DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

Respite Care Services

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV-positive client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

A caregiver is defined as someone who cares for an individual living with HIV.

Activities may include:

- Providing relief to the caregiver for a brief duration of time;
- Recreational and social activities are allowable program activities as part of a respite care service provided in a licensed or certified provider setting, including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities. However, funds may not be used for off-premise recreational and social activities, or to pay for a client's gym membership;
- Informal, home-based respite care. However, liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

II. INTAKE, ELIGIBILITY, & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White clients to maintain proof of eligibility annually. Supporting documentation is required to demonstrate client eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.
2. **Residency:** The following are acceptable methods of meeting the burden for residency:
   - Current lease or mortgage statement
   - Deed settlement agreement
   - Current driver's license
   - Current voter registration card
   - Current notice of decision from Medicaid
   - Fuel/utility bill (past 90 days)
   - Property tax bill or statement (past 60 days)

- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the customer (past 30 days)
- Letter from another government agency addressed to customer
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility, or a letter from landlord that customer is a resident

3. **Income:** Client income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the applicant and any household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

   The following are acceptable forms of proof of income:

   - Pay stubs for the past 30 days. The pay stub must show the year-to-date earnings, hours worked, all deductions, and the dates covered by the paystub
   - A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
   - Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the applicant projecting current annual income must be included
   - Copy of the tenant's lease showing client as the landlord and a copy of their most recent income tax return
   - SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
   - Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the applicant

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address, and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CAREWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of "no change" when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. KEY SERVICE COMPONENTS & ACTIVITIES

ASSESSMENT/SERVICE PLAN/PROVISION OF SERVICES	
Standard	**Measure**
NEEDS ASSESSMENT To identify customer issues and care needs. Each customer will participate in at least one face-to-face interview with their assigned non-medical case manager within ten (10) business days of determining Ryan White eligibility to complete the Needs Assessment. The following information must be recorded and is required if a customer does not already have a current assessment on file. The Needs Assessment must include an assessment of need in the following areas: 1. Finances/benefits 2. Housing 3. Transportation 4. Substance Use 5. Mental Health 6. Domestic violence 7. Basic needs, such as nutrition, food, and clothing 8. Support system 9. Current medical providers and medical case management providers 10. Identification of Legal Issues, if they exist 11. Any additional information required by the CAREWare system not obtained at the intake	Documentation of assessment in customer's record signed and dated by health educator
Subrecipient will support Respite Care that includes non-medical assistance for an HIV infected client, provided in community or home-based settings and designed to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV/AIDS Note: Funds may be used to support informal respite care provided issues of liability are addressed, payment made is reimbursement for actual costs, and no cash payments are made to clients or primary caregivers	Documentation that funds are used only: • To provide nonmedical assistance for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of that adult or minor • In a community or home-based setting If grantee permits use of informal respite care arrangements, documentation that: • Liability issues have been addressed

	• A mechanism for payments has been developed that does not involve direct cash payment to clients or primary caregivers Payments provide reimbursement for actual costs without over payment
Maintain program records in each customer file and make available to the grantee on request	• Number of clients served • Settings/methods of providing care • Client and primary caretaker eligibility o Services provided including dates and duration • Setting/method of services
Provide program and financial records and assurances that if informal respite care arrangements are used the following must be documented:	• Liability issues have been addressed, with appropriate releases obtained that protect the client, provider, and Ryan White program • No cash payments are being made to clients or primary caregivers • Payment is reimbursement for actual costs
TRANSITION & DISCHARGE	
Standard	**Measure**
Customer discharged when Respite Care services are no longer needed, goals have been met, upon death or due to safety issues. <u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with customer. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to customer's last known address. If customer is not present to sign for the letter, it must be returned to the provider. <u>Transfer</u>: If customer transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If customer moves to another area, transferring agency will make referral for needed services in the new location. <u>Unable to Locate</u>: If customer cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the customer's last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made. <u>Withdrawal from Service</u>: If customer reports that services are no longer needed or decides to no longer participate in	Documentation of discharge and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. <u>Documentation</u>: Customer's record must include: ● Date services began ● Special customer needs ● Services needed/actions taken, if applicable ● Date of discharge ● Reason(s) for discharge ● Referrals made at time of discharge, if applicable

the Service Plan, customer may withdraw from services. Because customers may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency customers should be referred to appropriate agencies. Administrative Discharge: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's chart.	
CASE CLOSURE	
Standard	**Measure**
Case will be closed if customer: ● Has met the service goals ● Decides to transfer to another agency ● Needs are more appropriately addressed in other programs ● Moves out of the EMA ● Fails to provide updated documentation of eligibility status thus, no longer eligible for services ● Can no longer be located ● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan ● Exhibits pattern of abuse as defined by agency's policy ● Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program ● Is deceased	Documentation of case closure in customer's record with clear rationale for closure

IV. PERSONNEL QUALIFICATIONS

Competencies, Knowledge and Skills

- If provided by an agency who provides professional respite or caregiver services, staff has the skills, experience, qualifications and licensure to provide respite care services.
- If the client designates a community respite care giver who is a member of their natural network, this designation suffices as the qualification.

Evaluation/Documentation

Demonstrated competencies, knowledge, and skills must be available upon request (e.g. participation in training, formal supervisory review, direct observation, case review, etc.)

V. CLINICAL QUALITY MANAGEMENT

Include at least one performance measure in the Clinical Quality Management Program for the service. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

VI. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on January 2, 2024. The next annual review is July 31, 2025.

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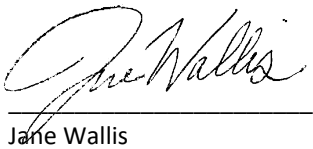

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