POLICY AND PROCEDURE NOTICE: PPPN-001
CLIENT ELIGIBILITY

Summary and Purpose of PPPN: To guide the administration of the Ryan White Part A Program client eligibility and reassessment/recertification of clients to determine eligibility as specified by the Fulton County Ryan White Program.

Authority:

- Ryan White HIV/AIDS Treatment Modernization Act of 2009, Public Health Service (PHS) Act under Title XXVI, as administered through the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau
- PHS 2605(a)(6)
- PHS ACT 2604(c)(l)
- PHS ACT 2611
- PHS ACT 2616 (b) (1-2)
- PHS ACT 2617 (b)(7)(B)
- PHS Act 2617 (b)(7)(F)
- PHS ACT 2616 (b) (1-2)
- PHS ACT 265l (c)(l)
- PHS ACT 2264(f)(1)
- PHS ACT 267l (a)
- PHS Act 2671(i)
- Funding Opportunity Announcement
- HRSA/HAB PCN #13-02 Clarification on Ryan White Program Client Eligibility Determinations and Recertifications Requirements
- HAB National Monitoring Standards – Universal - Part A & B
- Fulton County Ryan White Contract/Agreement
- PHS ACT 2605(a)(6)
- Section 300ff-27(b)(7)(F) of Title 42 under the United States Code requires assurances from the that Ryan White funding will not be "utilized to make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made . . ." by programs and sources other than Ryan White.
- HRSA/HAB PCN #15-03: Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income
- HRSA/HAB PCN#13-01: Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by the Ryan White HIV/AIDS Program

- HRSA/HAB PCN #16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

POLICIES AND PROCEDURES

General

1. Ryan White Part A is an eligibility program and not an entitlement program such as Medicaid; therefore, the services provided by Part A programs are subject to accessibility, availability, and funding.

2. Any individual adult or their court appointed representative, legal representative, or legal guardian may apply for services.

The following are the requirements that must be met for all clients seeking services under Ryan White Part A:

1. Documentation of the eligible individual having HIV.
2. Proof that the individual resides in one of the 20 counties of the Atlanta Eligible Metropolitan Area. These counties are – Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding and Walton.
3. Must have an income ≤ 400% of the most current Federal Poverty Level
4. Must have no other payer source for services provided through Ryan White.

Eligibility Category	Initial Eligibility Determination[1]	Semi-Annual Recertification with No Changes (At 6 months)	Semi-Annual Recertification with Changes OR Annual Eligibility Recertification (At least every 12 months)
HIV Status	**Documentation Required**	**No Documentation Required**	**No Documentation Required**
Income	**Documentation Required**	**No Documentation Required**	**Documentation Required**
Residency	**Documentation Required**	**No Documentation Required**	**Documentation Required**
Insurance Status	**Documentation of Coverage, Coverage Denial, or Agency's On-going Efforts to Vigorously Pursue Benefits Required**	**No Documentation Required**	**Documentation of Coverage, Coverage Denial, or Agency's On-going Efforts to Vigorously Pursue Benefits Required**

Fulton County's Ryan White Program does **not** require clients to produce photo identification as a pre-requisite for receiving services.

Requiring an individual to have State issued photo identification establishes a lengthy and sometimes costly barrier to care; this also creates an unnecessary barrier to care for undocumented individuals.

If an agency's internal policies require State issued photo identification, the lack of such identification shall not delay enrollment in Ryan White services, provision of medications, nor result in the discharge of a client from Ryan White Services.

All eligibility staff shall be made aware of this policy no less frequently than annually.

[1] A new or returning individual seeking program eligibility meets face-to-face with a member of the agency's eligibility staff to complete eligibility documentation.

It is not necessary to be a U.S. citizen to receive Ryan White Part A services. Applicants do not have to document citizenship or immigration status in order to be eligible for services. Service providers are not required to report undocumented clients to the US Citizenship and Immigration Services formerly known as the US Immigration and Naturalization Service (INS).

Programs of the Health Resources and Services Administration, including Ryan White Programs, are not subject to the Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 and are not required to verify immigration and citizenship status of clients.

Maintenance of Records

In an effort to facilitate access to care and to reduce the burden to clients and service providers it is not necessary for the client to provide eligibility documentation to all providers.

Original eligibility documentation shall be collected and maintained by the first service provider to assess eligibility or recertification – this entity is known as the Primary Record Holder. The Primary Record Holder is also required to scan the documentation and upload into the appropriate tabs in e2Fulton. **Also see: PPPN-006 Use of e2Fulton in Documenting Eligibility.**

Subrecipients have three business days to create the client's eligibility record in e2Fulton and scan and upload eligibility documentation[2].

Within the six-month period during which the client is deemed to be eligible, other providers (Non-Primary Record Holders) are not required to maintain original copies of eligibility documentation. These entities must print the required documents and maintain this print-out in the client file (electronic or manual) on site OR may notate in the client's record the date(s) the eligibility documents in e2Fulton were reviewed and the name and title of the staff person who verified eligibility. Subrecipients should exchange contact information in order to facilitate communication and information-sharing.

The Primary Record Holder may change over time as a result of recertification of services or discontinuation of services. Subrecipients may be Primary Record Holder for some clients and Non-Primary Record Holder for other clients depending on where the client first accesses services or conducts their six-month recertification.

[2] Refer to **PPPN-006 Use of e2Fulton in Documenting Eligibility**.

Services for Affected Individuals

Ryan White Part A core services including outpatient ambulatory health services, medical case management, medical nutrition therapy, mental health services, oral health services and substance abuse treatment-outpatient services may **only** be provided to persons who are **HIV positive**.

Affected individuals (people not identified with HIV) may be eligible for RWHAP services in limited situations, but these services for affected individuals must always benefit people living with HIV. Funds awarded under the RWHAP may be used for services to individuals affected with HIV only in the circumstances described below.

- The service has the primary purpose of enabling the affected individual to participate in the care of someone with HIV or AIDS. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for someone who is living with HIV.
- The service directly enables a person living with HIV to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a RWHAP client's portion of a family health insurance policy premium to ensure continuity of insurance coverage for a low-income family member who is living with HIV, or child care for children, while a parent or caregiver who is living with HIV secures medical care or support services.
- The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services, including mental health services funded by RWHAP Part D only, that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.
- Services to affected individuals that meet these criteria may not continue subsequent to the death of the family member who was living with HIV.

See **HAB PCN #16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds.**

Proof of Positive HIV status

1. Documentation of the eligible individual's HIV status shall be maintained.

2. Acceptable documentation for HIV status shall include, but not be limited to:
   - A positive HIV antibody test result (Reactive IA/EIA/ELISA screening test) confirmed by Western Blot, Immunofluorescense Assay (IFA), Nucleic Acid Testing (Aptima), Multispot® HIV-1/HIV-2 Rapid Test by blood or oral fluid.
   - A positive HIV direct viral test such as PCR or P24 antigen.
   - A detectable HIV viral load (undetectable viral load tests are NOT proof of positive HIV status).
   - A viral resistance test result.
   - Fourth-Generation testing.
   - A statement or letter signed by a medical professional (acceptable signatories are listed below), on office letterhead/prescription pad indicating that the individual is HIV positive and must accompany a lab test to confirm current HIV status within 60 days. It is the responsibility of the provider to follow up and receive the accompanying lab test from the medical provider's office within the 60 day period.

     Acceptable signatories include:
     - A licensed physician
     - A licensed physician assistant
     - A licensed nurse practitioner

   - Presumptive diagnosis based upon documented lab results, and/or medical therapies prescribed by a previous medical provider.

3. Exposed infants of HIV-positive mothers can be served with documentation of the mother's HIV-positive status up to the age of 12 months. Children 12 months or older must meet the same criteria for proof of HIV as listed above to continue services.

   ***NOTE**: Children (persons under 18) are generally **not** eligible for Part A Outpatient/Ambulatory Health Services in the Atlanta EMA due to the availability of other funding sources including Part D. Minors must be referred to Medicaid, the Division of Family and Children's Services or other third-party payer for appropriate eligibility determination. If a minor is determined to be ineligible under all of these options, and documentation to that effect is provided, exceptions may be considered on a case-by-case basis.*

4. Documentation shall be primary or through verification of the presence of test results which have been scanned into e2Fulton.

e2Fulton Documentation

- Proof of positive HIV status must be scanned and attached under Eligibility Tab in e2Fulton (see e2Fulton Manual for instructions and file nomenclature).
- Document must have an identifying name and URN which matches the client name and URN in e2Fulton.
- **Proof of HIV only needs to be collected and scanned during the initial enrollment**.

Presumptive HIV Diagnosis

PRESUMPTIVE HIV DIAGNOSIS IS ONLY ACCEPTABLE FOR INITIATION OF RYAN WHITE SERVICES

1. In order to be eligible for RWHAP-funded medical care, patients must have a "diagnosis of HIV disease".

   - There is no legislative requirement for a "confirmed" HIV diagnosis prior to linking clients to RWHAP-funded medical care, nor is there any specific statutory or program requirement related to the use of Western blot testing as the only means of confirmatory testing.
   - Having positive results from only one HIV antibody test should not be a barrier to linkage to care to a RWHAP-funded clinic, or other HIV care providers, since the majority of people receiving a positive result from a single test have HIV infection and would benefit from quick linkage to ongoing care and prevention services.
     - For example, an individual with one positive rapid test should be counseled about the likelihood of infection and the real (although small) possibility of a false positive result. He or she should be linked at that time to an HIV care provider to receive follow-up HIV testing and, if confirmed, medical care. **If negative, the client should be counseled/educated on PrEP and provided with referral for PrEP if interested.**

2. **Confirmatory testing may occur at the RWHAP-funded medical clinic.**

3. Tests to confirm the diagnosis of HIV disease could include the following:
   - Positive HIV immunoassay and positive HIV Western blot
   - Positive HIV immunoassay and detectable HIV RNA

- Two positive HIV immunoassays (should be different assays based on different antigens or different principles)

4. HIV testing sites that do not obtain confirmatory testing should have a memorandum of understanding with RWHAP-funded programs or other HIV care providers to facilitate the timely linkage of patients to HIV medical care and to accelerate the receipt of an appointment for those who test preliminarily positive. The receiving medical clinic must be informed of the individual's unconfirmed preliminary positive HIV test result and the need for confirmation. RWHAP-funded clinics that receive such individuals may choose to arrange an abbreviated first appointment during which the individual receives counseling about HIV testing and a limited evaluation that includes confirmatory HIV testing and potentially other HIV labs.

Provisional Enrollment

1. Ideally, all documentation should be provided prior to enrollment into services. However, lack of proper documentation should not impede enrollment into care. If a client is able to provide proof of HIV status but does not have income or residency documentation, that client may be enrolled into outpatient ambulatory health services, mental health services, substance abuse services, non-medical case management, medical case management and medical transportation services. It is understood that eligibility documentation MUST be provided at the next visit or the visit must be rescheduled until such time that documentation is provided.

2. **All eligibility documentation must be provided prior to initiation of any other service.**

Note: In most instances antiretroviral therapies may not be initiated until full enrollment is completed. In rare and urgent instances, antiretrovirals may be provided to a client by a clinician authorized in the State of Georgia to prescribe antiretrovirals based upon the medical necessity for immediate initiation of therapy. The clinician's authorization must be maintained in the client chart/record. No more than a 30 day supply should be provided or prescribed. In the event that antiretroviral therapies are provided in these rare circumstances and it is later determined that the client is ineligible for Ryan White services it would be necessary for the agency to reimburse the Ryan White Part A Program for the cost of the medication(s).

Proof of Residency

1. Documentation of the eligible individual's permanent physical residency in the Atlanta Eligible Metropolitan Area (Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding and Walton) must be maintained.

2. Any one of these documents will be accepted as proof of residency as long as the address is a land address, not a P.O. Box, issued within the past twelve months, not expired, and is the same as the client's stated address on intake/application documents. Such official documents with address present include:
   A. Food stamp documentation
   B. General assistance documentation
   C. TANF (Temporary Assistance for Needy Families) documentation
   D. Social Security or Veteran's Administration Benefits award letter
   E. Unemployment award/benefits statement
   F. Property tax statement
   G. Homeowners Association (HOA) assessment/fee statement, or
   H. Mortgage or lease agreement indicating the client's name and residence
   I. Non-property tax bill or tax assessment statement
   J. W-2 (tax) form from employer (most recent tax year)
   K. Check stub from employer (most recent tax year)
   L. Bank statement (most recent month)
   M. Driver's license issued by the State of Georgia
   N. State of Georgia issued identification card
   O. Utility bills
   P. Unemployment document with address
   Q. Current voter registration card
   R. Current school identification
   S. A billing statement from a department store, doctor's office, insurance company, or cell phone company
   T. An official document such as a jury summons
   U. A statement from a service provider indicating the provider has met with client in a home visit at a specific address in the Atlanta EMA
   V. If homeless, proof of residency may include:
      - A statement from the shelter in which the client resides or visits.
      - Physical observation from eligibility staff.
      - A written statement describing the client's living circumstances; it must be signed and dated. Eligibility staff may provide assistance with this.
      - A statement from a social service agency attesting to the homeless status of the client.

- Attestation of homelessness as determined by eligibility staff – may only be used as last resort and must demonstrate that other options were exhausted.

e2Fulton Documentation

- Proof of living in the Atlanta EMA must be scanned and attached under Eligibility Tab in e2Fulton (see e2Fulton Manual for instructions and file nomenclature).
- Document must have an identifying name which matches the client name in e2Fulton.

Documentation of Income

Federal Poverty Level

1. Client's annual income must be documented in relation to current Federal Poverty Level (FPL). Regulations require that Part A services are restricted to clients with specific household income limits based on Federal Poverty Level (FPL). In the Atlanta EMA eligibility is restricted to household income ≤ 400% of FPL. The current FPL can be found at http://aspe.hhs.gov/poverty/

Household Size

1. In order to determine eligibility it is necessary to determine how many people live in the household. The household consists of the tax filing unit. The size of the household used in determining the client's FPL will not necessarily include everyone in the household unit. Only specific individuals are counted when determining the household size for purposes of determining the client's FPL.

   Those counted in the household size are:
   - Client (always)
   - Spouse (always)

     Any client reported as married is required to provide documentation for verification of spouse's income or no income. Unless the client is legally separated or divorced from spouse, documentation of spousal income must be included.

   - Client's minor children (under 18 years old)
   - Adults who live with the client, and meet one or more of the following:
     - Claims the client as a dependent on a tax return
     - Has legal custody, or other legal arrangement or guardianship of the client.

   Not counted in household size are:

- Roommate(s) with separate finances who share only in the cost of room and board. Room and board includes household expenses, such as utility, cable, phone, rent or mortgage, and meals.
- Adults, such as parents, adult siblings, adult children, significant others, and partners who live with the client but have separate finances and/or share only household expenses.
- Live-in aides who receive payment for their services.
- Children who are not financially dependent on the client.

2. Household income is defined as income received by the client from all sources.
   - Adults living outside of the household who provide money to the client on a daily, weekly, or monthly basis are not included in the household size, but the amount of financial support (allowance) is counted.
   - Income includes items that generate funds, which may be counted as income. For example, a second home rented out generates income.

Gross Income

1. In determining income eligibility subrecipients may first check the potential client's Gross Income. If Gross Income is ≤ 400% FPL it is not necessary to evaluate Modified Adjusted Gross Income. If the potential client's Gross Income is > 400% FPL, he or she may still qualify for Ryan White Part A services based upon Modified Adjusted Gross Income which should then be calculated for the potential client (See **Modified Adjusted Gross Income**).

2. Documentation shall include, but not be limited to:

   a. **Earned income documentation**:

      - IRS 1040 Form or IRS W-2 Form for the most recent year.

      - . Pay stubs showing income before taxes and deductions.
        - Enough pay stubs should be collected to reasonably determine a person's annual income to be able to project forward. Generally, at least two paycheck stubs (eight weeks, if available) would suffice.
        - Seasonal Employment: clients employed seasonally by the same employer should submit a current paystub that shows "year to date earnings"
          - Year to Date (YTD) information can be used if only one paycheck stub is available. For example, a June 30, 2015, pay stub reflects YTD $19,055; and the client is paid bi-weekly. Calculate the income by dividing the YTD income ($19,055) by the number of pay periods to date (13) to determine bi-weekly pay ($1,465.77), and then multiply by 26 pay periods to get an annual income of $38,110 ($19,055 / 13 = $1,465.77 x 26 = $38,110).

- Multiple positions/employers throughout year: a copy of the most recent federal Income Tax return is required.
- If a client's weekly income fluctuates greatly (e.g., day labor), determine the total weekly income of each week worked by adding the gross income for each day the client worked in the week. Add the weekly totals together, and then divide by the number of weeks worked to determine the average weekly gross amount. Once the average weekly gross amount is determined, use the weekly income calculation above to determine the annual income. For example, a client comes in and provides two weeks of income information. The documentation shows the client worked only two days in one week earning $75 on Monday and $50 on Wednesday for a total weekly income of $125. The following week the client worked four days earning $50 on Monday, $120 on Tuesday, $35 on Wednesday, and $75 on Friday for a total weekly income of $280. The two weekly totals ($125 and $280) are added together ($405), which is divided by the number of weeks provided (two) to equal the weekly gross amount of $202.50. Multiply $202.50 by 52 to equal an annual income of $10,530 ($125 + $280 = $405 / 2 = $202.50 x 52 = $10,530).

If a client is deemed ineligible based on overtime that occurred in the month prior to certification, the agency should request additional information (e.g. two months prior or 3-6 months of pay stubs) to determine income eligibility.

- A signed and dated employer statement on company letterhead may be used. It must state the name of client, rate and frequency of pay, a phone number, and whether the client is currently receiving or is eligible to receive health benefits from the employer.

- If self-employed:
  - IRS 1040 Form for the most recent year with corresponding attachments (Schedule C or Schedule SE)
  - Most recent IRS W-4 Forms
  - Company accounting books showing business revenue and expenses
  - If the client has not been self-employed long enough to have filed taxes, the client can submit records of their monthly self-employment income for at least the past three months. A Self-Employment Tracking Sheet may serve as proof of income in these cases.

  Self-employment income includes, but is not limited to:
  - Small businesses, including proprietorships and partnerships
  - Paid professional, paraprofessional, or occupational services such as lawn care, domestic work, handyperson, landscaping, farming, or salesperson
  - Royalty or honoraria from intellectual property or authorship

- Notarized letter from Head of Household (HOH) detailing the client's relationship to the HOH and the level of financial assistance provided to the client.

- A zero income letter (on letterhead) from a shelter or residential treatment facility located in the Atlanta EMA.

- Documentation from the Georgia Department of Labor indicating income earned by the individual applying for services.

- Verification of employment or income through Equifax Verification services https://www.theworknumber.com/

b. **Unearned income documentation**:

Unearned income is all income that is not earned, such as Social Security benefits, pensions, disability payments, unemployment benefits, interest income, property rental income, and cash contributions from relatives. Unearned income documentation is:

- Retirement income statement from Social Security
- Old-Age and Survivors Insurance (OASI) statement
- Retirement pension statement from private or public fund
- Trust fund income documentation
- Military/veteran pension benefits statement
- A recent Third Party Query (TPQY) printout from Social Security
- IRS 1040 Supplemental Income and Loss (Schedule E) for property rental income (net income is counted in this circumstance)
- Unemployment benefit statement
- Alimony payments
- Benefits from dependent children (i.e., survivor's benefits)
- Child support payments
- Cash assistance by relatives and other individuals (included in letter of support)
- Interest on investments
- Supplemental Security Income (SSI) checks or benefit/award letters
- Social Security Administration (SSA) checks or benefit/award letters
- Temporary Assistance to Needy Families (TANF) checks or benefit/award letters
- Section 8 Rental Assistance Statement
- Other letters of Notification of Benefits (e.g., Medicaid, Medicare, SNAP, private disability, retirement/pension, Worker's Compensation, Veteran's Administration, WIC Program, Low Income Subsidy, etc.)
- Deemed income (which is all earned and unearned income from the client's spouse if married and from the adults living in the home who are counted in the household size.

- In extreme and rare cases, a notarized self-declaration letter from the client indicating their income along with a statement as to how the client receives food, clothing, and shelter.

c. **Income Not Counted**:

Income that is not counted includes grants, scholarships, fellowships, value of SNAP benefits, 401K if not accessed, and any other non-accessible income, such as trust funds.

Modified Adjusted Gross Income

1. For clients with a Gross Income > 400% FPL, subrecipients will use the potential client's Modified Adjusted Gross Income (MAGI) to determine eligibility for Ryan White services (MAGI is used by ADAP, Medicaid and ACA). Generally, MAGI is the potential client's adjusted gross income plus non-taxable social security benefits, tax-exempt interest and/or foreign income.

2. Documentation shall include, but not be limited to information referenced in the Earned Income Documentation, Unearned Income Documentation, and Income Not Counted sections.

Clients who refuse to divulge or document income will not be able to complete the financial eligibility assessment and will, therefore, be determined ineligible for Ryan White Part A services.

Following is a summary of the MAGI Documentation:

MAGI Form Line Item	Definition	Documentation
Rental Real Estate, Partnerships, S Corporations, Trusts, Etc.	Income or loss from rental real estate, royalties, partnerships, S corporations, estates, trusts, and residual interest.	▪ Line 26 on Schedule E* ▪ Line 17 on Form 1040*
Farm Income or Loss	Income and expenses for self-employed farmers.	▪ Line 34 on Schedule F* ▪ Line 18 on Form 1040*
Unemployment Income	An insurance that is paid as a result of a taxpayer's inability to find gainful employment. Unemployment income is paid from either a federal or state-sponsored fund. The recipient must meet certain criteria in trying to find a job.	▪ Line 19 on Form 1040* ▪ Letter of award
Retirement Income from Social Security	The monetary benefits received by retired workers who have paid into the Social Security system during their working years.	▪ Bank Statement ▪ Letter of award indicating pay period
Disability Income from Social Security (SSDI)	SSDI recipients are considered "insured" because they have worked for a certain number of years and have made contributions to the Social Security trust fund in the form of FICA Social Security taxes. SSDI candidates must be younger than 65 and have earned a certain number of "work credits".	▪ Bank Statement ▪ Letter of award indicating pay period

Supplemental Income from Social Security (SSI)	SSI is a program that is strictly needs-based, according to income and assets, and is funded by general tax funds. To meet the SSI requirements a person must have less than $2,000 in assets (or $3,000 for a couple) and a very limited income.	▪ Bank Statement ▪ Letter of award indicating pay period
Other Income (Jury Duty Pay, Gambling, Winnings)	Miscellaneous income. "Other income" usually includes unexpected money from an event from which a person did not receive any W-2 form.	▪ Line 21 on Form 1040* ▪ Documentation of gambling or winning earnings ▪ Documentation of jury duty pay
Child Support Received, Workers Comp, Monetary Gifts	Listing of child support received, workers compensation income, and/or monetary gifts.	▪ Documentation of child support received, workers compensation, and/or monetary gifts
Educator Expenses	If the person is an eligible educator, he/she can deduct up to $250 ($500 if married, filing jointly and both spouses are educators, but not more than $250 each) of any unreimbursed expenses paid or incurred for books, supplies, computer equipment (including related software and services), other equipment, and supplementary materials used in the classroom.	▪ Line 23 on Form 1040* ▪ Documentation of expenses incurred as an eligible educator.
Business Expenses	Any expense incurred in the ordinary course of business. Business expenses are deductible and are netted against business income.	▪ Line 6 on Form 2106 or 2106-EZ* ▪ Line 24 on Form 1040*
Health Savings Account	A savings account used in conjunction with a high-deductible health insurance policy that allows users to save money tax-free against medical expenses.	▪ Line 13 on Form 8889* ▪ Line 25 on Form 1040*
Moving Expenses	When an individual and/or family relocate for a new job or due to the location transfer of an existing job. Based upon specified criteria for time and distance.	▪ Line 5 if "Yes" on Form 3903* ▪ Line 26 on Form 1040* ▪ Documentation of moving expenses
Deductible Portion of Self-Employment Tax	The self-employment tax refers to the employer portion of Medicare and Social Security taxes that self-employed people must pay.	▪ Line 12 on Schedule SE* ▪ Line 27 on Form 1040*
Self-Employed SEP, SIMPLE Plans	Self-employment retirement plans.	▪ Line 28 on Form 1040*
Self-Employed Health Insurance Deduction	The deduction for medical, dental, or long-term care that self-employed people pay for themselves, their spouse, and their dependents.	▪ Line 29 on Form 1040*
Penalty on Early Withdrawal of Savings	Penalty incurred when an early withdrawal of savings is made.	▪ Line 30 on Form 1040*
Alimony Paid	Alimony is payment to or for a spouse or former spouse under a divorce or separation instrument. It does not include voluntary payments that are not made under a divorce or separation instrument.	▪ Line 31a on Form 1040*
IRA Deduction	Deductions that apply when a person makes contributions to a traditional IRA.	▪ Line 32 on Form 1040*

Student Loan Interest Deduction	Deduction of interest related to repaying a student loan.	▪ Line 33 on Form 1040*
Tuition and Fees	Deduction of qualified tuition and related expenses that a person pays for themselves, spouse, or dependent, as tuition and fees deduction.	▪ Line 6 on Form 8917* ▪ Line 34 on Form 1040*
Domestic Production Activities	A deduction against income derived from domestic manufacturing activities. It Is also known as the "manufacturer's deduction".	▪ Line 25 on Form 8903* ▪ Line 35 on Form 1040*

*Documentation lists annual amount. Totals must be divided by 12 if using a monthly MAGI form.

To assist agencies in calculating MAGI, two Excel forms have been established:

1) **Modified Adjusted Gross Income (MAGI) Worksheet for Income Tax Filers**
   - **Part 1 MAGI is calculated**
   - **Part 2 Determining Household Poverty Level**
   - **Part 3 Determining Cap on Charges**

   This spreadsheet also includes a worksheet (tab) with Directions and two worksheets (tabs) with Examples.

2) **Modified Adjusted Gross Income (MAGI) Worksheet for Non-Income Tax Filers**
   - **Part 1 MAGI is calculated**
   - **Part 2 Determining Household Poverty Level**
   - **Part 3 Determining Cap on Charges**

   This spreadsheet also includes a worksheet (tab) with Directions and two worksheets (tabs) with Examples.

While it is not necessary to use these forms it is strongly suggested. Another form may be used so long as all required elements are incorporated.

e2Fulton Documentation

- The Ryan White Provided MAGI calculation forms (or similar) which indicate proof of income ≤ 400% FPL EMA must be scanned and attached under Eligibility Tab in e2Fulton (see e2Fulton Manual for instructions and file nomenclature).
- Document must have an identifying name which matches the client name in e2Fulton.

Documentation of Third Party Payer Source

Once eligibility is certified it is required that third party payer sources are identified:

1. Determination of uninsured or underinsured status
2. Determination of eligibility and enrollment in third party insurance programs including Medicaid and Medicare
3. For underinsured, proof that the service to be provided is not covered by other third party insurance programs such as Medicaid and Medicare.

Policy and Procedure:

Screening for other available programs is a required step in the eligibility process. Determining whether an applicant/client is already participating in local, state, or federal programs is necessary to eliminate duplication of services and adhere to federal requirements associated with the funding of the programs.

1. For each client served, Subrecipient agrees to provide documentation upon request which indicates the Subrecipient's efforts to determine if a client has an eligible third-party payment source (e.g., private insurance, including plans available through the health insurance marketplace, Medicaid, Children's Health Insurance Plan [CHIP], and Medicare) and the process for vigorously screening and enrolling clients in all programs for which they are eligible to ensure that Part A funds are the payor of last resort.

2. Subrecipients must coordinate planning with all other public funding for HIV/AIDS to:
   - ensure that Ryan White HIV/AIDS Program funds are the payer of last resort,
   - maximize the number and accessibility of services available, and
   - reduce any duplication.

3. A client may not be eligible for services from the Ryan White Part A program if the client is already receiving or is eligible for the same benefits/services from other programs. The services provided by Ryan White Part A may be used for HIV-related services only when no other source of payment exists. This requirement does not preclude an individual from receiving allowable services not provided by other local, state, or federal programs or pending a determination of eligibility from these other programs.

- **Exceptions:**
  - HRSA has allowed an exception for those persons able to access services under Department of Veterans Affairs (VA). **See FCRW PPPN-024 Veterans and VA Benefits**.
  - HRSA has allowed an exception for those persons able to access services under Indian Health Services. **See FCRW PPPN-025 Indian Health Services**.

4. Subrecipients may not use Part A funds for any item or service to the extent that payment has been made, or reasonably can be expected to be made, with respect to that item or service under any State compensation program, insurance policy, Federal or State health benefits program or by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services).

5. Subrecipient shall maintain documentation that eligibility determination policies and procedures that do not consider VA health benefits as the veteran's primary insurance and deny access to Ryan White services citing "payer of last resort". Policies and procedures must classify veterans receiving VA health benefits as uninsured, thus exempting these veterans from the "payer of last resort" requirement.

   - Subrecipient shall maintain annual documentation that all staff involved in determining eligibility have been informed of policies surrounding veterans with VA health benefits.

6. Subrecipient shall maintain documentation that eligibility determination policies and procedures do not consider Indian Health Services benefits as the client's primary insurance and deny access to Ryan White services citing "payer of last resort". Policies and procedures must classify persons receiving Indian Health Services benefits as uninsured, thus exempting these clients from the "payer of last resort" requirement.

   - Subrecipient shall maintain annual documentation that all staff involved in determining eligibility have been informed of policies surrounding clients with Indian Health Service benefits.

7. Subrecipients must have policies and staff training on the requirement that Ryan White be the payer of last resort and how that requirement is met. Subrecipient shall maintain documentation that all provider staff have been informed of Part A eligibility requirements for determination of third-party payment source and process for vigorously screening and enrolling clients in all programs for which they are eligible to ensure that Part A funds are the payer of last resort.

8. For each client served, subrecipients must maintain documentation which indicates the Subrecipient's efforts to determine if a client has an eligible third-party payment source (e.g., private insurance, including plans available through the health insurance

marketplace, Medicaid, Children's Health Insurance Plan [CHIP], and Medicare) and the process for vigorously screening and enrolling clients in all programs for which they are eligible to ensure that Part A funds are the payer of last resort.

9. Subrecipient shall maintain documentation that all fiscal and intake staff have been informed of policies that direct funds will not be used to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, by another third party benefits program or by an entity that provides services on a prepaid basis.

10. Subrecipients must carry out internal reviews of files and billing systems to ensure that Ryan White resources are used only when a third party payer is not available.

11. Subrecipients are expected to vigorously pursue third party payer coverage for which a client may be eligible such as insurance through the marketplace as a result of the Affordable Care Act, Medicaid, etc.
    - Subrecipients must have policies and standard operating procedures regarding the required process for the pursuit of enrollment for all clients.
    - Subrecipients must document the steps during their pursuit of enrollment for all clients.
    - Subrecipients must vigorously pursue Medicaid enrollment for individuals who are likely eligible for coverage, seek payment from Medicaid when they provide a Medicaid-covered service for Medicaid beneficiaries, and back-bill Medicaid for RWHAP-funded services provided for all Medicaid-eligible clients upon determination.[3]
    - RWHAP grantees must make every effort to expeditiously enroll individuals in Medicaid if eligible and inform clients about any consequences for not enrolling.
    - Subrecipients must keep on file documentation showing whether the subrecipient is eligible to be a Georgia Medicaid service provider and a description of the process by which it was determined whether subrecipient service(s) are Medicaid-reimbursable.

12. Clinics can utilize a certificate of exemption, a printout/screenshot of non-eligibility from the health insurance marketplace portal, or proof of income if the client is below 100% FPL as documentation for non-eligibility to a marketplace plan.

Under no circumstances may RWHAP funds be used to pay the fee for a client's failure to enroll in minimum essential coverage.

[3] See Joint CMCS and HRSA Informational Bulletin dated May 1, 2013. Available online at: https://hab.hrsa.gov/sites/default/files/hab/Global/medicaidinfobulletin.pdf

e2Fulton Documentation

- Proof of third party insurance and/or screening for Medicaid must be scanned and attached under Insurance Tab in e2Fulton (see e2Fulton Manual for instructions and file nomenclature).
- Document must have an identifying name which matches the client name in e2Fulton.

Verification of Health Insurance Coverage: Medicaid/Medicare or Third-Party Payer

Adequate Health Insurance

1. All forms of health insurance are considered third party payer.

2. Clients with health insurance available from an employer or other private insurance must apply for and access the offered health insurance.
   - If a client has an adequate employer-sponsored-insurance but has elected NOT to use it, the client must be advised of the restrictions with public funding and that this is not an option.
   - Clients who still choose not to use their insurance must be given a Notice of Ineligibility and this notice must be scanned and uploaded into e2Fulton.

3. For clients with health insurance, services from any of the patient care programs funded under the Ryan White Part A Program will only be considered under the following circumstances:
   - Insurance is inadequate, and does not cover required medical care or pharmaceuticals.
   - The co-pays or premiums are too costly for the client. Unaffordable co-payments mean:
     - The client's monthly total out-of-pocket HIV medication costs are greater than $250 or 10% of household monthly income.
     - The client's monthly total out of pocket costs is less than $250 a month but greater than 10% of client's monthly income.
   - If the client's insurance policy is assessed to have partial coverage or full coverage but co-pays, deductibles and premiums are too high, staff must work with the client to obtain assistance under the Georgia Department of Public Health's Ryan White Part B/ADAP Medicare Part D and Health Insurance Continuation Program (HICP) Prescription Co-Pay Assistance.[4]

[4] The Georgia HICP is a state administered program which assists eligible persons who are unable to pay their health insurance premiums for private/individual or Consolidated Omnibus Budget Reconciliation Act (COBRA) plans. This special program pays a maximum monthly health insurance premium of $1,100.00, which may

Screening for Health Insurance

1. Ask the client if they currently have health insurance.
2. Determine if the client is eligible for insurance.

- **If the client has insurance**:
  - If you are the originating Subrecipient/primary record holder, obtain a copy of the insurance card (front and back), policy coverage, and maintain a copy in the client's eligibility file. Then, scan these documents and upload to the appropriate tab in e2Fulton. If you are not the originating Subrecipient, verify the documentation is in e2Fulton. Note this in the client's file with the date and time the information was verified and by whom OR print a copy of the insurance card and keep in client file. See: **PPPN – 006 e2Fulton.**
  - Determine if the coverage is viable, including pharmaceutical coverage (seek assistance from ADAP staff for assistance as needed).
  - Determine the premium cost to the client, and if help is needed with their portion to maintain coverage (not everyone needs assistance with premium payments).
  - If assistance with premium payments is needed, refer the client (once determined eligible) to the State Ryan White Part B Program for insurance assistance.

- **If the client (or spouse) is employed and insurance is available through the employer, take the following steps**:
  - Determine if the client will have access to insurance, and when access will be available (usually there is an open enrollment period).
  - If open enrollment is not immediate, complete a statement that the client will have access to insurance during open enrollment and document timeframe. Scan the document into e2Fulton. Client will be eligible for coverage for Ryan White Part A services until such time that those services are covered by insurance.
  - The client must access insurance during open enrollment and provide insurance documentation as specified above.
  - Refusal to access employer-based insurance is justification to deny eligibility.

---

include a spouse and children on a family health insurance plan, as well as dental and vision. The HICP has expanded insurance assistance to cover medication co-pays, in addition to premiums, for eligible individuals. The program will only accept new clients who have insurance plans that include both outpatient primary care coverage and prescription coverage without a yearly cap. The HICP allows clients the opportunity and flexibility to continue to access their doctors, maintain a continuum of primary health care and sustain an improved quality of life. In addition, the program has also expanded prescription co-pay assistance to eligible Medicare Part D participants. The Medicare Part D co-pay assistance component of the program will assist individuals with out-of-pocket costs for ADAP approved formulary medications. Georgia HICP services are available to all eligible residents of Georgia at all ADAP-HICP enrollment sites.

- Clients who are not eligible for ADAP assistance and meet all other Ryan White Part A eligibility requirements will not be denied services based on potential eligibility for the Health Insurance Marketplace.

Please note: Proper documentation is required. It is not acceptable to take a client's word they have no access to insurance when employed.

- **If the client has no insurance:**
  - Document steps taken to ensure insurance is not available.
  - If the client is employed but without insurance, the client will need to provide proof that they have no access to insurance from their employer. This can be done in various ways. For example:
    - Letter from employer.
    - Personnel handbook that describes benefits.

- **Additional Considerations**
  - Clients who are in the process of completing the COBRA application may have a lapse in health insurance coverage for a period of 30 to 60 days (during the application process). The application for COBRA should be completed as soon as possible since this option is time limited.
  - Part A dollars may be used to pay for stop-gap medications in the interim for clients who meet other eligibility requirements.

Medicaid

Medicaid, Title XIX of the Social Security Act, is the largest source of public financing for HIV/AIDS care in the United States. Created in 1965, Medicaid is a jointly funded, jointly administered Federal–State health insurance program for low-income people who meet one or more of several categorical eligibility requirements, including disability. The program is administered through the Centers for Medicare and Medicaid Services (CMS). Through Medicaid, the Federal Government provides matching funds to States that meet certain minimum Federal standards in operating their Medicaid programs.

To be eligible for Medicaid, a person must meet the categorical and financial eligibility criteria in his or her State's Medicaid program. Most adults with HIV/AIDS who qualify for Medicaid do so because they meet the disability, income, and assets criteria of the Federal Supplemental Security Income (SSI) program for persons who are aged, blind, or disabled. For purposes of SSI eligibility, a person is disabled if he or she is unable to engage in any gainful activity due to a medically determined physical or mental impairment expected to result in death or last for a continuous period of at least 12 months.

Medicaid is a state and federally-funded entitlement program. The Georgia Department of Community Health (DCH) and/or the Social Security Administration (SSA) determine Medicaid recipient eligibility. Individuals who might be eligible for Medicaid include:

- Single parent household with children under age 18
- Two parent household unemployed or underemployed
- Disabled individuals as determined by the SSA or DCH
- Pregnant women

Ryan White HIV/AIDS Program funds are the payer of last resort in relation to all other state and federal funding sources. This includes Medicaid.

Clients who are Medicaid eligible will not be eligible for Ryan White Part A or HIV/AIDS patient care programs where the same service is covered by Medicaid. Specifically, federal policy requires:

- Ryan White HIV/AIDS Program funds may not be used to pay for Medicaid covered services for Medicaid beneficiaries.
- Ryan White HIV/AIDS Program providers who provide Medicaid covered services must be Medicaid certified.
- Ryan White HIV/AIDS Program providers are expected to vigorously pursue Medicaid enrollment for individuals who are eligible for Medicaid coverage.
- Ryan White HIV/AIDS Program providers must seek payment from Medicaid when they provide a Medicaid covered service for a Medicaid beneficiary.
- Ryan White HIV/AIDS Program providers must back bill Medicaid for any Ryan White Act funded services provided to Medicaid eligible clients once Medicaid eligibility is determined.
- Providers are expected to exhaust mandatory Medicaid dollars before utilizing discretionary Ryan White HIV/ AIDS Program funds.

Ryan White Program funds can be used to fill service and population gaps not covered by Medicaid. When a State's Medicaid program does not cover a specific service, Ryan White funds can be used for payment.

- A copy of Medicaid eligibility must be verified and scanned into e2Fulton every six months for those currently on Medicaid to show current Medicaid status.

- Once an individual is enrolled in Medicaid, RWHAP funds may be used to pay for any medically necessary services which Medicaid does not cover or only partially covers, even when those services are provided at the same visit as Medicaid-covered services.

- Medicaid coverage may start retroactively for up to 3 months prior to the month of application, if the individual would have been eligible during the retroactive period had

he or she applied then.[5] RWHAP services received between the retroactive date of coverage and the date the client is enrolled in Medicaid will need to be back-billed and reimbursed to the RWHAP.

- If the Medicaid prescreening tool determines the client is possibly eligible for Medicaid services, the client must apply for Medicaid. The form must be printed, the client's name and date of screening must be written on the form, and the documents must be scanned into e2Fulton.

- Clients who are deemed ineligible based on the prescreening also must have the form printed; the client's name and date of screening must be written on the form, and the document scanned into e2Fulton.

- It is also expected that RWHAP subrecipients collect and maintain documentation verifying client eligibility for Medicaid or a certificate of exemption from the Marketplace or IRS.

Useful Tools

- **GAMMIS:** The Georgia Medicaid Management Information System (GAMMIS) serves as the primary web portal for Medicaid, PeachCare for Kids® and all related waiver programs administered by the Department of Community Health's Medical Assistance Plans Division. The GAMMIS portal provides timely communications, data exchange and self-service tools for members and providers with both secure and public access areas.
  https://www.mmis.georgia.gov/portal/

  GAMMIS is accessible by all Georgia Medicaid providers and is used to document whether a client has Medicaid coverage.

- Georgia Gateway is the state's integrated system for determining eligibility across multiple benefits programs. These programs include Medical Assistance (Medicaid, PeachCare for Kids®, Planning for Healthy Babies, Aged, Blind and Disabled Medicaid, etc.), Supplement Nutrition Assistance Program (SNAP/Food Stamps), Temporary Assistance for Needy Families (TANF), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Childcare and Parent Services (CAPS)
- Gateway may also be used to locate community partners in each of Georgia's counties that can assist with applying for benefits or managing current benefits.

[5] See http://www.medicaid.gov/Medicaid

Or call 1-877-423-4746.

Types of Medicaid

- Medicaid Qualified Medicare Beneficiary (QMB) – individuals who are eligible to have Medicaid pay for Medicare premiums (Parts A and B), Medicare deductibles, and Medicare coinsurance within limits
- Medicaid Special Low Income Medicare Beneficiaries (SLMB) - individuals eligible to have Medicaid pay Medicare directly for Medicare Part B premiums
- MEDS for Aged and Disabled (MEDS-AD) – entitles a limited group of aged or disabled individuals to receive full Medicaid coverage

A client must meet the requirements, and must NOT have Medicare Part A or B.

Medicare Parts A, B and C

Medicare (Title XVIII of the Social Security Act) is the nation's Federal health insurance program for the elderly and disabled. It was established in 1965 and is also administered by the US Centers for Medicare and Medicaid Services (CMS). Medicare is an important source of coverage for people with HIV/AIDS who are disabled, have sufficient work history to qualify for disability insurance, and live long enough to qualify for Medicare. Some individuals with Medicare coverage also qualify for Medicaid because they have low income levels; they are considered to be dual-eligible. For these individuals, Medicaid provides varying levels of coverage, including payment of premiums, some cost sharing, coverage of services during the waiting period (for those under 65 years), and coverage of prescription drugs.

Medicare is a federally funded entitlement program administered by the US Centers for Medicare and Medicaid Services (CMS). Programs include:

- Health insurance for people aged 65 or older, under age 65 with certain disabilities and at any age with end-stage renal disease.
- Persons with disabilities are eligible for Medicare after two years of being determined disabled by the SSA.

Most Americans ages 65 and older are entitled to Medicare as soon as they are eligible for Social Security payments. People under age 65 who receive Social Security Disability Insurance (SSDI) benefits and individuals with end-stage renal disease may also qualify for Medicare. People with HIV/AIDS who meet SSDI eligibility criteria are eligible for Medicare benefits. The Social Security Administration defines disabled to mean that an individual 18 years or older is unable to engage in any substantial gainful activity due to any medically determinable physical or mental impairment(s) that can be expected to result in death or that has lasted or can be expected to last for a period of not less than 12 months (SSA, 2004). In addition, individuals must have paid Social Security taxes through their workplace for a

minimum number of fiscal quarters. Federal law, however, requires a 5-month waiting period after disability determination to receive SSDI benefits and then a 24-month waiting period before an SSDI beneficiary can join Medicare, resulting in a total of 29 months before receipt of health benefits (SSA, 2004).

Most people receive Medicare health coverage in one of two ways:

- An original Medicare plan (Part A Hospital Insurance or Part B Medical Insurance), or
- A Medicare Advantage Plan, (sometimes referred to as Part C or MA Plans.) Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).

Individuals who are eligible for Medicare must enroll in all coverage that is available.

A significant number of PLWHA are dually eligible for both Medicare and Medicaid. Despite coverage by both sources of public insurance, gaps in care may exist.

Additional information on Medicare can be found at:
http://www.medicare.gov/default.aspx

Medicare Part D

Many Medicare beneficiaries with HIV/AIDS qualify for some type of low-income subsidy (LIS). Dual eligible Medicare beneficiaries on Supplemental Security Income (SSI) and currently in a Medicare Savings Program are automatically eligible for full or partial LIS.

Medicare eligible persons without full LIS or “extra help” must also apply for a Medicare Part D plan.

Part D is prescription drug coverage for Medicare Part A and B recipients.

- Clients eligible to receive Part D must apply through the SSA in order to be eligible for HIV/AIDS patient care programs.
- Part D recipients are required to select a drug plan.
- Monthly premium costs vary depending on the plan selected.
- There are two ways to get Medicare prescription drug coverage:
  - Join a Medicare prescription drug plan that adds drug coverage to the original Medicare plan; or
  - Join a Medicare plan (like an HMO) that includes prescription drug coverage as part of the plan.
- Clients accessing Part D do not need to spend down pharmaceutical benefits prior to enrolling in ADAP; however, clients must apply for the Medicare Part D Low Income Subsidy.

- Additional information can be found at: http://www.medicare.gov

Medicare Part D Low Income Subsidy (Extra Help)

Dual Eligible Clients:

- Have Medicaid and Medicare, and qualify for the Low-Income Subsidy (LIS) automatically. They do not need to apply.
- Must enroll in a Medicare Part D plan.
- Can switch plans every month; however, this is discouraged as it takes several weeks for the information to be finalized, and clients may have challenges accessing medications during this time.

Non Dual Eligible Clients

- Have Medicare only.
- MUST apply for the LIS, and be determined eligible or receive a denial letter.

Clients Eligible for LIS

- Must apply for a Medicare Part D Plan.
- May be enrolled in ADAP and will receive an information packet about the Pharmacy Benefits Manager.

Clients NOT Eligible for LIS

- If income is greater than 150% of the FPL, will most likely fall in the “donut hole” and not be eligible for LIS.
- Must meet the asset requirements for Medicare Part D, apply for the LIS and receive a denial letter.
- May apply for an ADAP waiver. Proof of LIS denial is a requirement.
- May be enrolled in ADAP.
- Must also enroll in a Medicare Part D plan for all non-ADAP medications.

Other Third Party Providers

Patient Assistance Program (PAP)

Patient Assistance Programs are available through most pharmaceutical companies to provide access to free medications to people with limited income.

- Qualification guidelines vary among pharmaceutical companies.

Temporary Assistance to Needy Families (TANF)

The purpose of TANF, previously called Aid to Families with Dependent Children (AFDC), is to:

- Provide assistance to needy families with children so that they can live in their own home or the homes of relatives;
- End the dependency of needy parents on government benefits through work, job preparation, and marriage;
- Reduce the incidence of out-of-wedlock pregnancies; and
- Promote the formation and maintenance of two-parent families.

Supplemental Nutrition Assistance Program (SNAP)

Food stamp benefits are intended to supplement other household income and may only be used to purchase food. Other household items such as cleaning supplies, paper goods, clothes, and alcohol or tobacco products may not be purchased with SNAP benefits.

- To receive SNAP benefits, a household must meet certain conditions. Everyone in the household who is applying must have or apply for a Social Security number and be a U.S. citizen, U.S. national or have status as a qualified alien (documented alien with a green card).

Veterans Affairs (VA)

The VA is an agency created to assist all former members of the Armed Forces of the United States and their dependents in preparing claims for and securing compensation, hospitalization and other medical benefits for eligible persons.

- Veterans will be issued documentation of VA eligibility or denial.
- Enrollment in VA services is not required in order to be eligible for patient care services funded by Ryan White Part A; however, VA services provide comprehensive health care coverage for veterans while the Ryan White Part A only provides coverage for HIV-related services.

Georgia's Children's Medical Services (GCMS)

The Georgia Centers for Medicaid and Medicare Services (GCMS) program provides children with special health care needs with a family centered, managed system of care.

- Children with special health care needs are those children under age 21 whose serious or chronic physical, developmental, behavioral, or emotional conditions require extensive preventive and maintenance care beyond that required by typically healthy children.
- GCMS provides a comprehensive continuum of medical and supporting services to medically and financially eligible children, and high-risk pregnant women.

For more information: http://dph.georgia.gov/CMS

Social Security Disability Insurance (SSDI)

SSDI is a payroll tax-funded federal government insurance program managed by the SSA.

- Provides income to people who are unable to work due to a disability.
- To qualify, individuals must have a physical or mental condition that prevents them from engaging in "substantial gainful activity". The condition is expected to last at least 12 months or result in death. They are under the age of 65 and have worked 40 quarters (at least 10 years).

To apply for SSDI or find more information visit: http://www.ssa.gov/disability/

Supplemental Security Income (SSI)

SSI is a cash assistance program administered by the SSA.

- Provides financial assistance to aged, blind, or disabled individuals who have little or no income.
- Provides cash to meet basic needs for food, clothing, and shelter.
- To be eligible, a person must be a U.S. citizen, have resources of no more than $2,000, and have an income less than $674 a month for an individual.
- Persons eligible for at least $1 in SSI automatically receive Medicaid.

To apply for SSI or find more information, visit http://www.ssa.gov/ssi/

e2Fulton Documentation

- All forms of third party payer insurance must be scanned and attached under Eligibility Tab in e2Fulton (see e2Fulton Manual for instructions and file nomenclature).
- Document must have an identifying name which matches the client name in e2Fulton.

Recertification

1. Clients must be recertified as Ryan White-eligible every 6 months or sooner if circumstances change.

Eligibility Determination (any day during that month)		Eligibility End Date (recertification must be done by last day of the month)	
1	January	July 31st	7/31
2	February	August 31st	8/31
3	March	September 30th	9/30
4	April	October 31st	10/31
5	May	November 30th	11/30
6	June	December 31st	12/31
7	July	January 31st	1/31
8	August	February 28th or 29th	2/29
9	September	March 31st	3/31
10	October	April 30th	4/30
11	November	May 31st	5/31
12	December	June 30th	6/30

2. Eligibility recertification processes may be conducted electronically and through self-attestation.

3. At six month recertification one of the following is acceptable: *full application and documentation, self-attestation of no change or self- attestation of change with documentation.* **See Self-Attestation below**.

4. Staff must remind the client of their responsibility to advise the eligibility staff of any circumstances that could impact their eligibility status.

5. A 30 day **grace period** will be allowed for clients who are pending eligibility documents in order for the client to obtain necessary documentation. The grace period begins on the Eligibility End Date.
   - Enrollment staff must place a note in the annual review screen in e2Fulton to ensure that other subrecipients know what documents are pending and the current staff person (and contact information) working with that client.
   - When clients finalize their eligibility the 30 day grace period is included in the 6 months. For example: A client is pending from January 1, 2021 to February 1, 2021; the client would need to recertify by July 31, 2021.
   - If a client has not recertified prior to the end of the grace period, they will be dropped from all elements of the Ryan White program. If a waiting list were to be present at

this time, the individual that did not recertify in a timely fashion would be placed at the end of the waiting list.

Self-Attestation

Self-attestation allows flexibility in meeting the needs of clients and reducing administrative burden on subrecipients.

- Clients may self-attest by phone, Skype, Face Time, e-mail or similar methods so long HIPPA rules are not violated and the methodology used is clearly documented in the client's file. Clients do not need to have a separate in person visit to recertify.
- Subrecipient must document method of self-attestation in clients file.

1. Once during each 12 month period the client needs only to self-attest that there have been no changes in eligibility requirements (e.g., income, residency, third-party payer status).

   To self-attest:
   - The staff person working with the client to assess eligibility will print out a copy of the one page client report from the Demographics tab in e2Fulton.
   - The staff person or the client will write on the report that that there have been no changes and sign. The staff person working with the client to assess eligibility will scan the form into e2Fulton.

2. If there are changes in income, health insurance status, etc. client will need to bring or securely send electronically relevant documentation so that eligibility may be determined.

Verification:

- Review charts (paper or electronic) to ensure presence of acceptable documentation of HIV status, residency in EMA, and income ≤ 400% FPL. Ensure that documentation has been scanned into e2Fulton as appropriate.
- Verify that subrecipient internal policies requiring issued photo identification clearly state that the lack of such identification shall not delay enrollment in Ryan White services, provision of medications, nor result in the discharge of a client from Ryan White Services.
- Verify that affected family members or partners of HIV positive clients who have received Ryan White Part A services meet specific eligibility requirements.
- Monitoring to determine that Ryan White is serving as the payer of last resort, including review of client records and documentation of billing and collection policies and procedures and information on third party contracts.
- Review client records for proof of screening for health insurance coverage.
- Document that clients provisionally enrolled have received only those services allowed under this policy.

- Ensure that ART has not been provided via RW Part A funds without clinician's statement of medical necessity for the immediate initiation of therapy.

- Ensure clients with VA benefits are classified as uninsured.
- Ensure clients eligible for Indian Health Services Benefits are classified as uninsured.
- Verify documentation of steps during their pursuit of enrollment for all clients,
- Review policies and proof of consistent implementation of efforts to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance or other programs.
- Verify back-bill to Medicaid for RWHAP-funded services provided for all Medicaid-eligible clients upon determination.
- Review documentation showing whether the subrecipient is eligible to be a Georgia Medicaid service provider and a description of the process by which it was determined whether subrecipient service(s) are Medicaid-reimbursable.
- Review recertification process. Verify recertification in client charts.
- Review documentation that enrollment and client eligibility staff are aware of this policy.
- Review documentation indicating staff have been trained on this policy and reminded of this policy no less frequently than annually.

Approved October 2016

Reviewed March 2021