to the date of enrollment.</p> <p>b. Client signed acknowledgement of receipt of grievance policy and procedure dated on or within 15 days prior to the date of enrollment.</p> <p>c. For MCWP, client signed acknowledgement of receipt of information related to Notice of Action and Right to a State Fair Hearing.</p> <p>12. 100% of records contain:</p> <p>a. Client's receipt of NOA and Right to State Fair Hearing as required in the MCWPP.</p>

<b>REQUIREMENT 4</b>	
<b>Quality Improvement/ Quality Management (QI/QM) Plan</b>	
<b>Indicators</b>	<b>Standards</b>
<p>1. QI/QM plan describes the project monitoring in terms of what, who, how, how often, and lists expected standards. <i>Minimum</i> required elements of the plan include:</p> <p>a. Client record review</p> <p>b. Client satisfaction survey</p> <p>c. Grievance and disenrollment, monitoring</p> <p>d. Risk assessment and mitigation</p> <p>2. QI/QM committee</p> <p>3. QI/QM meetings</p> <p>4. Corrective action</p> <p>5. Semi-Annual Progress Report (PR)</p>	<p>1. Written QI/ QM Plan includes all indicators and the plan is annually reviewed by PD, and revised if indicated as required by the Department's consultants.</p> <p>a. Client record review conducted annually. See Client Medical Record Review section for a list of the required record review indicators.</p> <p>b. Client satisfaction survey conducted annually. All enrolled clients should be surveyed.</p> <p>c. All grievances and disenrollment monitoring conducted on an ongoing basis. Log(s) to be maintained that document the reason for disenrollment and or grievance, client and project actions (including information related to the timelines of the actions), and resolution</p> <p>d. All instances of abuse, neglect, or exploitation are appropriately reported. Risk assessment and mitigation is documented in assessments, reassessments, comprehensive service plan, and progress notes.</p> <p>2. Mandatory members are: The PD (who is the designated QI/QM coordinator), and representatives from the core case management team. Representation from both NCM <i>and</i> SWCM staff is required. PD may appoint a qualified staff member to act in his/her place but must have a policy/procedure depicting how QI/QM meeting activities, client survey and client record results, and how recommendations for corrective action(s) are communicated to PD for PD approval and oversight.</p> <p>3. QI/QM committee to meet quarterly at a minimum. Client record review results, client satisfaction survey, and findings related to disenrollment/grievances are analyzed for patterns or trends, appropriateness and timeliness of action(s). Committee recommends and develops corrective action plan(s) when appropriate. Summary of minutes of meetings must be kept on file at the project.</p> <p>4. Corrective action plan(s) implemented for substandard indicators and identified problems. Plan(s) use a "systems" approach to address problems and issues. Committee follows up to assess efficacy of the action plan.</p> <p>5. Provide a summary of the results of QI/QM activities, recommendations, and corrective action(s) taken to be submitted with the PR. At a minimum, the summary should include annual report on indicators 1 a., 1 b., 1c.</p>

**QUALITY IMPROVEMENT/QUALITY MANAGEMENT (QI/QM) GUIDELINES**

<b>REQUIREMENT 5 Provider Education</b>	
<b>Indicators</b>	<b>Standards</b>
1. Staff education is current: a. Case management practices and issues b. HIV/AIDS issues  2. Staff member credentials	1. PD shall have on file for all core NCM and SWCM staff members at the project, evidence of NCM/SWCM attendance at a minimum of a) one (1) training annually related to current HIV/AIDS issues and trends <i>and</i> b) one (1) training on current case management practices and issues. A training that combines both case management and HIV/AIDS update is acceptable. Case management practices/issues can include topics such as team building, client advocacy, cultural and ethnic diversity, etc.  2. PD has a system in place to provide oversight/monitor current status of NCM/SWCM and sub-contracted staff member credentials and qualifications
<b>REQUIREMENT 6 Coordination and Continuity of Care</b>	
<b>Indicators</b>	<b>Standards</b>
Coordination of service   Communication with other AIDS service organizations in the community	1. There is evidence of coordination of services between the project and other community AIDS service organizations. Example may include referral system between Part B and/or HCP and the MCWP, and other community service organizations.  2. There is evidence of periodic communication between the project and other community AIDS service organizations. Examples may include: PD participation in Part B consortia meetings, etc.
<b>REQUIREMENT 7 Monthly Data Submission</b>	
<b>Indicators</b>	<b>Standards</b>
1. Accurate data in correct format  2. Timely data	1. Contractor collects and reports client and service data using the required standardized statewide system.  ARIES data should be entered no later than two weeks from the date services were rendered.

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