Required Documentation and/or Forms for

Ryan White Part A and B Client Assistance Fund (CAF) Requests

Before submitting a CAF request, please make sure you have reviewed the CAF Policies and Procedures.

1. ACT Fax Checklist: This document outlines all materials needed to be submitted with a HAF Request. Ensure that all materials are submitted with a request by checking off materials included in the application on the checklist.

2. Request for Service Form: This form outlines the service payment is requested for and other options that have been explored to assist with the request. The request form must be filled out in its entirety and signed by the requesting case manager and case manager supervisor. This form is available on our website (http://www.aids-ct.org/assistance.html).

3. Referral: Referral for service can be made through CAREWare or if your agency doesn't use CAREWare, use the *Referral for Ryan White Part A Services* Form. A referral should be made with every request.

4. Ryan White Intake Form OR CAREWare Demographic Report: If client's CAREWare record is up-to-date, and sharing is granted, CAF staff can see the client's demographic report in CAREWare **and a paper form is not needed**. The intake includes basic information about the client including name, date of birth, race/ethnicity and mode of HIV transmission. Intake forms are formatted on an agency basis. If you need an example of an intake form, please email cafhaf@aids-ct.org.

5. Up-to-Date Annual Review: If client's CAREWare record is up-to-date, and sharing is granted, CAF staff can see the client's annual review in CAREWare and **a paper form is not needed**. The annual review includes an assessment of the client's income, needs for mental health and substance use services and housing arrangement. If your agency does not use CAREWare, this information is often included on the agency's intake form.

6. Ryan White Eligibility Worksheet and Income Verification: There are two Ryan White required forms, along with income verification required for a CAF request to be considered. The two required forms are: Ryan White Eligibility Worksheet and Client CAP and Sliding Fee Determination. Income verification includes: two consecutive, **recent** bi-weekly paystubs, four consecutive weekly paystubs, unemployment, and SSI statement. Clients or other household members with no income are required to fill out a zero income affidavit. Notarized letters documenting income will be considered on a case-by-case basis. The Eligibility Worksheet and Income Verification expires every six months. A sample is included here, and a fillable Excel spreadsheet is available on our website (http://www.aids-ct.org/assistance.html).

7. Release of Information: The Release of Information (ROI) grants the referring case manager/agency permission to share the client's information with AIDS Connecticut. The ROI should be made out specifically to AIDS Connecticut, or AIDS Connecticut should be initialed on the Network of Providers sheet. An ROI made out to the Network of Providers should not also be initialed for "This agency only**." The ROI is valid for 18 months** from the date of client's signature.

8. ACT Bill of Rights: The ACT Policies and Procedures outline the client's rights as a participant in ACT's programs, ACT's privacy and consent/release of information practices, and ACT's grievance procedure. **This form is valid for 12 months** from the date of client's signature.

9. Consent Agreement Statement: This form grants the referring agency consent to coordinate services on the client's behalf. This form should be made out to the referring agency and **is valid 18 months** from the date of client's signature.

10. ACT CAREWare Consent for Sharing: This form grants ACT the right to share the client's CAREWare information with the referring agency and other agencies for the coordination of services and for the agency to input data into CAREWare. This form should be made out to AIDS Connecticut and is **valid for 18 months** from the date of client's signature.

11. Referring Agency CAREWare Consent for Sharing: This form grants the referring agency the right to share the client's CAREWare information with other agencies for the coordination of services and for the agency to input data into CAREWare. This form should be made out to the referring agency and is **valid for 18 months** from the date of client's signature.

12. Up-to-Date Labs: CD4 and Viral Load labs should be within the last six months. If CD4 or Viral Load are not medically necessary every six months, a doctor's note should be included stating as such.

13. Supporting Documentation: Supporting documentation can include an itemized bill or detailed invoice.

FAX

TO: AIDS Connecticut Client Assistance, Fax # 860-761-6711

FROM:_____ Email:_____

DATE:_____ PAGES:_____ (including cover)

RE: **ACT CAF Request**

Required Checklist:

In CW Attached

- ❑ Request for Service Form
  - ❑ Health Insurance Premium & Cost Sharing Assistance
  - ❑ Medication Assistance
  - ❑ Transportation, including Transportation Arrangement Form
  - ❑ Food Voucher
  - ❑ Utilities

❑ ❑ Signature of Requesting Case Manager

❑ ❑ Signature of Supervisor

❑ ❑ Referral (and grant Clinical and Service Sharing in CAREWare, if applicable)

❑ ❑ Ryan White Intake Form OR CAREWare Demographic Report

❑ ❑ Up-to-date Annual Review

❑ ❑ Ryan White Eligibility Worksheet and Income Verification

❑ ❑ Release of Information to AIDS Connecticut *(external agencies ONLY)*

❑ ❑ Signed ACT Policies and Procedures

❑ ❑ Signed Consent Agreement Statement

❑ ❑ Signed ACT CAREWare Consent for Sharing

❑ ❑ Signed CAREWare Consent for Sharing *(external agencies ONLY)*

❑ ❑ CD4/VL within last 6 months (or doctor's note stating not medically necessary)

❑ ❑ Supporting documentation (e.g., detailed invoice, itemized bill)

****For housing requests, please use the HAF Fax Checklist**

REFERRAL FORM FOR RYAN WHITE PART A SERVICES

CLIENT ID (LLFFMMDDYYG)*

OLD CLIENT ID (DDMMYYFFLL) (if applicable)

Last Name _____ **First Name** _____ **Date of Birth** _____

Client Phone No. _____ **Town** _____ **Zip Code** _____

Gender:
___Male
___Female
___Transgender
___Unknown/Unreported

Ethnicity:
___Hispanic/Latino/a
___Non Hispanic/Latino/a
___Unknown/ Unreported

Race:
___White
___Black
___Asian
___Native Hawaiian/Pacific Islander
___American Indian
___More than one race
___Unknown/Unreported

Transmission Category:
_____MSM
_____IDU
_____MSM /IDU
_____Heterosexual
_____Perinatal
_____Transfusion
_____Other / Unknown

HIV Status:
_____HIV Positive (non-AIDS)
_____HIV Negative (non-AIDS)
_____HIV Status Unknown
_____Indeterminate (non-AIDS)
_____AIDS Diagnosis

Insurance: (if Title XIX, see boxes below)
____Known, Specify _____
____Unknown/unreported
____No Insurance

Living Arrangements:
____Homeless on street
____Homeless in shelter
____Transitional housing
____Residential - Psych
____Residential - Group
____Residential Drug Tx
____Nursing facility/Hospice
____Hospital
____Correctional facility
____Permanent housing - Rent
____Permanent housing - Owns
____With relations/friends

Language_____

Household Size _____

Referral Addressed to _____ **at** _____
(Agency Representative) (Agency)

Referral for _____ **at** _____
(Type of Service) (Site where services are sought if other than at above agency)

Referred by: _____ **at** _____
(Person Making Referral) (Referring Agency)

Contact Referring Person at Phone # _____ Fax # _____

____Documentation of HIV Status is on file.

X Client meets Ryan White financial eligibility criteria: **Annual Income $** _____
____Financial documentation/proof of income on file:_____ Kind and date of documentation:

Client eligibility expires on: Date _____ (no more than 6 months after date of documentation)

For Accessing Transportation, the Follow Must Be Completed:

The client has tried to access transportation services through:

Date of Application Source

_____ Title XIX (Medicaid)

_____ Is not eligible for SSI or SSD (transportation) and is not eligible for Reduced Bus Pass/Free transportation (Veterans). Client is not on a fixed bus route (Connecticut Transit Authority) or cannot access a bus for health reasons (document).

For Accessing Dental Services, the Following Must Be Completed:

The client is not able to access dental services through Title XIX (Medicaid) or other public or private insurance or entitlements. (Documentation by the case manager must accom0any this referral for all Title XIX recipients).

I certify (a) that I have the above noted documentation on file for this client; (b) that the client meets the Federal Ryan White financial eligibility criteria of less than 300% of the poverty level; and/or (c) the accuracy of the transportation information.

_____ _____
Signature of Case Manager / Provider Representative Date of Referral

Release of Information Form **must** accompany this form.

Ryan White Part A

AUTHORIZATION TO RELEASE INFORMATION

This is to certify that I hereby give my consent to, and authorize:

_____ _____
(name of agency) (case manager/counselor)

to release a copy of the following information in their possession, including oral disclosure, consisting of but not limited to the following: *(**INSTRUCTIONS**: Client must initial to signify approval, or write "NO" to signify disapproval. All blanks must be filled in or marked "N/A", not applicable)*

_____Medical records, including HIV related information
_____Psychiatric, psychological, psychotherapy or other counseling records
_____Alcohol and/or drug treatment related information
_____Public assistance
_____Financial
_____Employment
_____Other

OF: _____ Date of Birth:_____
(client name)

TO:_____ _____
(name of agency) (case manager/counselor)

_____
(address of agency)

In addition, I have been given the opportunity to review an attached list of the provider network member agencies and also authorize release of information, including oral disclosure between agencies, of the above-cited information to access services within the provider network, as follows:

(Initial to signify approval, or write "NO" to signify disapproval)
_____This agency only
_____Entire network of service providers (not valid without attached list of initialed service providers)
_____Other agencies, as noted:_____
_____ Decline Early Intervention Services

All records are confidential pursuant to Connecticut General Statutes §§ 19a-583. I understand that the records to be released may contain confidential HIV/AIDS related information. I understand that I may revoke this authorization for release at any time by notifying the above-authorized person in writing, except to the extent that information has already been shared. If not revoked by me, I understand this release is valid for **eighteen** months from the date it was signed. By signing this form, ***I further acknowledge that if I fail to show for scheduled medical and other service appointment, I may be contacted by an authorized representative of the Early Intervention Service Program in order to re-engage and link me back to care.*** This release shall be considered invalid without an attached dated copy of network providers.

_____ _____ _____
(Signature of client or legal representative) (Witness) (Date signed)

PROHIBITION OF REDISCLOSURE: This information is disclosed to you from records of persons whose confidentiality is protected by Federal and State law. State law and regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. *Please honor a mechanical reproduced copy of this release.*
Revised 4/16HFTDTGA

Ryan White A & B Provider Network

	Client Initials		Client Initials
AIDS Connecticut 110 Bartholomew Ave Hartford, CT 06106		Hartford Hospital/ Brownstone Clinic 80 Seymour Street Hartford, CT 06102	
Hartford Gay & Lesbian Health Collective P.O. Box 2094 Hartford, CT 06145		Health Collective East 64 Church Street Manchester CT 06040	
St Francis Hospital/Burgdorf Clinic 131 Coventry Street, Hartford, CT 06112		Human Resources Agency of New Britain, Inc. 83 Whiting Street, New Britain, CT 06051	
City of Waterbury Health Department 95 Scovill Street Waterbury, CT 06320		Hispanic Health Council 175 Main Street Hartford, CT 06106	
Community Health Services, Inc. (CHS) 500 Albany Avenue Hartford, CT 06112		Latino Community Services 184 Wethersfield Avenue Hartford, CT 06114	
Community Health Center, Inc. (CHC) 33 Ferry Street Middletown CT 06457		Mercy Housing & Shelter 211 Wethersfield Avenue Hartford, CT 06114	
Community Renewal Team (CRT) 555 Windsor Avenue Hartford, CT 06120		Rockville/Vernon General Hospital 145 Union Street Rockville CT 06066	
University of CT Medical Health Center 263 Farmington Ave. Hartford, Ct 06106		THOCC-New Britain Campus 100 Grand Street New Britain, CT 06050	
CT Children's Medical Center 282 Washington Street Hartford CT 06106		Charter Oak Health Center 21 Grand St Hartford, CT 06106	
CT AIDS Drug Assistance Program (CADAP) CT Dept. of Social Services (DSS), 55 Farmington Ave Hartford, CT 06106			

Client Signature: _____ Date: _____

Witness: _____ Date: _____

Revised 4/16 RWHtfd

Ryan White Parte A

AUTORIZACION PARA LA ENTREGA DE INFORMACIÓN

Esto es para certificar que por este medio doy mi consentimiento para, y autorizar:

_____ _____
(Nombre de la Agencia) (Administrador de casos/Consejero)

Para entregar una copia sobre la siguiente en su poder, incluyendo la divulgación verbal, que consiste en, pero no limitada a lo siguiente:
***(INSTRUCCIONES**: Cliente necesita inicial al lado de lo que aprueba o escribir "NO" a lo desaprobado. Todos los espacios en blanco deben ser llenados o marcados "N/A, no aplica)*

_____Registros médicos, incluyendo la información relacionada con el VIH
_____ Psiquiatría, psicológica, psicoterapia u otros registros de asesoramiento
_____ Información relacionada con el tratamiento de alcohol y/o drogas
_____ Asistencia Pública
_____Financiero
_____Empleo
_____Otro

DE: _____ Fecha de Nacimiento:_____
(nombre del cliente)

PARA :_____ _____
(nombre de la agencia) (administrador de casos/consejero)

_____
(Dirección de la agencia)

Además, se me ha dado la oportunidad de revisar una lista adjunta de los miembros de agencias de la red de proveedores y también autorizar y proveer mi información, incluyendo divulgación verbal entre las agencias antes citadas para acceder a servicios dentro de la red de proveedores como sigue:

Cliente necesita inicial al lado de lo que aprueba o escribir "NO" a lo desaprobado.
_____Esta agencia solamente
_____Toda la red de proveedores de servicios (no válidos y sin lista adjunta de proveedores de servicios)
_____Otras agencias anotadas:_____
_____ Rechazar los servicios de intervención temprana

Todos los registros son confidenciales a conformidad con los estatutos generales de Connecticut 19a-583. Entiendo que los expedientes puedan estar expuestos en libertad y puede contener información confidencial relacionada con el VIH / SIDA. Entiendo que puedo revocar esta autorización para la liberación en cualquier momento mediante notificación a la persona anteriormente autorizado por escrito, salvo en la medida en que la información que ya ha sido compartida. Si no revocado por mí, entiendo este comunicado es válido durante **dieciocho meses** desde la fecha de su firma. *Al firmar esta forma, yo reconozco que si no puedo mantener la cita de servicio médico y de otra, puedo ser contactado por un representante autorizado del programa de servicio de intervención con el fin de volver a participar en mí cuidado médico.* Este comunicado se considerará inválido y sin una copia fechada adjunta de proveedores de la red.

_____ _____ _____
(Firma del cliente o representante legal) (Testigo) (Fecha de la firma)

PROHIBICIÓN DE DIVULGACIÓN: Esta información se da a conocer a usted de los registros de las personas cuya confidencialidad está protegida por la ley federal y estatal. Leyes y reglamentos del Estado que prohíben hacer cualquier otra revelación de esta información sin el consentimiento expreso y por escrito de la persona a quien pertenece, o según lo permitido por dicha ley. Una autorización general para la divulgación de información médica o de otro no es suficiente para este propósito. Por favor honrar una copia mecánica reproducido de este comunicado.
Revisado 4/16 de Hartford TGA RW Parte A

Ryan White Parte A & B Red de Proveedores

	Iniciales del Cliente		Iniciales del Cliente
AIDS Connecticut 110 Bartholomew Ave Hartford, CT 06106		Hartford Hospital/ Brownstone Clinic 80 Seymour Street Hartford, CT 06102	
Hartford Gay & Lesbian Health Collective P.O. Box 2094 Hartford, CT 06145		Health Collective East 64 Church Street Manchester CT 06040	
St Francis Hospital/Burgdorf Clinic 131 Coventry Street, Hartford, CT 06112		Human Resources Agency of New Britain, Inc. 83 Whiting Street, New Britain, CT 06051	
City of Waterbury Health Department 95 Scovill Street Waterbury, CT 06320		Hispanic Health Council 175 Main Street Hartford, CT 06106	
Community Health Services, Inc. (CHS) 500 Albany Avenue Hartford, CT 06112		Latino Community Services 184 Wethersfield Avenue Hartford, CT 06114	
Community Health Center, Inc. (CHC) 33 Ferry Street Middletown CT 06457		Mercy Housing & Shelter 211 Wethersfield Avenue Hartford, CT 06114	
Community Renewal Team (CRT) 555 Windsor Avenue Hartford, CT 06120		Rockville/Vernon General Hospital 145 Union Street Rockville CT 06066	
University of CT Medical Health Center 263 Farmington Ave. Hartford, Ct 06106		THOCC-New Britain Campus 100 Grand Street New Britain, CT 06050	
CT Children's Medical Center 282 Washington Street Hartford CT 06106		Charter Oak Health Center 21 Grand St Hartford, CT 06106	
CT AIDS Drug Assistance Program (CADAP) CT Dept. of Social Services (DSS), 55 Farmington Ave Hartford, CT 06106			

Firma del Cliente: _____ Fecha: _____

Testigo: _____ Fecha: _____

Revisio 4/16 RWHtfd

AIDS Connecticut
Policy and Procedure Acknowledgement

I have received a copy (or have had read to me) the following AIDS Connecticut policies and procedures: 1) Client Consent and Agreement; 2) Notice of Privacy Practices; 3) Client Bill of Rights; 4) Grievance Procedure and 5) Release of Information Procedure

1. Client Consent and Agreement

Policy: ACT requires that a signed informed consent agreement be signed between the agency submitting an application to ACT and the client. This agreement must be submitted to ACT as part of an application for services. This form authorizes the information on the application to be submitted. Applications cannot be reviewed without the client's express permission.

2. Notice of Privacy Practices

Policy: All records are confidential as per CT state law. Client information is made available to funding agencies without written permission for quality assurance and reporting purposes. Information obtained by the funding agencies for quality assurance and reporting purposes will utilize a coded client identifier when reported. All other client data will be maintained at ACT's office in a secured location with access limited to provider designated staff and quality assurance staff from funding sources. Additional ACT office practices regarding confidentiality are spelled out on our website at: www.AIDS-CT.org. A copy of the CT state law is provided below.

Sec. 19a-581. Definitions. (8) **"Confidential HIV-related information"** means any information pertaining to the protected individual or obtained pursuant to a release of confidential HIV-related information, concerning whether a person has been counseled regarding HIV infection, has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify a person as having one or more of such conditions, including information pertaining to such individual's partners;
(9) "Release of confidential HIV-related information" means a written authorization for disclosure of confidential HIV-related information which is signed by the protected individual or a person authorized to consent to health care for the individual and which is dated and specifies to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information is not a release of confidential HIV-related information, unless such authorization specifically indicates its dual purpose as a general authorization and an authorization for the release of confidential HIV-related information and complies with the requirements of this subdivision…

Sec. 19a-583. Limitations on disclosure of HIV-related information. (a) No person who obtains confidential HIV-related information may disclose or be compelled to disclose such information, except to the following:
(1) The protected individual, his legal guardian or a person authorized to consent to health care for such individual; (2) Any person who secures a release of confidential HIV-related information; (3) A federal, state or local health officer when such disclosure is mandated or authorized by federal or state law; (4) A health care provider or health facility when knowledge of the HIV-related information is necessary to provide appropriate care or treatment to the protected individual or a child of the individual or when confidential HIV-related information is already recorded in a medical chart or record and a health care provider has access to such record for the purpose of providing medical care to the protected individual; (5) A medical examiner to assist in determining the cause or circumstances of death; (6) Health facility staff committees or accreditation or oversight review organizations which are conducting program monitoring, program evaluation or service reviews; (7) A health care provider or other person in cases where such provider or person in the course of his occupational duties has had a significant exposure to HIV infection, provided …. criteria are met (8) Employees of hospitals for mental illness operated by the Department of Mental Health and Addiction Services information. Disclosure shall be limited to as few employees as possible and only to those employees with a direct need to receive the information to achieve the purpose authorized by this subdivision;…

3. Client Bill of Rights

As a participant in ACT's programs, you have the right . . .

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, sex/gender, gender expression or identity, ethnicity, national origin, religion, age, class, sexual orientation, physical and or mental ability.
- To participate in creating a plan with the case manager submitting your application to ACT.
- To be informed about services and options available to you.
- To withdraw your voluntary consent to participate in the program, but you will no longer be eligible for our services.
- To have your medical records and case management records be treated confidentially.
- To have information released only in the following circumstances: (a) When you sign a written release of information; (b) When there is a medical emergency; (c) When a clear and immediate danger to you or to others exists; (d) When there is possible child or elder abuse; (e) When ordered by a court of law.
- To file a grievance about services you are receiving or denial of services.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

As a participant in our program you have the responsibility...

- To treat the staff of this agency with respect and courtesy.
- To participate as much as you are able in creating a plan for stable living with your case manager.
- To let your case manager know any concerns you have about your needs.
- To provide to the best of your ability the required documentation outlined in the program application.
- To stay in communication with your case manager by informing him/her of changes in your address or phone number and responding to the case manager's calls or letters to the best of your ability.
- To not subject agency case managers, staff, or other clients to physical, sexual, verbal and/or emotional abuse or threats.

4. Grievance Procedure

Policy: If an applicant for ACT's programs is denied assistance or deemed ineligible, the client has the right to file an appeal/grievance.

Procedure: The client should instruct his/her case manager to complete a copy of ACT's appeal/grievance policy form. This form and step-by-step instructions must be used to file an appeal/grievance. All case managers have a copy of this form, which is also available on-line at www.AIDS-CT.org.

5. Release of Information Procedure

Policy: AIDS Connecticut will not release client information, unless required by law, without a completed release of information form. A client will be informed in writing of the reason for the request and will be presented with a release of information form. (ACT requires a completed release of information in order to receive an application from a client, but will not release any information without one specifically allowing ACT to do so. A release of information will be provided at the time a request to release information is made to the client.)

I, _____, understand the above policies.

_____

Client Signature Date

_____

Case Manager Signature Date

This is valid for 1 year from date of signature.

AIDS Connecticut
Aceptación de Pólizas y Procedimientos

He recibido (o me han leído) una copia de los siguientes procedimientos y pólizas de AIDS Connecticut: 1) Acuerdo y Consentimiento del Cliente; 2) Información sobre Práctica Privada; 3) Los Derechos del Cliente; 4) Procedimiento para presentar una querella y 5) Procedimiento de Autorización de permiso.

1. Acuerdo y Consentimiento del Cliente

Poliza: ACT requiere que una forma de acuerdo y Consentimiento sea firmada por el cliente y la agencia que esta sometiendo una solicitud de servicios a ACT. Este acuerdo deberá ser sometido a ACT como parte de la solicitud de servicios. Esta forma autoriza que la información en la solicitud sea sometida. Solicitudes no pueden ser revisadas sin la autorización de el cliente.

2. Información sobre Práctica Privada

Poliza: De acuerdo a las leyes de CT, todos los expedientes son confidenciales. La información del cliente esta disponible a las agencias que costean los programas sin permiso escrito con el objetivo de evaluar calidad de servicios y para auditoría interna solamente. La información obtenida por las agencias que costean los servicios para evaluación de servicios y auditoría interna, utiliza un código para identificar al cliente cuando someten sus informes. Toda otra información del cliente será mantenida en las oficinas de ACT en un lugar seguro con acceso limitado al persona que hace las evaluaciones y someten las auditorías internas. Información adicional relacionada a las prácticas de confidencialidad de las oficinas de ACT puede encontrarse en nuestro website: www.AIDS-CT.ORG . Una copia de de la ley del estado de CT se provee a continuación.

Sec. 19a-581. Definiciones. (8) **"Información confidencial relacionada con VIH"** quiere decir que cualquier información relacionada con la protección de la persona, o obtenida conforme a un permiso de confidencialidad de información relacionada con la infección d el VIH, preocupación de que una persona recibió consejería relacionada con la infección del VIH, a sido objeto de la prueba del VIH, o tiene la infección del VIH, o enfermedades relacionadas con el VIH o SIDA, o información que pueda identificar o razones que puedan identificar a una persona teniendo una o mas de estas condiciones, incluyendo información que pueda identificar a los parejos;
(9) "Permiso confidencial de información relacionada con el VIH" quiere decir un permiso escrito autorizando a divulgar información confidencial relacionada con el VIH firmado por la persona protegida o persona autorizada a aprobar el cuidado de la salud de la persona protegida y que deberá tener la fecha y especificaciones a quien se autoriza a compartir la información, el propósito de compartir la información y la duración que el permiso será efectivo. Un permiso general autorizando la divulgación de información medica u otras informaciones no es un permiso de confidencialidad de información relacionada con el VIH, a menos que el permiso específicamente indique que tiene un propósito doble como una autorización general y autorización para proveer información confidencial relacionada con el VIH y cumple con los requisitos de esta subdivisión…

Sec. 19a-583. Limitaciones en la divulgación de información relacionada con el VIH. (a) Ninguna persona que obtiene información confidencial relacionada con el VIH puede divulger o esta obligado a divulgar la información, except los siguientes:
(1) El individuo protegido, el tutor legal o persona autorizada a approval el cuidado de salud del individuo protegido; (2) Cualquier persona que tenga un permiso de confidencialidad autorizando a divulgar información relacionada con el VIH; (3) Un oficial federal, estatal o del departamento de salud cuando la divulgación de información es mandatorio o autorizada por las leyes federales o estatales; (4) Un proveedor de salud o facilidad donde se ofrece cuidado de salud cuando la información del VIH es necesaria para proveer un cuidado de salud apropiado o tratamiento para la persona protegida o un hijo de la persona protegida o cuando la información del VIH esta en el record medico y un proveedor de salud tiene acceso al dicho record para proveer cuidado medico apropiado a la persona protegida;. (5) Un patólogo para asistir en la determinación de las causas o circunstancias de la muerte; (6) Comites de personal de facilidades medicas o agencias que dan acreditación o supervisan y evalúan las organizaciones donde conducen monitoria, evaluación de los programas o servicios; (7) Un proveedor de de servicios médicos u otra persona en caso que durante los servicios proveidos por esa persona o proveedor en el curso de sus responsabilidades de trabajo a sido expuesto significamente a la infección del VIH, proveyendo…. Que los criterios han sido seguidos (8) Empleados de hospitales de salud mental operados por el Departamento de de Salud Mental y Servicios de Adición pueden tener acceso a la información, Divulgación de la información deberá estar limitada a un grupo limitado de empleados y solamente aquellos empleados que necesitan la información para lograr los propósitos autorizados por esta subdivisión;…

3. Ley de los derechos del Cliente

Como participante de los programas de ACT's, usted tiene el derecho a…

- A ser tratado con respeto, dignidad, consideración y compasión.
- A recibir servicios sin discriminación basado en la raza, color, sexo/género, expresión de género o identidad, etnicidad, origen nacional, Religión, edad, clase, orientación sexual, habilidades físicas y mentales.
- A participar en crear un plan con la trabajadora de caso médico sometiendo su solicitud de servicios a ACT.
- A ser informado sobre las opciones y servicios disponible para usted.

- A terminar su consentimiento voluntario a participar en este programa, aunque eso resulte en la inelegibilidad para recibir nuestros servicios.
- A que sus expedientes médicos y los expedientes de su trabajadora médico de caso sea tratados con confidencialidad.
- Su información deberá ser divulgada solamente en las siguientes circunstancias: (a) Cuando usted firma un permiso escrito; (b) Cuando hay un caso de emergencia; (c) Cuando existe evidencia de daño inmediato hacia usted u otros; (d) Cuando existe posible abuso hacia niños o adultos; (e) Cuando sea ordenado por una corte.
- Para presentar una querella sobre los servicios que recibe o que se le niegue un servicio.
- Que no sea sometido a abuso o amenazas físicas, verbales, sexuales, y/o abuso emocionar.

Como participante de nuestro programa usted tiene la responsabilidad de:

- Tratar al personal de esta agencia con respeto, dignidad y cortesía.
- Participar al máximo posible en la creación de un plan estable con su trabajadora de caso.
- Dejarle saber cualquier preocupación que usted tenga sobre sus necesidades.
  Proveer de acuerdo a sus habilidades los documentos requeridos en la solicitud de servicios del programa.
- Mantenerse en comunicación con su trabajador médico de caso informandole a el/ella de cualquier cambio en su dirección o número de teléfono y respondiendo a las llamadas de su trabajador médico de caso o cartas de acuerdo a sus habilidades.
- No someter a su trabajadora médico de caso, personal u otros clientes a abuso o amenazas fisicas, sexuales y/o verbales.

4. Procedimiento para presentar una Querella

Poliza: Si a un solicitante de los programas de ACT se le niega asistencia o se considera ilegible, el cliente tiene derecho a presentar una querella/apelación.

Procedimiento: El cliente deberá solicitar a su trabajador médico de caso que complete un formulario de querella de acuerdo a las normas y reglas de ACT. Este formulario y las instrucciones de los pasos a seguir, deberán ser seguidos durante la presentación de la querella/apelación. Todos los trabajadores médicos de caso tienen una copia de este formulario, que también se encuentra en el website www.AIDS-CT.ORG.

5. Procedimiento de Autorización de Permiso

Póliza: AIDS Connecticut divulgará información del cliente, a menos que sea requerido por un proceso legal, únicamente con un permiso completamente firmado. El cliente será informado por escrito las razones para pedir el permiso y recibirá una copia del formulario para la Autorización de Divulgación de Información. ACT requiere una forma de autorización de permiso completada para poder recibir una solicitud de servicios de el cliente, pero no divulgará ninguna información que no sea específicamente autorizada por el cliente. Un permiso de autorización de información será presentada al cliente en el momento que se requiera divulgación de información.

Yo, _____, Entiendo las polizas mencionadas arriba.

_____

Firma del Cliente Fecha

_____

Trabajador Médico de Caso Fecha

Esta forma es valida por un año desde el día que fue firmada.

AIDS Connecticut
Client/Housing Assistance Fund

APPEAL/GRIEVANCE POLICY

Purpose: If an applicant for the Client/Housing Assistance Fund is denied assistance or deemed ineligible, the following appeal/grievance procedure is available to that applicant.

Process: The following is the procedure that AIDS CT asks clients to follow to file an appeal/grievance:

1.) Client should inform their primary case manager of their desire to appeal/grieve within 90 days of decision.

2.) The case manager will contact AIDS CT and request an appeal/grievance form. (Attached)

3.) Client will complete top half of form stating why he/she believes he/she is eligible based on the published criteria for the fund. (Attached)

4.) The AIDS CT Housing/Client Assistance Administrator will review the form with his/her immediate supervisor to determine if there is new or different information presented that would allow for eligibility based on the published criteria.

5.) If there is new information that overturns the Housing/Client Assistance Administrator's original decision, an acceptance letter will be sent to the case manager. If there is not new information that qualifies the client, the application will continue to be denied and the case manager will be informed.

6.) If the client is still not satisfied and would like to take a last and final step, he/she must re-submit the form with additional information or explanation to the Executive Director of AIDS CT for final determination.

7.) All decisions of the Executive Director are final and binding.

AIDS Connecticut
Client/Housing Assistance Fund

APPEAL/GRIEVANCE POLICY FORM

Top half to be filled out by client

Today's Date: _____

Client Name: _____

Grievance: (Please be as specific as possible) _____

_____

_____

(Use additional sheets if necessary. Attach all supporting documentation.)

Case Manager's Name _____

_____

Client Signature

Bottom half to be filled out by* AIDS CT *staff

Received _____

Reason for Denial given on Application:

- Applicant's rent less than 50% of income
- Rent exceeds 80% of household income
- Request exceeds maximum amount of assistance
- Lack of long-term planning/solution to housing problem
- Failure to comply with program requirements

Re-determination decision and reason:_____

_____

_____

Supervisor's Signature and Date_____

Executive Director's Comments: _____

_____

_____

Client URN _____

Ryan White Service Provider Network

CONSENT AGREEMENT AND STATEMENT OF CONFIDENTIALITY FOR HEALTH CARE, CASE MANAGEMENT AND/OR SUPPORTIVE SERVICES

Client Name: _____

Date of Birth: _____

This agency, _____, is part of a network of providers which have agreed to coordinate services to provide you with health care, case management services, social and support services, and coordination of family/client care.

All clients are entitled to receive humane and dignified treatment at all times, with full respect for personal dignity and right to privacy. All records are confidential pursuant to State law. Client information is made available to funding agencies and their designees without written permission for purposes of quality assurance and reporting requirements. Information obtained by funding agencies for quality assurance and reporting requirements will utilize a coded client identifier when reported. All other client data will be maintained at the provider agency site in a secured location with access limited to provider-designated staff and quality assurance staff from funding sources.

I have read this statement, or it has been read to me, and I have been given the opportunity to have questions answered, and do understand the content. I understand that I may revoke this Consent Agreement at any time. If not revoked by me, this Consent Agreement is valid for the period of eighteen months from the date this agreement was signed.

Furthermore, this agreement will expire sixty days following the termination of services with this agency.

_____ _____

Signature of client or legal representative Date

_____

Signature of Witness

Note: This document DOES NOT authorize the release of any client information.

Revised 4/16 RWHtfd

Cliente URN _____

Ryan White Service Provider Network

ACUERDO DE CONSENTIMIENTO Y DECLARACION DE CONFIDENCIALIDAD PARA CUIDADO DE SALUD, ADMINISTRACION DE CASO Y/O SERVICIOS DE APOYO

Nombre del Cliente: _____

Fecha de Nacimiento: _____

Esta agencia, _____, es parte de una red de proveedores que han acordado coordinar sus servicios para proveerle a usted cuidado de salud, servicios de manejador de caso médicos, servicios sociales y de apoyo así como coordinación del cuidado de familia/cliente.

Todos los clientes tienen derecho a recibir en todo momento un trato digno y humano, respetándose por completo la dignidad personal y el derecho a privacidad. Para conformidad con las leyes del Estado, todo expediente es confidencial. Toda la información de los clientes se hace disponible, sin previa autorización por escrito, a las agencias que proveen la ayuda económica así como a sus representantes, para asegurar la cálida y cumplir así con el requisito de los informes. La información dada a las agencias de ayuda económica para asegurar la calidad y los requisitos de información serán transferidos utilizando un sistema de identificación por código para cada cliente.

Alguna otra información del cliente se mantendrá en la agencia local que provee el servicio en un lugar seguro cuyo acceso será limitado únicamente a miembros del personal de la agencia proveedora y el personal de las organizaciones de ayuda económica que resguardan la calidad del servicio.

He leído esta declaración, o me la han leído y se me ha dado la oportunidad de hacer preguntas y obtener respuestas y declaro que he entiendo el contenido. Entiendo que puedo revocar el presente Acuerdo de Consentimiento en cualquier momento. Si no es revocado por mí, este Acuerdo de Consentimiento es válido por el término de diez y ocho meses a partir de la fecha en que fue firmado. De la misma forma, este acuerdo expirara sesenta (60) días después de la terminación de servicios con esta agencia.

_____ _____

Firma del cliente o representante legal Fecha

_____

Testigo/Manejador de Caso

Nota: Este documento NO autoriza la entrega de ninguna información del cliente.

Consent for the collection and sharing of patient information to providers for persons who have HIV under Ryan White CAREWare Program

AIDS Connecticut is mandated to collect certain personal information that is entered and saved in a database system called CAREWare. CAREWare records are maintained in an encrypted statewide database, in a secure server by the City of Hartford. CAREWare aggregate reports may be used for advocacy, both statewide and federally; any client information used will be done so without revealing names or other information that would identify any specific client.

The CAREWare database program allows for certain medical and support service information to be shared among providers involved with your care, this includes but is not limited to medical visits, lab results, medications prescribed, emergency financial assistance, nutritional supplements, case management, transportation, substance abuse and mental health counseling.

You have a right to opt out of this electronic sharing. If you choose to opt out of electronic sharing it may make it more difficult for you to receive Ryan White Services.

I _____ (print name) hereby provide my consent and authorization for AIDS Connecticut to enter my client-specific health, treatment, and support service information in the encrypted CAREWare database program which is operated and maintained by the City of Hartford through its Health Department.

I further provide consent and authorization for the City of Hartford through its Health Department to allow the disclosure and sharing of the information entered into the encrypted CAREWare database program by AIDS Connecticut. This information will be shared with any other provider to which I apply for Ryan White services that requests the information for the purpose of informing and coordinating treatment and benefits I receive under the Ryan White Program. By signing this form, I further acknowledge that if I fail to show for scheduled medical and other support appointments, I may be contacted by an authorized representative of the Early Intervention Service Program in order to re-engage and link me back to care.

This consent will expire eighteen months from the date of this document

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Developed by the state of CT ACDS; rev by the city of Hftd. 3/15, 9/15, 4/16

El consentimiento para la recopilación y el intercambio de información de los pacientes a los proveedores para las personas que tienen el VIH bajo el Programa Ryan White CAREWare

AIDS Connecticut está obligada a recopilar cierta información personal que se documenta y se guarda en el sistema de base de datos llamada CAREWare. Registros CAREWare se mantienen en una base de datos estatal cifrada, en un servidor seguro de la ciudad de Hartford. Informes globales CAREWare se pueden utilizar para la promoción, tanto a nivel estatal y federal, y cualquier información de cliente utilizado se hará de modo sin revelar nombres u otra información que pueda identificar a cualquier cliente específico.

El programa de base de datos CAREWare permite cierta información médica y servicios de apoyo que se repartirán entre los proveedores involucrados en su atención médica, lo que incluye pero no se limita a las visitas médicas, resultados de laboratorio, medicamentos recetados, la asistencia financiera de emergencia, suplementos nutricionales, manejo de casos, transporte, abuso de sustancias y salud mental.

Usted tiene el derecho de optar por este intercambio electrónico. Si decide optar por no compartir mediante servicios electrónico puede hacer más difícil para que usted reciba servicios de Ryan White.

Yo _____ (nombre) decido proporcionar mi consentimiento y autorización para AIDS Connecticut para entrar datos a mi expediente de salud, tratamiento y la información de servicios de apoyo específico del cliente en el programa de base de datos CAREWare que es operado y mantenido por la Ciudad de Hartford a través del Departamento de Salud.

Además proporciono mi autorización hacia la ciudad de Hartford a través del Departamento de Salud para permitir la divulgación y el intercambio de la información introducida en el programa de datos CAREWare proporcionada por medio de AIDS Connecticut. Esta información será compartida con cualquier otro proveedor el cual Yo solicite de los servicios de Ryan White y para compartir la información con el propósito de coordinar el tratamiento y los beneficios que recibo bajo el Programa Ryan White. Al firmar este documento, reconozco que si no mantengo las citas médicas asignadas, puedo ser contactado por un representante autorizado del programa de servicio de intervención con el fin de volver a participar en mí cuidado médico.

Este consentimiento expirará diez y ocho meses desde la fecha de este documento.

_____ _____

Firma del cliente Fecha

_____ _____

Firma del testigo Fecha

Developed by the state of CT ACDS; rev by the city of Hftd. 3/15, 4/16

Consent for the collection and sharing of patient information to providers for persons who have HIV under Ryan White CAREWare Program

_____ is mandated to collect certain personal information that is entered and saved in a database system called CAREWare. CAREWare records are maintained in an encrypted statewide database, in a secure server by the City of Hartford. CAREWare aggregate reports may be used for advocacy, both statewide and federally; any client information used will be done so without revealing names or other information that would identify any specific client.

The CAREWare database program allows for certain medical and support service information to be shared among providers involved with your care, this includes but is not limited to medical visits, lab results, medications prescribed, emergency financial assistance, nutritional supplements, case management, transportation, substance abuse and mental health counseling.

You have a right to opt out of this electronic sharing. If you choose to opt out of electronic sharing it may make it more difficult for you to receive Ryan White Services.

I _____ (print name) hereby provide my consent and authorization for _____to enter my client-specific health, treatment, and support service information in the encrypted CAREWare database program which is operated and maintained by the City of Hartford through its Health Department.

I further provide consent and authorization for the City of Hartford through its Health Department to allow the disclosure and sharing of the information entered into the encrypted CAREWare database program by _____. This information will be shared with any other provider to which I apply for Ryan White services that requests the information for the purpose of informing and coordinating treatment and benefits I receive under the Ryan White Program. By signing this form, I further acknowledge that if I fail to show for scheduled medical and other support appointments, I may be contacted by an authorized representative of the Early Intervention Service Program in order to re-engage and link me back to care.

This consent will expire eighteen months from the date of this document

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

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Yo _____ (nombre) decido proporcionar mi consentimiento y autorización para **_____**para entrar datos a mi expediente de salud, tratamiento y la información de servicios de apoyo específico del cliente en el programa de base de datos CAREWare que es operado y mantenido por la Ciudad de Hartford a través del Departamento de Salud.

Además proporciono mi autorización hacia la ciudad de Hartford a través del Departamento de Salud para permitir la divulgación y el intercambio de la información introducida en el programa de datos CAREWare proporcionada por medio de **_____**. Esta información será compartida con cualquier otro proveedor el cual Yo solicite de los servicios de Ryan White y para compartir la información con el propósito de coordinar el tratamiento y los beneficios que recibo bajo el Programa Ryan White. Al firmar este documento, reconozco que si no mantengo las citas médicas asignadas, puedo ser contactado por un representante autorizado del programa de servicio de intervención con el fin de volver a participar en mí cuidado médico.

Este consentimiento expirará diez y ocho meses desde la fecha de este documento.

_____ _____

Firma del cliente Fecha

_____ _____

Firma del testigo Fecha

Developed by the state of CT ACDS; rev by the city of Hftd. 3/15, 4/16