Housing Assistance Fund

&

Client Assistance Fund

Administered by: CARC

CARC

Connecticut AIDS Resource Coalition

Contact Information:

110 Bartholomew Ave, Suite 4000
Hartford, CT 06106
Phone (860) 761-6699
Fax (860) 761-6711

Staff:

Aaron Lucas, Administrator
aaron@ctaidscoalition.org

Cecilia Lewis, Supervisor
cecilia@ctaidscoalition.org

Hours of Operation:

CARC is open from 8:00 am to 5:00 pm Monday – Friday. The agency has no evening or weekend hours.

CARC follows the state of Connecticut calendar for holidays and closings due to severe weather.

A message for any CARC staff or administration may be left after hours on CARC's voicemail.

This application can also be found at:
www.ctaidscoalition.org/assistance.htm

CONTENTS

Section 1.

Required Documentation and/or Forms for All Ryan White Part A services

Documentation of HIV Status: The following may be submitted as proof of HIV status:

- an HIV lab test result with the consumer's name
- a letter from the physician on stationary or with physician's stamp
- a copy of a medical file, or
- a CADAP application signed by a physician

Ryan White Part A Client Intake Form - See attached form.

Case managers may submit a URS generated Client Intake Form. If not available, case managers may submit the Ryan White Part A Client Intake Form.

Ryan White Part A Eligibility Worksheet and Financial Documentation - See attached form.

This form is required to be updated every six months. A current form must be submitted as necessary.

Documentation of Income: The following may be submitted as proof of income:

- TPQY
- 3 consecutive pay stubs
- Notarized letter, reviewed on a case-by-case basis

URS Referral Form - See attached form.

A URS referral form may be used when a URS generated intake form or a Ryan White Part A Client Intake Form is already on file with CARC.

Release of information - See attached form.

This form is required to be updated every twelve months (annually). A current form must be submitted as necessary.

CARC Policy & Procedure Acknowledgement with copy of Client Grievance forms

The policy and procedure acknowledgement form is required to be submitted by each client once every contract period, March 1 – February 28. A signed copy should be given to the client for his/her records. Case Managers should use the Client Grievance forms upon request of the client.

The cities and towns that are part of the Greater Hartford Eligible Metropolitan Area are:

• Amston	• Coventry	• Farmington	• Middletown	• Suffield
• Andover	• Cromwell	• Glastonbury	• New Britain	• Tolland
• Avon	• Deep River	• Granby	• Newington	• Union
• Berlin	• Durham	• Haddam	• Old Saybrook	• Vernon
• Bloomfield	• East Granby	• Hartford	• Plainville	• Westbrook
• Bolton	• East Haddam	• Hartland	• Portland	• West Hartford
• Bristol	• East Hampton	• Hebron	• Rocky Hill	• Wethersfield
• Burlington	• East Hartford	• Killingworth	• Simsbury	• Willington
• Canton	• East Windsor	• Manchester	• Somers	• Windsor
• Chester	• Ellington	• Mansfield	• Southington	• Windsor Locks
• Clinton	• Enfield	• Marlborough	• South Windsor	
• Columbia	• Essex	• Middlefield	• Stafford	

ELIGIBILITY WORKSHEET(use for eligibility determination)

I. Indicate household/family source(s) of income, frequency, and amount:
(complete for all items checked on section III, page 1; please attach documentation)

SOURCE(S) OF INCOME	SPECIFY HOUSEHOLD MEMBER	INCOME($)	WEEKLY(W); BIWEEKLY(B); MONTHLY(M)	ANNUAL AMOUNT($)
Client work income	Client			
Family member(s) work income				
Unemployment Compensation				
Workers Compensation				
Social Security Disability Insurance (SSDI)				
Pension				
Supplementary Security Income				
SAGA (State Administrd Gen'l Assistance)				
TANF (Temporary Aid to Needy Families)				
State Supplement for the Disabled				
Other(specify)				
Total:		$	Total:	$

II. Indicate any medical out-of-pocket expenses that should be taken into account as adjustments in determining income(e.g. copayment, insurance premiums, deductibles, etc):

TYPE OF EXPENSE	DATE PAID	OUT-OF-POCKET EXPENSE($)
	______/______/______	
	______/______/______	
	______/______/______	
	______/______/______	
TOTAL OUT-OF-POCKET EXPENSES:		$

Medical expenses taken into account must be within a 12-month period of time and can only be used to calculate and pay for future RW bills.

III. Subtract II from the total of I above and indicate adjusted income: $_________________________

IV. What is family /household size?(# of people): ____________

V. Eligibility Determination:
What is 300% of the poverty level for this household/family size? $_________________________
(Compare this with III (adjusted income):
If adjusted income is less, then the client is eligible for RW funds:
☐Eligible ☐ Ineligible Date_________________

VI. Household Income (has to be completed):
Equal to or below FPL ☐, 101-200% FPL ☐, 201-300% FPL ☐, 301 – 400% FPL ☐, Greater than 400

REFERRAL FOR RYAN WHITE PART A SERVICES REV.11.03

URS CLIENT ID | | | | | | | | | | | | **OLD CLIENT ID** | | | | | | | | | **(if applicable)**

(LLFFMMDDYYG)* (DDMMYYFFLL)*

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.
____Client meets Ryan White financial eligibility criteria: income less than 300% of the Federal poverty level. Specify:
___Equal to or below FPL, ___101-200% FPL, ___201-300% FPL, ___301-400% FPL, ___Greater than 400% FPL
Amount of 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 Services, the following 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 (which also provides transportation) and the client is not eligible for a Reduced Bus pass/free transportation (Veterans); and the client is not on a fixed bus route (Connecticut Transit Authority) or can access a fixed bus route because of 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 case manager must accompany 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.

*LL=First 2 letters of Last name, FF=First 2 letters of First name, DDMMYY=Day, Month, Year of Birth; G=Gender

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
______Academic
______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 service providers)

_______Other agencies, as noted: ______________________________

____

All records are confidential pursuant to Connecticut General statutes 19a-581-590 and 592. 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 one year from the date it was signed. This release shall be considered invalid without an attached copy of network providers.

______________________________ ______________________________
(Signature of client or legal representative) (Date signed)

PROHIBITION OF REDISCLOSURE: This information is disclosed to you from records whose confidentiality is protected by Federal and State law. Regulations prohibit making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Please honor a mechanically reproduced copy of this release

CARC
Policy and Procedure Acknowledgement

I have received a copy (or have had read to me) the following CARC 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: CARC requires that a signed informed consent agreement be signed between the agency submitting an application to CARC and the client. This agreement must be submitted to CARC 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 CARC's office in a secured location with access limited to provider designated staff and quality assurance staff from funding sources. Additional CARC office practices regarding confidentiality are spelled out on our website at: www.ctaidscoalition.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 CARC'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, 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 CARC.
- 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 CARC'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 CARC'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.ctaidscoalition.org.

5. Release of Information Procedure

Policy: The Connecticut AIDS Residence Coalition 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. (CARC 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 CARC 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.

Connecticut AIDS Resource Coalition
Client/Housing Assistance Fund

APPEAL/GRIEVANCE POLICY

Purpose: If a 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 Connecticut AIDS Resource Coalition asks clients to follow to file an appeal/grievance:

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

2.) The case manager will contact CARC 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 CARC 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 <u>is</u> new information that overturns the Housing/Client Assistance Administrator's original decision, an acceptance letter will be sent to the case manager. If there <u>is not</u> 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 <u>additional</u> information or explanation to the Executive Director of CARC for final determination.

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

Connecticut AIDS Resource Coalition
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 CARC 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: ____

____

____

Section 2.

Protocols and Process for Ryan White Part A Housing Assistance Fund

On the following pages you will find CARC's policies and procedures for administering the Housing Assistance Fund, including:

- the purpose of the fund
- what the funds may be used for
- the eligibility requirements
- the financial caps of the program
- how to apply
- required supporting documentation,
- the determination process
- and the geographical area of service (TGA)

We have also provided "Supplemental Information" on frequently asked questions:

- Ryan White Act policy on housing related expenditures
- Definition of "household," and household income
- Income documentation required by CARC
- How to calculate income using weekly and bi-weekly paychecks
- IRS requirements - W-9 and Misc-1099 overview

Housing Assistance Fund Coversheet with Checklist Form

. To be completed by medical case manager. All required documentation needs to be submitted before an application can be processed.

Housing Assistance Fund Use of Funds Form

. To be completed by medical case manager. Evidence that other funds have been sought is required. This form must be signed by the client, medical case manager, and supervisor.

Rental Verification (First Month's Rent) Form

. To be completed by the landlord when applying for first month's rent. Copy of a rental verification form or lease,copy of paid security deposit, and W-9 Form must be submitted.

Rental Verification (Arrearage) Form

. To be completed by the landlord when applying for first month's rent. Copy of a lease and W-9 Form must be submitted.

W-9 Form for Landlords

. This form is required by the IRS and must be completed by the landlord. A Misc-1099 is sent to the landlord at the end of the year stating the amount paid.

Sample HAF Acceptance Letter
Sample HAF Pending Letter
Sample HAF Denial Letter

Ryan White Part A
Greater Hartford Housing Assistance Fund

Purpose: To prevent homelessness among people living with HIV/AIDS and assist people living with HIV/AIDS in maintaining their housing in the greater Hartford TGA, the Ryan White Part A program has funded a Housing Assistance Fund for contract year, March 1, 2012 - February 28, 2013. This is an *emergency housing fund* defined as "**necessary to gain or maintain access to medical care** and must be accompanied by a **strategy to identify, relocate, and/or ensure the applicant is moved to, or capable of maintaining long-term, stable living situation" as stated in (HAB-99-02).** Furthermore, this is a *homelessness prevention program,* a **last resort fund** for people who might otherwise end up on the street, in a shelter or in substandard housing if not for this emergency assistance.

What funds may be used for:

1. First month's rent for a new apartment. There must be documentation that the client has paid the security deposit.
2. Arrearage (with supporting documentation). If a client is CURRENTLY receiving a CARC subsidy, missed the re-application process or did not pay that portion of their rent, we will not pay arrearage for those months or the "CARC" subsidy for those months. If the client is in local subsidized housing or has Section 8, RAP etc; CARC will look at these applications on a case by case basis.
3. Six month's of short-term rental assistance.
4. One-time Emergency Housing payment for those not eligible for 1-3 above.

Eligibility requirements

Each applicant must satisfy <u>all</u> of the following requirements:

- Provide documentation of HIV+ or AIDS diagnosis and that client is in care.
  Federal income cap of 300% of poverty (by family size) using **gross income**.
- Medical Case Manager Certification that request for assistance is consistent with HAB-99-02 (page 6)
- Criteria for assistance with accompanying documentation
  - Paying more than 40% of income in rent, but less than 80%; or
  - being evicted with notice to quit with justifying reasons
  - sudden and temporary loss of income due to illness
  - sudden and temporary expenses exceeding income with justifying reasons
- When applicable, prior to applying for funds, case managers **<u>must</u>** apply for:
  - State of Connecticut Security Deposit Program.
  - State of Connecticut Eviction Prevention Program.
  - State of Connecticut Section 8/Rental Assistance Program.
  - Other rent subsidies such as Shelter + Care, HOPWA funded rent subsidies or local housing authority
  - Other emergency funding sources: (CADAP for medications and insurance continuation, etc.).
- In addition, medical case managers and applicants must **<u>document</u>** a plan or long-term strategy addressing the applicant's ability to address the cost of maintaining their housing. If requesting arrearage, please provide documentation as to why the client got behind in their rent.

* Clients who do not fall within the limits of 40%-80% ***<u>may</u>*** qualify for a one-time Emergency Housing payment.

Housing Assistance Fund Policies

1. Funds must be applied for through a medical case manager.
2. If an applicant has no documented income when funds are requested, documentation must be submitted with the application, <u>clearly</u> outlining why the client has no income. The applying medical case manager must also provide documentation that applicant will have income in place within two months that supports the eligibility requirement that they pay between 40% and 80% of their income towards rent.
3. The Housing Assistance Fund has created a limited number of slots per month for short-term rental assistance. Those households that are currently receiving rental assistance will be given priority but must reapply by

February 2012. Applications will be reviewed and approved on a first come, first served basis. A waiting list will be created for additional applying households.

4. Applicants are eligible for up to six months of short-term rental assistance, with another six months of assistance available based on eligibility, availability of funds and re-application.
5. Those households receiving rental assistance must provide their case manager with a copy of monthly rent receipt/canceled check/money order to demonstrate that they are current with rent, and by default are ineligible to apply for arrearage.
6. In determining rent-to-income ratios for financial eligibility for families, CARC will allow a standard <u>per year</u> allowance of $750 for families with 1- 2 children, $1,500 for families with 3- 4 children; and $2,250 for families with 5-6 children.
7. If granted, first month's rent and arrearage payments will be limited to <u>one per client per contract year</u>. Applicant must provide documentation that they have sufficient income to pay security deposit and ongoing rent. **<u>Arrearage cannot exceed two month's rent</u>.**
8. All re-applications for six-months of short-term rental assistance must provide documentation that the tenant is CURRENT with their rent.

How to apply

Individuals must apply for housing assistance through a medical case manager or social worker from the Greater Hartford Transitional Grant Area (TGA). The case manager is responsible for determining the individual's eligibility and must submit a completed application form to CARC. The application form includes:

1. A checklist/review form;
2. The standard 2 page Ryan White client intake or URS form;
3. Eligibility worksheet;
4. Referral form;
5. A Release of Information form;
6. Acknowledgement of CARC policies and procedures;
7. The two page housing assistance/use of funds form;
8. A Rental Verification form;
9. Income verification (TPQY, **<u>3 recent paystubs,</u>** notarized letter documenting other income);
10. Documentation of HIV status; and
11. Completed landlord W-9.

Supporting documentation which substantiates the applicant's income and housing costs must be attached to the application for it to be considered. Outstanding **medical bills** with documentation for which the individual is him/herself responsible, may be considered in determining income eligibility. Likewise, if the applicant's annual salary is above 300% of poverty but he or she is not receiving a full year's salary due to temporary unemployment, the individual **may** qualify for emergency assistance. Income eligibility is based on **gross income**, including any overtime the client may have received within that recent time period.

The process for awarding funds

1. CARC will review and date applications upon receipt. If an application is **incomplete**, CARC will fax and email the applying medical case manager within two business days of receipt, detailing missing information or inaccurate/conflicting information. If a fax does not go through, we will mail the notice to the applying case manager. The application will be filed as a pending application. Pending applications will be reviewed the following week and if a complete/corrected application has not been received within 10 business days, it will be denied. A letter of denial will be faxed and mailed to the applying case manager.
2. The Program Manager and his/her supervisor will review all applications on a weekly basis and based on eligibility criteria, the Program Manager will approve or deny each application.
3. When an application is **denied,** a fax and letter will be sent to the applying medical case manager detailing the reason(s) why and a copy of that letter will be placed in the applicant's file.
4. When an application is denied due to income eligibility, it will be screened to see if eligible for one-time emergency housing payment.

5. When an application is **approved,** depending upon availability of funds, a check will be cut and sent to the applying case manager within 10 business days of approving the application.

6. Depending upon availability of funds, checks for ongoing rental assistance will be cut and sent to the applying case manager at least 7 days before the start of each month to forward to the landlord.

7. **Agencies must never give checks directly to the client. Failure to comply will revoke agency's privileges and the client's eligibility.**

8. Checks will be made out to the landlord/vendor and sent to the applying medical case manager. The memo section of each check will contain the address for which rent is intended. One exception is that if an application is approved and CARC is waiting for funds, the applying agency may cut a check and CARC will reimburse the agency. Checks do not have CARC's name on them. NOTE: Agencies paying for emergency housing for an applicant will not be reimbursed by CARC without **prior written approval from the Housing Assistance Funds Program Manager or Supervisor.**

9. **Confidentiality** of all client information is strictly maintained by CARC staff. We will use codes rather than the names of the applicants. All applications are kept in a locked file cabinet to which only the three employees involved in the Housing Assistance Fund have access.

Updated 4/2010

CARC's Ryan White Titles Housing Assistance and Emergency Housing Funds
Supplemental Information on Eligibility

CARC must have back up documentation in order to process applications appropriately and to ensure that we can demonstrate the rationale for our decisions to our auditors. Enclosed is information on a variety of issues related to what qualifies as documentation as per the requirements for demonstrating eligibility for CARC's Housing Assistance and Emergency Housing Funds. What follows are definitions primarily from the Ryan White CARE Act legislation. We have included descriptions of what CARC will accept as documentation.

Ryan White CARE Act definitions:

1. **Housing Services**
   HAB Notice 99-02: The Use of Ryan White CARE Act Funds

The following policy establishes guidelines for allowable housing-related expenditures under the Ryan White CARE Act. The purpose of all Ryan White Care Act funds is to ensure that eligible HIV-infected person and families gain or maintain access to medical care.

   A. Funds received under the Ryan White CARE Act (Title XXVI of the Public Health Service Act) may be used for the following housing expenditures:
      a. Housing referral services defined as assessment, search, placement, and advocacy services must be provided by case managers or other professionals who possess a comprehensive knowledge of local, State and Federal housing programs and how they can be accessed; or Short-term or emergency housing defined as necessary to gain or maintain access to medical care and must be related to either:
         i. Housing services that include some type of medical or supportive service: including, but not limited to, residential substance abuse or mental health services (not including facilities classified as a Institute of Mental Diseases under Medicaid), residential foster care, and assisted living residential services; or
         ii. Housing services that do not provide direct medical or supportive services but are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment. Necessity of housing service for purposes of medical care must be certified or documented.
   B. Short-term or emergency assistance is understood as transitional in nature and for purpose of moving or maintaining an individual or family in a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term, stable living situation.
   C. Housing funds cannot be in the form of direct cash payments to recipients or services and cannot be used for mortgage payments.
   D. The Ryan White CARE Act must be the payer of last resort. In addition, funds received under the Ryan White CARE Act must be used to supplement but not supplant funds currently being used from local, State, and Federal agency programs. Grantees must be capable of providing the HIV/AIDS Bureau with documentation related to the use of funds as payer of last resort and the coordination of such funds with other local, State, and Federal funds.
   E. Ryan White CARE Act housing-related expenses are limited to Titles A, B, and D and are not an allowable expense for Part C.

2. **What constitutes a household? Who is included in a household?**
   A household can be made up of family members, a spouse, partner, or non-family members that reside together.

   US Census definition
   Household -- A household includes all the people who occupy a housing unit. A housing unit is a house, an apartment, a mobile home, a group of rooms, or a single room that is occupied (or if vacant, is intended for occupancy) as separate living quarters. Separate living quarters are those in which the occupants live separately from any other people in the building and which have direct access from the outside of the building or through a

common hall. The occupants may be a single family, one person living alone, two or more families living together, or any other group of related or unrelated people who share living arrangements.

3. **What constitutes household income?**
Household income: The total household income is the income of all HIV positive clients and others (including parents, children, roommates, partners) living in the household. If two eligible clients live together, they must apply as a household. If one eligible client owns the home and is paying a mortgage on that home, the household is not eligible given that Ryan White funds cannot be used for mortgage payments.

CARC requirements:
If the **applicant(s) live(s) in another person's home**, in a room or on a floor within that house, in addition to the client's income and documentation of paying "rent" or "room and board", CARC requires a copy of the lease or monthly mortgage payment for that unit or home. In this situation, if the applicant **pays 30% or less** towards rent/mortgage, CARC will consider the application. If the applicant pays **more than 31%** to the mortgage or rent, we will deny the application. All other eligibility requirements apply.

If the applicant lives in a separate **apartment** (not a room) in a family member's home please provide documentation such as copies of ***the client's*** phone/utility/cable bills that **CLEARLY** show that there are separate apartments/units. For example, a utility or other bill should indicate they live on the 3rd floor of the building and that the landlord lives in a separate unit. If it is unclear, we will ask for the family member's utility bill to show separate living quarters.

If the applicant is in a roommate situation whereby two persons pay rent to a landlord, CARC needs to see a copy of the lease, canceled Money Orders or checks to determine the percentage of ***actual*** rent the applicant pays. If the applicant pays more that 50% of the total rent, the application may be denied.

4. **Income Documentation**
With regard to individual income, CARC requires TPQY and/or ***3 <u>recent</u> pay-stubs***. If someone has just started a new job and has only one pay stub, the application will be considered if it is accompanied by a letter from the employer documenting date of hire.

For those who are undocumented and who work "under the table" or baby-sit, perform odd jobs, etc., we will process these requests if they are accompanied by either a written note from their employer indicating amount of weekly pay OR a notarized letter from the applicant.

If applicants have incurred an expense, which made it difficult for them to pay their rent, please provide **documentation of those expenses and payment** for those expenses. Examples of such expenses have included costs of attending out of state family funerals; school costs for children; hospitalizations; or car repair costs. We do not consider the purchase of gifts as an eligible out of pocket expense. **<u>We will only consider these applications IF there is documentation that provides back-up for those expenses.</u>** These are particularly important if applicants are already receiving a rent subsidy.

If the applicant is receiving a rent subsidy, provide back up documentation from the housing authority as to what the client's portion is as well as the amount of the Public Housing Authority, Department of Social Services, or AIDS housing program's portion for rent. For first month's rent, if all other eligibility requirements are met, CARC can pay **the tenant's portion** of first month's rent.

In order to pay arrearage, please be sure that the request from the landlord includes the breakdown of back rent owed, late fees, and legal fees. CARC can **only** pay the back rent owed, not late or legal fees. This becomes especially important if the arrearage is not equal to the number of month's arrearage you are requesting.

CARC *__will not__* reimburse programs that have paid housing expenses for clients *without PRIOR written approval.*

To Calculate income using **Weekly** Paychecks	To Calculate income using **Bi-weekly** paychecks.
Add together 3 pay stubs	Add together 3 pay stubs
Divide by 3 to find average weekly amount	Divide by 3 to find average bi-weekly amount
Multiply by **52** (pay periods), then divide by 12 (months)	Multiply by **26** (pay periods), then divide by 12 (months)
Result is Monthly income	Result is Monthly income

5. IRS requirement – W-9 and MISC-1099

The IRS requires that any organization providing payments to landlords must report payments over $600 per year to the IRS. This is done by having a Landlord fill out a W-9 form prior to receiving payment. At the year's end, a MISC-1099 is sent to the Landlord with a copy going to the IRS. CARC's housing assistance checks simply have the name Housing Assistance Fund or Emergency Housing Fund on them, with no other identifying information.

Landlords need only be made aware that the client is participating in a rental assistance program and as such, are required to provide their Tax ID number to assure that they continue to receive payments. While some clients have explained to their landlord that they qualify for housing assistance due to a disability, under no circumstance should the client feel that they have to reveal their HIV status or any other diagnoses. Under the Americans with Disabilities Act, a landlord has no right to ask WHAT their disability is.

CARC uses a separate phone line for our Housing Assistance Funds and we make this number available for any landlords seeking more information on why they are required to complete the W-9. We will not explain what our funds are, who administers them, or how a person qualifies.

Rev. 4/10

RYAN WHITE
CASE MANAGER CHECKLIST / REVIEW FORM

Client Code________________________________ Date application received:________________________________

Case Manager: ____________________________________ Agency: ____

Telephone:____ Fax:____

Agency Mailing Address: __________________________________ City _______________Zip Code _____________

HOUSING ONLY Landlord ____

Rental Unit Address ____

CASE MANAGER CHECKLIST:

☐ Ryan White Intake or URS Form
☐ Referral for Ryan White Services
☐ Release of Information
☐ Acknowledgement of CARC P&P
☐ Income Verification
☐ HIV/AIDS Diagnosis and Verification that Client is in Care

Housing Assistance ONLY
☐ Use of Funds Page
☐ Case Manager Signature
☐ Client Signature
☐ CM Supervisor Signature
☐ Lease or rental verification form
☐ W-9 (for housing assistance)

Case Manager's Certification (Initials)

_______ I certify that the applicant is eligible for Ryan White Client Assistance and has no other options or resources for payment.

_______ I certify that the applicant needs short-term/ emergency housing to gain/ maintain access to medical care in accordance with HAB- 99-02

Revised 4/10

Hartford Eligible Metropolitan Area Ryan White Part A Housing Assistance Fund - Use of Funds

Please fill out the following two pages along with standard Ryan White Client Intake Form and attach all necessary supporting documentation. Failure to submit a complete application and required documentation may result in request being denied and returned to applying case manager.

I. Personal Household Information

Household Size: ________________ # and age(s) of adults ___________________________________

and age(s) of children _________________________________

Monthly rent payment _________________ ÷ Income ____________ = _________________%

II. Is the applicant currently receiving, on a waiting list or been denied for other forms of housing assistance?

	Receiving (date)	Waiting List (date)	Ineligible (date)
Section 8	______________	____________________	____________________
RAP	______________	____________________	____________________
Shelter + Care	______________	____________________	____________________
Other	______________	____________________	____________________

Case manager must access all other available programs before applying to the HAF. Please indicate the programs that have been applied to. Keep in mind that there are programs that pay specifically for the "causes" of some HAF requests: CADAP pays for drug treatments and also/pays for health insurance premiums; assistance and/or arrangements can be made with utility vendors.

	Received	Date Applied	Denied
DSS Security Deposit Program	__________	__________	__________
DSS Eviction Prevention	__________	__________	__________
Other: _________	__________	__________	__________

If the person is not currently receiving or on a waiting list for other housing assistance, explain why: __________________

____

Describe the steps to be taken by applicant to keep current housing affordable in the event that this assistance is terminated: ____

____

Clearly describe the reason for arrearage (documentation should back up reason): ________________________________

____

____

III. Please specify the use of funds requested.

A. First month's rent: Month/Year __________ Amount: $_________

B. Ongoing rental assistance of $150 _____________ **to** _____________
Month/Year Month/Year

C. Arrearage: Month/Year ___________ Amount: __________
Month/Year ___________ Amount: __________
Total: __________

D. One-Time Emergency Payment: Reason: ____

Attach all of the following information. Applications submitted without complete documentation will be denied

_______**Verification of income for all members of household** (i.e. current W-2s, child support, alimony, 3 **recent** pay stubs, Social Security entitlement paperwork, State Supplemental paperwork).

_______**Lease, or rental verification** from landlord or property manager which verifies tenancy OR

rent receipts/canceled rent checks for 3 immediate previous months OR documentation of mortgage payment.

_______**Statement from property owner/bank not to evict** if payments are brought up to date.

_______**Signatures:** client signatures on release form, application form (below); case manager and supervisor signatures on application form (below).

IV. Rental Unit/Landlord/ Manager Information (Person or agency to whom check will be made out)

____
Rental Unit Address

____
Name of Landlord/Manager Telephone/Fax

____
Mailing Address City State Zip Code

I acknowledge that all information contained in this application is true and correct to the best of my knowledge. I authorize my case manager to discuss the information contained in this application with representatives of the Housing Assistance Fund. I also promise to immediately inform my case manager of any and all changes to my income or housing situation.

____
Client Signature Date

____
Case Manager Signature, Telephone, Fax # Date

____
Agency Mailing Address City State Zip Code

____
Supervisor's Signature Date

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RENTAL VERIFICATION (First Month's Rent)

I, ____ do hereby state that
(Landlord name)

____is/will be my tenant at
(tenant name)

____
(address of apartment site)

Individuals that will also be living at this address are____
(specify adult or child)

______________________________________ ____
(specify adult or child) (specify adult or child)

______________________________________ ____
(specify adult or child) (specify adult or child)

They will reside at this address on_____________________paying a monthly rent of $______________
(date moving in)

The lease calls for: ( ) first month and security. (Assistance will be for first month's rent.)

The first month's rent of __________________ is for the month of ______________________.
(amount of rent)

Security deposit of _______________________ was paid on ____________________________.

All of the following must have landlord's initials:

( ) Copy of lease attached

( ) Copy of Security Deposit receipt attached

( ) W-9 Form completed and attached

( ) I understand that my tenant is applying for financial assistance and that **these funds cannot be used for security deposit under any circumstances.** Documentation that the security deposit has been paid accompanies this form.

( ) I understand that these funds will pay for first month's rent only if the lease calls for first month's rent and security deposit.

( ) I understand that I will be issued a tax form Misc.1099 at year's end and that this assistance is reportable income.

____

(Landlord/Property Manager's Signature/Date)

RENTAL VERIFICATION (Arrearage)

I, ____ do hereby state that
(landlord name)

____ is/will be my tenant at
(tenant name)

____
(address of apartment site)

Individuals that will also be living at this address are____
(specify adult or child)

______________________________________ ____
(specify adult or child) (specify adult or child)

______________________________________ ____
(specify adult or child) (specify adult or child)

They have resided at this address since__________________paying a monthly rent of $______________
(date moving in) (amount of rent)

They are in arrearage in the amount of $_____________ for the following months:

________________ (Month)	___________ (Amount)	__________________ (Late Fees)
________________ (Month)	___________ (Amount)	__________________ (Late Fees)
________________ (Month)	___________ (Amount)	__________________ (Late Fees)
________________ (Month)	___________ (Amount)	__________________ (Late Fees)

All of the following must have landlord's initials:

( ) Copy of lease attached

( ) W-9 Form completed and attached

( ) I understand that I will be issued a tax form Misc. 1099 at year's end and that this assistance is reportable income.

____
(Landlord/Property Manager's Signature/ Date)

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ------------------ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
[| |] – [|] – [| | |]

or

Employer identification number
[|] – [| | | | | |]

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person ▶** **Date ▶**

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov/online/ss-5.pdf*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Housing
Assistance
Fund

c/o CARC, 110 Bartholomew Ave., Suite 4000, Hartford, CT 06106

____
Date

Dear

The Housing Assistance Fund application for _____________________ was **approved** for
Client (s)

_____________ for payment of rent arrears for the month(s) of ________________.
Amount

Client is responsible for payment of any late fees or legal fees imposed by landlord. CARC does not pay legal fees or late fees.

Sincerely,

Cecilia Lewis
Program Manager,
Housing Assistance Fund

<u>Please forward a copy of this notice to your client.</u>

Note: On February 27, 2008, HRSA issued Policy Notice 99-02, which is a change from the December 2006 proposed Policy Notice which was withdrawn last year. Policy Notice 99-02 enacts a cumulative period of 24 months per household for use of Ryan White dollars for emergency and transitional housing beginning 27 March 2008. Please alert your housing assistance clients to this change.

The policy is **NOT** retroactive so that for consumers **currently** receiving assistance, the clock won't start until 27 March 2008.

Your client has currently received ___ **months** of assistance since the enactment of the afore mentioned policy.

Housing Assistance Fund

c/o CARC, 110 Bartholomew Ave., Suite 4000, Hartford, CT 06106

____
Date

Dear

The Housing Assistance Fund application for ___________________________ is **PENDING**.
Client (s)

WE REQUIRE THE FOLLOWING INFORMATION IN ORDER TO MAKE A DECISION:

- ❒ HIV Verification
- ❒ 3 current pay stubs:
- ❒ Family member's income:
- ❒ Lease or rental verification form: See below
- ❒ Signed Release of Information form
- ❒ Signed Housing Funds Application:
- ❒ **Documentation of: see below**
    - o Separate apartments:
    - o Signed lease or mortgage agreement**:**
    - o Rent paid by program (invoice, canceled check)
    - o Breakdown of rent and late fees owed
    - o Notarized letter documenting income
    - o Rental agreement from Section 8*, S+C, RAP program, HOPWA /MHSC/ Chrysalis/ICSHC etc
    - o Dramatic decrease in income:_____________________________________
    - o Dramatic increase in expenses:____________________________________
- ❒ Other:____

Please get this information to us by ___________. If we do not receive the information by that date, we will deny the application. You would still be eligible to re-apply on behalf of the client. If you have any questions, please feel free to call me at (860) 761-6699.

Thank you.

Sincerely,

Cecilia Lewis
Program Manager,
Housing Assistance Fund

Please forward a copy of this notice to your client.

Housing
Assistance
Fund

c/o CARC, 110 Bartholomew Ave., Suite 4000, Hartford, CT 06106

____
Date

Dear

The Housing Assistance Fund application for ________________________________
Client (s)

HAS BEEN **DENIED** FOR THE FOLLOWING REASON(S):

- ❒ Rent to income ratio is outside of the guidelines
- ❒ HIV verification:
  - o 3 recent pay stubs
  - o Current TPQY:
  - o Family member's income
  - o Landlord's W9
  - o Lease or rental verification form**:**
  - o Signed Release of Information form
  - o Signed Housing Funds Application:
  - o Documentation of the following was not provided:
    - ▪ Separate apartments
    - ▪ Rent paid by program (invoice, canceled check)
    - ▪ Breakdown of rent and late fees owed
    - ▪ Notarized letter documenting income
    - ▪ Rental agreement from Section 8, S+C, RAP, or Public Housing Authority
    - ▪ Dramatic decrease in income:
    - ▪ Dramatic increase in expenses:
- ❒ Other:____

Should the client's circumstances change or you obtain the required documentation, you are still eligible to re-apply on behalf of the client. If you have any questions, please feel free to call me at (860) 761-6699.

Thank you.

Sincerely,

Cecilia Lewis
Program Manager, Housing Assistance Fund

Please forward a copy of this notice to your client.

Section 3.

Protocols and Process for Ryan White Part A Client Assistance Fund

On the following pages you will find CARC's policies and procedures for administering the Client Assistance Fund, including:

- The purpose of the fund
- General client eligibility requirements
- The process by which applications are approved/denied and the staff person responsible
- The case manager partnership
- Explanation of financial caps on the program
- The geographic area of service (TGA)
- Determination Process
- Description of Client Assistance Fund Services including required documentation

Request for Medical, Dental, Mental Health, Prescription Assistance, Insurance Continuation, Utilities Assistance Forms, Transportation and Food Vouchers.

See attached forms. Please use these client assistance request forms when applying for funding for your clients. It is required that other sources of funding be pursued and denied before applying to CARC for client assistance funds.

Sample Client Assistance Fund Acceptance Letter
Sample Client Assistance Fund Denial Letter

See attached forms. The Program Manager or CAF/HAF Supervisor will complete one of these two forms for each request submitted and will send to case managers. Applications denied because of lack of documentation may resubmit their request once documentation is gathered.

Protocols and Process for Ryan White Part A Client Assistance Fund

Purpose of Fund

The Client Assistance Fund is a set of nine financial assistance services funded by Ryan White: (1) Medical Fee-for-Service, (2) Dental fee-for-service, (3) Mental Health fee for service, (4) Prescription Assistance, (5) Insurance Continuation, (6) Utilities, (7) Food Vouchers, and (8) Transportation.

The Ryan White Part A Client Assistance Fund can be used to help clients maintain their quality of life and to meet emergency needs. In order to apply for these funds, clients must meet the Greater Hartford TGA Eligibility Requirements. All funds must be accessed through case managers working on behalf of a Ryan White Part A eligible clients.

Ryan White Part A and II are funds of last resort. Clients and case managers ***must*** seek assistance elsewhere and ***be denied*** before applying for these funds. All requests for assistance must document that other sources were approached and were denied. <u>Documentation of denials or proof of ineligibility will be expected with all requests for client assistance fund applications.</u>

Due to federal regulations and protocol, Ryan White funds cannot be used for: funeral or burial expenses or transportation of the deceased; to subsidize <u>routine or ongoing</u> needs related to utilities, rent, meals, and cleaning supplies; costs for staying at an emergency shelter; to pay for credit checks , or to pay for driver's licenses, car registrations or car insurance. Clients cannot be reimbursed for any out-of-pocket expenses that they have already paid.

Emergency funding assistance for some relocation and essential furnishings expenses will be reviewed on a case-by-case basis. Payments will only be made on approved cases that ***have prior written authorization*** from CARC.

Eligibility

To access most services, a client must be certified as Ryan White eligible. Eligibility consists of:

(a) HIV or AIDS diagnosis
(b) Income under 300% of federal poverty guidelines, based on **<u>gross</u>** income,
(c) In cases where the client is affected rather than infected, the service(s) must be intended to provide direct benefit for the infected individual (s), and,
(d) Must be a resident(s) of the Greater Hartford Transitional Grant Area (TGA)

Required Client Eligibility Documentation

1. Recent Medical Evaluation Form. This must include a recent (within 6 months of application) of the client's CD4 and Viral Load.
2. Ryan White Client Intake Form or CareWare Referral Form if Intake Form is on file
3. Ryan White Eligibility Worksheet and Financial Documentation (updated every six months), especially for Housing Assistance to document any increases/decreases in income.
4. Release of information (update annually)
5. CARC Policy & Procedure Acknowledgement with copy of Client Grievance forms
6. Documentation of Income - TPQY or **3 consecutive RECENT paystubs**. If someone receives cash for their work, we will accept a notarized letter indicating the hours worked, services performed and income.

Case Manager Partnership
Case managers are crucial to the success of the Client Financial Assistance Funds Program. Since Ryan White funds are funds of last resort it, is incumbent upon case managers to coordinate their efforts to access a wide range of client-centered, culturally sensitive services to link their clients with all available entitlement programs, subsidized and affordable housing programs, utility and food assistance programs, as well as provide any budgeting assistance that might be needed to ensure client self-sufficiency and success.

Timely, complete and accurate submission of required client documentation, intake forms, food voucher and transportation logs, and client request forms to CARC will assist in expediting approvals and payments.

CARC will provide both formal and informal training to current and new case managers and cothers regarding the client assistance funds, CARC housing assistance information, appropriate forms to be used, required client documentation, CARC policies, procedures, and grievance processes. For questions about processes or to arrange a case manager training, contact Cecilia Lewis, Program Manager.

Caps
Designated service category funds can be used up to an established cap per client per contract year to assist with requests that may be emergency in nature, or when only one expenditure per year will be made. These emergency needs can include utility shutoffs, foods not obtainable through a food bank, and other emergency situations. Funding can also be used for the continuation of medical insurance, if the client is not eligible for the CT Insurance Premium Assistance (CIPA) under CADAP.

These caps may vary depending on availability of TGA funding appropriations. If there are any changes to the cap levels, a letter will be sent from the Ryan White Program Manager to all Ryan White contractors.

To contact the Ryan White Program Manager
860-547-1426, ext. 7028

CARC will also notify the Part A and Part B Program Managers of any changes.

TGA Service Area
Ryan White Part A funds are available to any eligible client in the Greater Hartford TGA – Hartford, Tolland and Middlesex Counties.

• Amston	• Coventry	• Farmington	• Middletown	• Suffield
• Andover	• Cromwell	• Glastonbury	• New Britain	• Tolland
• Avon	• Deep River	• Granby	• Newington	• Union
• Berlin	• Durham	• Haddam	• Old Saybrook	• Vernon
• Bloomfield	• East Granby	• Hartford	• Plainville	• Westbrook
• Bolton	• East Haddam	• Hartland	• Portland	• West Hartford
• Bristol	• East Hampton	• Hebron	• Rocky Hill	• Wethersfield
• Burlington	• East Hartford	• Killingworth	• Simsbury	• Willington
• Canton	• East Windsor	• Manchester	• Somers	• Windsor
• Chester	• Ellington	• Mansfield	• Southington	• Windsor Locks
• Clinton	• Enfield	• Marlborough	• South Windsor	
• Columbia	• Essex	• Middlefield	• Stafford	

CARC Determination Process

1. Case managers may submit completed applications via fax, mail or drop-off to CARC. Applications are available on our website: http://www.ctaidscoalition.org/assistance.htm CARC will open one file per client per contract period with the receipt of required client eligibility documentation so that a case manager will not be required to submit two sets of standard documentation for the housing assistance fund and the client assistance fund programs. New clients will be able to apply for both housing and direct client assistance funds simultaneously. However, client income verification must be updated every six months and there must be documentation of a Viral Load and CD4 count within 6 months of the application or request for service.

2. Within 24 hours (M-F) of receiving request forms, the **Fund Administrator**, Aaron Lucas, will check the forms for completion, accuracy and eligibility. A file will also be created for each application, using the CareWare-designated unique identifier. CARC will adhere to the existing established criteria for making a determination (e.g. eligibility, documentation, etc).

3. When the initial application/request is **incomplete,** the **Fund Administrator** will contact the case manager via phone/fax or email and detail what additional information is needed to complete the file or request. This application will be designated a "pending application." Pending applications will be held for 21 days before being classified as denied. For a drug-reimbursement request, the pharmacy will be contacted and informed of a denial until additional information is provided by the case manager. Once a completed application is received, it will be forwarded to the **Program Manager** for approval.

4. If the application is deemed as complete, the **Program Manager** will approve it and forward it to the **Supervisor**, Shawn Lang, for final approval. If the **Program Manage or Supervisor** requires additional information, the applying case manager will be contacted via phone or email. The applying case manager will then **contact the Program Manager or Supervisor** to complete the application.

5. When an application is **approved**, a check for the approved assistance fund will be cut by the Fund Administrator within 5 business days of the approval and mailed either directly to the indicated vendor or case manager for disbursement. For drug reimbursements, if an application/request is approved, the case manager and/or pharmacy will be informed by phone, fax or email. The case manager should inform the client of the request approval, particularly if the request was for a new prescription or refill. Pharmacies have been instructed to bill CARC on a 30-day basis.

6. When the application/request is **denied**, the case manager and, for medication reimbursement requests the pharmacy, will be notified by the Program Manager by phone/fax or email with the appropriate reason. A denial form will be sent to the case manager and a copy of the denial form will be placed in the respective client file. The case manager should notify the client immediately with the reason for denial and develop alternative plans for payment.

7. Checks for client assistance funds will NOT have CARC's name imprinted on them. Checks will be made out directly to the vendor. The memo line will include the account number and the client's CareWare code. A copy of the bill or invoice will be attached to the check. A confirmation with check number and date of payment will be sent to the case manager or supervisor within five days following check disbursement and a copy of the documentation will also be maintained in the client file. Bank protocol does not allow us to send copies of the original check.

8. Checks will not be given directly to clients under any circumstances. If you are unclear about this policy, please contact John Merz, Executive Director of CARC. Failure to adhere to this policy will disqualify a case manager from submitting applications to CARC.

   Please note: Payments for emergency requests may be made within 2 business days. Requests must come directly from case managers and detail specifically why the request is deemed an emergency. Failure to plan on the part of the client or the case manager does not qualify as an emergency.

Client Assistance Fund Services and Required Documentation:

<u>Medical/Dental/Mental Health/Home Health Care Fee-for-Service</u>

Provides assistance for ambulatory outpatient medical bills, dental services, mental health, and home health care services not covered by any other programs. This can include co-payments and deductibles for medical appointments; counseling, optometry and ophthalmic services; purchase of corrective prescription eye wear that is necessitated by HIV infection, and water filtration/purification devices as prescribed by a medical provider. Any changes to LIA beneficiaries during the contract period, CARC will notify Case Managers. Outstanding balances, costs incurred prior to the contract period, and accounts in collection will be considered on a case-by-case basis.

Ryan White funds will be disbursed for prescriptive eye wear only after all alternative funding sources have been pursued. These funds will pay for one prescription per year if the prescription has changed and is deemed necessary because of HIV infection. These payments will cover up to $150 for single vision lenses and $250 for bi-focal or tri-focal lenses. Sunglasses and contact lenses are not included.

<u>Required Documentation:</u>
Client Eligibility Documentation
Client Assistance Funds Form- **Medical**/Dental/Mental Health/Home Health Care
Corresponding bills or invoices, documentation from medical provider, eye prescription indicating change.
Documentation of Denial/Cap/Ineligibility from: Private Insurance, Medicaid/SAGA/HUSKY, Medicare, VA

<u>Medication Reimbursement</u>

This fund provides assistance to clients in paying for prescriptions not covered by insurance or other programs (e.g. Title XIX). This may include co-pays, new prescriptions, refills of medications, vitamins, supplements, durable medical equipment, supplies (such as ostomy bags, insulin syringes, wound dressings, etc,) or over the counter medications **<u>prescribed</u>** by a physician.

To apply for assistance, the client brings a prescription to a case manager, who in turn makes a copy for the client file. The client brings the original prescription to the pharmacy. The case manager faxes the prescription request to CARC with Client Assistance Request Form. The respective pharmacy contacts CARC to get approval to fill the prescription. CARC will review the client file to verify eligibility, updated paperwork and balance remaining.. If funds are sufficient to pay for the request, CARC authorizes the pharmacy to approve the prescription and notifies the case manager of the approval. Upon approval of the prescription request, the client may then pick up the medications, vitamins or supplements. CARC will be billed by the pharmacy for the prescription. However, should client funds be insufficient to pay for the prescription, CARC will deny the request to both the pharmacy and case manager. A list of approved pharmacies is included at the beginning of the **FORMS** section. Additional pharmacies can be added as needed.

<u>Required Documentation:</u>
Same as above

<u>Insurance Continuation</u>
This fund provides insurance coverage payments for consumers who have an existing health insurance plan. This may include co-pays on premiums, employee cost share, health insurance payments for clients who are not eligible for the CT Insurance Premium Assistance (CIPA) under CADAP or have reached the end of their COBRA.

<u>Required Documentation:</u>
Same as above

<u>Emergency Utilities Assistance</u>
These funds are to be used for **emergency assistance** to pay for electricity, electric heat, heating oil and gas payments and **basic** phone service. ***Cable TV bills are not eligible for assistance***. Case managers must document that clients have an established payment plan to avoid additional emergency situations. Other funding sources ***must*** be pursued and denied before applying for client assistance in this service category.

This fund is not available to pay for *ongoing* utility bills. Clients who make ***<u>no</u>*** utility payments over a period of time may not have their request awarded. We require documentation to confirm that they are in arrears, have made efforts to pay, and that they are **in danger of receiving a shut-off notice** or have already **received a shut-off notice**. Clients who apply for CARC's energy assistance each contract period are STRONGLY urged to be referred to and attend a budgeting class offered by the Utility Company or local Community Action Program, such as CRT.

Bills with back-up documentation, including an account and payment history, and dates of service for the request, must be included with the request form. Checks will only be issued to the vendor(s) designated on the request form. Bills must be in the client's name.

Consumers must apply for any available utility emergency assistance program.
Electricity Payments - The case manager should call Northeast Utilities and arrange to have the client placed on the NU-START program. Ryan White funding can be used to pay the required match amount. Case managers are also asked to work with the client and NU to arrange appropriate payment plans to pay any arrearage. This fund will pay for the $25 sponsor fee but ***<u>will not be used to make any payments in the event the client does not adhere to the payment plan</u>*****.**

Electric Heat and Oil Payments - Case managers should refer clients to the Community Renewal Team (CRT) Energy Assistance Program and Operation Fuel.

Gas - Case managers should refer clients to the Community Renewal Team (CRT) Energy Assistance Program, the Connecticut Natural Gas (CNG) forgiveness and payment programs and Operation Fuel.

Phone - For clients who do not have land line phones, cell phone bills will be reviewed on a case-by-case basis with a cap of $40 towards current basic service on approved cases. *CARC requires documentation that extra services have been eliminated, particularly from the telephone charges (e.g. directory assistance, call waiting, automatic call back, 900 numbers, caller-ID or answering machine rental and internet services).* Application to LifeLine, for phone service when deemed medically necessary, must be made when appropriate.

<u>Required Documentation:</u>
Required Client Eligibility Documentation

Request for Client Assistance Funds – Utilities
Corresponding phone, electric, gas or oil bill <u>in client's name</u>

<u>Food Voucher Program</u>

Any medical case manager (MCM) or social worker who serves Ryan White Part A eligible clients and is willing to abide by the Food Voucher Agreement is eligible to participate in the Food Voucher program. Upon request, MCMs will receive an initial monthly supply of $10 food vouchers (gift cards to local grocery stores). MCMs must fill out and submit a monthly food voucher log with receipts to CARC by the 3rd of each month in order to receive additional food vouchers. For subsequent requests, MCMs must fill out a Food Voucher Request Form, including the amount requested. The number of food vouchers available per month to each MCM will depend on funding availability, client needs, and spending trends. MCM s must come to CARC to pick up food vouchers. No food vouchers will be mailed.

These food vouchers are available for the purchase of food items only. They are designed as an emergency source to supplement other sources of food such as entitlement programs or food pantries, and are not meant as the sole source of the client's nutrition. The voucher enables a client to purchase nutritious food items from a designated grocery store.

All clients who are accessing food vouchers much first be counseled by their MCM regarding all other sources of food income and resources must be discussed (i.e., food stamps, food pantries, soup kitchens, Food Share, etc.). The MCM must provide documentation that the client has expended SNAP funds and exhausted other options. MCMs must remind clients that Ryan White programs are not entitlements, are intended to address emergencies and – by statute - are the payer of last resort.

Receipts must be submitted to case managers following the purchase of items. Clients who do not submit a receipt will not be eligible for additional vouchers from their case manager.

CARC strongly encourages case managers to engage in developing a budget with their clients to prevent "ongoing" emergencies.

<u>Required Documentation:</u>
Required Client Eligibility Documentation
Request for Food Vouchers
Ryan White Part A Food Voucher Log (submitted by MCM)
For additional vouchers, store receipt(s) from client showing the food voucher was spent on special/healthy foods and a statement by the MCM stating that the client has exhausted all other sources.

<u>Transportation</u>

The Ryan White Part A Transportation Program is used to enable PWHIV/AIDS to access medical or support services. As with all Ryan White Services, it must be the payer of last resort for those clients who may be otherwise unable to attend their medical appointments due to lack of access to other programs or lack of personal funds. Tokens/bus passes are for medical purposes only.

Clients will be issued a **Transportation Log,** which must be filled out and returned upon requesting additional tokens/bus passes. Failure to do so or misuse of tokens /bus passes will result in the immediate termination of assistance. Use **of tokens/bus passes for recreational purposes is prohibited.**

Eligibility

Clients who are on **Medicaid are not eligible** for this program. Medicaid has contracted with **Coordinated Transportation Solutions** for non-emergency medical transportation in the Greater Hartford area, therefore, recipients of Medicaid living within the Hartford TGA must contact **Coordinated Transportation Solutions at 1-877-423-6794** to determine eligibility for and/or schedule transportation to medical appointments. Eligible clients must call at least **48hrs** in advance of their appointment to schedule for livery cab. Rides to appointments may be scheduled up to a month in advance. **Please note:** Tokens and bus passes are also provided to disabled clients who are able to take the bus through this program. Clients may be eligible for bus passes depending on the number of ongoing appointments they may have in any given week. Clients must call **3 – 4 business** days in advance of their appointments for this service.

Medicaid LIA clients who are actively participating in substance use treatment or mental health treatment may be able to get non-emergency medical transportation . Please contact **Coordinated Transportation Solutions** at **1-877-423-6794** to ***determine eligibility for your client before*** submitting your request for transportation assistance to CARC.

Standard documentation required as outlined in previous sections.

Please see the full Transportation Policies and Procedures Document for more detailed information.

Updated 12/11

RYAN WHITE PART A APPROVED PHARMACIES

Ryan White Part A Funds can be used for prescriptions that are not covered by Title XIX, CADAP or private insurance. See information in the Client Assistance Fund Section on procedures for prescription authorization/ applications.

The following pharmacies have been approved for the drug reimbursement program.

Arrow Prescription Center*
500 Farmington Avenue
Hartford, CT 06106
Attn: Lydia
Bookkeeping Ph: 570-0543
Bookkeeping Fax: 570-0529
Pharmacy Phone: 522-9289
Pharmacy Fax: 231-7007

Arrow Prescription Center*
Burgdorf/Fleet Health Center
131 Coventry Street
Hartford, CT o6112
Attn: Wendy/Darcy
Phone: 286-2766
Fax: 286-2981

Community Health Service*
Arrow Pharmacy
500 Albany Avenue
Hartford, CT
Attn: Jerry Ouellette
Phone: 249-9625
Fax: 524-5304

Arrow Prescription Center
85 Seymour Street
Hartford, CT 06105
Attn: Steve Aucoin
Phone: 727-1123
Fax: 520-4703

Arrow Prescription Center
886 Main Street
East Hartford, CT 06108
Attn: Steve
Phone: 528-6553
Fax: 289-4672

Arrow Pharmacy
838 Farmington Ave.
Farmington, CT
Attn: John
Ph: 676-0850
Fax: 674-9933

Big-Y Pharmacy
67 Prospect Hill Rd.
East Windsor, CT 06088
Attn: Sue
Phone: 623-1407
Fax: 623-1640

Brooks (formerly Pelton's)
100 Main Street
Middletown, CT 06457
Attn: Paula
Phone: 346-8603
Fax: 346-7035

Beacon
543 West Main Street
New Britain, CT 06052
Att: Chris/Jack
Phone: 225-6487
Fax: 229-4488

CVS
308 Main Street Extension
Middletown, CT 06457
Attn: Pharmacist
Phone: 345-9623
Fax: 344-8018

Medicine Shoppe
348 Main Street
Manchester, CT 06040
Attn: Roy Katz
Phone: 649-1025
Fax: 649-0457

Medicine Shoppe
553 Hazard Avenue
Enfield, CT 06082
Attn: Garrett
Phone: 749-2250
Fax: 749-5973

Rite-Aid
430 A North Main street
Bristol, CT 06010
Attn: Joe
Phone: 582-3491
Fax: 582-5396

Rite-Aid
School Street Plaza
271 Ellington Rd
East Hartford, CT 06108
Attn: Carlene
Phone: 528-6115
Fax: 289-0433

*These three Arrow Pharmacies bill through the Arrow Prescription Center Bookkeeping Department at the Farmington Avenue address in Hartford.

The other Arrow Pharmacies bill contractor directly.

Medicine Shoppe in Manchester will deliver prescriptions free of charge and covers a wide area including Broadbrook, Ellington, Coventry, Manchester area, East Hartford and also into Hartford.

Ryan White Part A
Request for Client Assistance Funds:
MEDICAL, DENTAL, MENTAL HEALTH, HOME HEALTH CARE,
MEDICATION REIMBURSEMENT, INSURANCE CONTINUATION
Contract Year March 1, 2012 - February 28, 2013

Client Code: ____________________________________ **CareWare Code:**________________

Case Manager: __________________________________ **email:**________________________

Agency:____

Address: ____

Telephone: ____________________________________ **Fax:**_________________________________

Request: ❑ **Medical** ❑ **Dental** ❑ **Mental Health** ❑ **Home Health Care**
❑ **Medication Assistance** ❑ **Insurance Continuation**

Reason for Request (Please be specific. "No other funding available" is not acceptable):

____

____

____

____

____

Identify all other funding sources you have applied to in order to get this request paid, and note amount(s) received. That amount will be deducted from the requested amount, unless otherwise indicated.

❑ **Medicaid/LIA/Husky** _______ ❑ **ConnPace** _______ ❑ **CADAP** _______ ❑ **CIPA**_______

❑ **Medicare** _______ ❑ **Other (e.g. VA)** ____

Amount of Request:________________________

Check Payable to:____

Mail payment to: ____

____

Case Manager Signature:____ **Date**____________

Case Manager Supervisor Signature:___________________________________ **Date**____________

Please Mail or Fax request to: CARC

Ryan White Part A
Request for Client Assistance Funds: UTILITIES
Contract Year March 1, 2012 - February 28, 2013

Client Code: ________________________ **CareWare Client Code** ______________

Case Manager: ________________________ **email** ______________________

Agency: ____

Address: ____

Telephone: ________________________ **Fax:** ______________________

Reason for request (please be specific):

____

____

____

List the other funding sources you have attempted to access to get this request paid. If you received a payment, please indicate the amount (s). That amount will be deducted from the request.

____

____

Has the client applied for any of the following assistance programs? Is so, please indicate date of application and outcomes

❒ **NUSTART** __________ ❒ **CRT** __________ ❒ **Gas Co.** __________

❒ **Operation Fuel** __________ ❒ **Other** ______________________________

____

Amount of Request: ______________________

Check Payable to: ____

Mail payment to: ____

____

Case Manager Signature: ________________________________ **Date** ________

Case Manager Supervisor Signature: ________________________ **Date** ________

Please Mail or Fax request to: CARC

Ryan White Part A
Request for Client Assistance Funds: TRANSPORTATION
Contract Year March 1, 2012 - February 28, 2013

Client Code: ______________________________ **CareWare Client Code**______________

Case Manager: ________________________ **email**__________________________

Agency:____

Address: ____

Telephone: ______________________________ **Fax:**___________________________

Reason for request (please be specific):

____

____

____

List the other funding sources you have attempted to access to get this request paid. If you received a payment, please indicate the amount (s). That amount will be deducted from the request.

____

____

Has the client applied for any of the following assistance programs? Is so, please indicate date of application and outcomes

❒ First Transit _____________ ❒ Basic Needs Program ______

❒ GHTD Ambassador Wheel Chair Service_______________________________________

____

____

Amount of Request: _________________________

Send bus pass/tokens to: ____

____

Case Manager Signature:_______________________________________ **Date**_______

Case Manager Supervisor Signature:_____________________________ **Date**_______

Please Mail or Fax request to: CARC

Ryan White Part A
Request for Client Assistance Funds: Food Vouchers
Contract Year March 1, 2012 - February 28, 2013

Client Code: ____________________________________ **CareWare Client Code**_________________

Case Manager: __________________________________ **email**_______________________________

Agency:____

Address: ____

Telephone: ____________________________________ **Fax:**_________________________________

Reason for request (please be specific):

____

____

____

List the other funding sources or services that you have attempted to access to obtain food.

____

____

Has the client applied for any of the following assistance programs? Is so, please indicate date of application and outcomes

❒ **SNAP** ______________ ❒ **Other**____

____

Amount of Request: _____________________________

Case Manager Signature:____ **Date**________

Case Manager Supervisor Signature:_________________________________ **Date**________

Please Mail or Fax request to: CARC

Client Assistance Fund

Transportation Log

Date of Service	Appointment	Provider Signature

For each bus pass or token issued, the recipient is required to identify the date of service; appointments attended, and have the provider of the service sign off. This is to ensure the proper use of transportation assistance. Any abuse of this service may result in termination of assistance.

If signatures aren't provided, please indicate why:

____

____

____

____

____

____

4/2010

CARC

Connecticut AIDS Resource Coalition

Food Voucher Log Form

Please fill out form in its entirety and return it via fax to 860 761-6711.

Client ID:			Date:	
Client Name:			Age:	
Street Address:			Apt.	
City:			State: **CT**	Zip:
Client Phone:		Agency:		
Case Manager:			Phone:	
Race:	Ethnic:	Gender:	HIV Status:	Transmission:

Date	**Store**	**Voucher #**	**Amount**	**Receipt (Y/ N, if no explain why)**

Please attached all receipts to this form, and return to CARC by the 3rd of the month to receive Food Vouchers.

If there are no receipts attached please explain why.

____

____

____

____

This form will be filed in the client's file at CARC.

110 Bartholomew Ave., Suite 4000, Hartford, CT 06106 | Phone (860) 761-6699 | Fax (860) 761-6711 | www.ctaidscoalition.org

Client
Assistance
Fund

c/o CARC, 110 Bartholomew Ave., Suite 4000, Hartford, CT 06106

____
Date

Dear

The Client Assistance Fund application for ______________________________ has been approved for:
Client (s)

- ☐ Medical Fee-for-Service ____
- ☐ Dental____
- ☐ Mental Health____
- ☐ Prescription Medication Reimbursement___________________________
- ☐ Insurance Continuation____
- ☐ Food Vouchers
- ☐ Client Financial assistance (Utilities)__________________________
  - Telephone___________________________
  - Electric____________________________
  - Gas________________________________
  - Oil_________________________________
- ☐ Transportation

If you have any questions, please feel free to call me at (860) 761-6699.

Thank you,

Cecilia Lewis, Program Manager
Client/Housing Assistance Fund
Phone: 860.761.6699 Fax: 860.761.6711

Case Managers: Please forward a copy of this to your client and keep a copy for your records.

Client Assistance Fund

c/o CARC, 110 Bartholomew Ave., Suite 4000, Hartford, CT 06106

____
Date

Dear

The Client Assistance Fund application for ______________________________ for the following service(s)
Client (s)

☐ Medical Fee-for-Service	☐ Dental	☐ Mental Health
☐ Prescription Assistance	☐ Insurance Continuation	
☐ Utility Assistance	☐ Food Voucher	☐ Transportation

IS PENDING FOR THE FOLLOWING REASON(S):

☐ Client did not meet eligibility criteria
☐ Required information was not provided
- Missing documentation on client:
- Incomplete client intake packet:
- CareWare client referral form
- Documentation of HIV status/Medical Evaluation form
- Signed Release of Information form
- Income verification

☐ Missing lease or rental verification
☐ No attached bill or invoice
☐ Insufficient funds (Client has reached cap)
☐ Other: ____

Please get this information to us by ______________. If we do not receive this information by that date, we will deny the application. You will still be eligible to reapply on behalf of the client. If you have any questions, please feel free to call me at (860) 761-6699.

Thank you.

Sincerely,

Cecilia Lewis, Program Manager
Client/Housing Assistance Fund
Phone: 860.761.6699 Fax: 860.761.6711

Case Managers: Please forward a copy of this notice to your client.

Client Assistance Fund

c/o CARC, 110 Bartholomew Ave., Suite 4000, Hartford, CT 06106

____

Date

Dear

The Client Assistance Fund application for ________________________________ for the following service(s)

Client (s)

☐ Medical Fee-for-Service	☐ Dental	☐ Mental Health
☐ Prescription Assistance	☐ Insurance Continuation	
☐ Utility Assistance	☐ Food Voucher	☐ Transportation

WAS DENIED FOR THE FOLLOWING REASON(S):

☐ Client did not meet eligibility criteria ____

☐ Required information was not provided

- Missing documentation on client____
- ***Incomplete client intake packet***
- CareWare client referral form
- Documentation of HIV status/Medical Evaluation form
- Signed Release of Information form
- Income verification

☐ No attached bill, payment history or invoice (Utilities)

☐ Other sources of funding were not sought

☐ Insufficient funds (Client has reached cap)

☐ Other ____

A copy of this denial form has also been placed in the client's file.

Should the client's circumstances change or you obtain the required documentation, you are still eligible to re-apply on behalf of the client. If you have any questions, please feel free to call me at (860) 761-6699.

Thank you.

Sincerely,

Cecilia Lewis, Program Manager
Client/Housing Assistance Fund
Phone: 860.761.6699 Fax: 860.761.6711

<u>Case Managers: Please forward a copy of this to your client.</u>

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET * HARTFORD, CONNECTICUT 06106

Connecticut AIDS Drug Assistance Program (CADAP) Formulary – Effective: July 1, 2011

Anti-Virals: Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs) - 13		
Abacavir (Ziagen)	Emtricitabine (Emtriva)	Stavudine (d4T, Zerit)
Abacavir/Lamivudine/Zidovudine (Trizivir)	Emtricitabine/Tenofovir (Truvada)	Tenofovir DF (Viread)
Didanosine (ddI, Videx, Videx EC)	Lamivudine (3TC, Epivir, **Epivir HBV**)	Zalcitabine (ddC, Hivid)
Efavirenz/Emtricitabine/Tenofovir (Atripla)	Lamivudine/Zidovudine (Combivir)	Zidovudine (AZT, Retrovir)
	Lamivudine/Abacavir (Epzicom)	
Anti-Virals: Integrase Inhibitors - 1		
	Raltegravir (Isentress)	
Anti-Virals: Protease Inhibitors (PIs) - 11		
Amprenavir (Agenerase)	Indinavir (Crixivan)	Ritonavir (Norvir)
Atazanavir Sulfate (Reyataz)	Lopinavir/Ritonavir (Kaletra)	Saquinavir (Fortovase)
Darunavir (Prezista)	Nelfinavir (Viracept)	Saquinavir mesylate (Invirase)
Fosamprenavir (Lexiva)		Tipranavir (Aptivus)
Anti-Virals: Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) - 4		
Delavirdine (Rescriptor)	Etravirine (Intelence)	**Rilpivirine (Edurant)**
Efavirenz (Sustiva)	Nevirapine (Viramune, **Viramune XR**)	
Anti-Virals: Entry Inhibitors - 2		
Enfuvirtide, T-20 (Fuzeon) - *injectable*		Maraviroc (Selzentry) - *oral*
Anti-Virals: Herpes Treatments/CMV Disease - 7		
Acyclovir (Zovirax)	Famciclovir (Famvir)	Valacyclovir (Valtrex)
Cidofovir (Vistide)	Foscarnet (Foscavir)	Valganciclovir (Valcyte)
	Ganciclovir (Cytovene)	
Anti-Virals: Hepatitis B Treatments - 1		
	Entecavir (Baraclude)	
Anti-Virals: Hepatitis C Treatments - 5		
PEG-Interferon alfa-2a (Pegasys)	PEG-Interferon alfa-2b (PI - REDIPEN)	Ribavirin (Copegus)
PEG-Interferon alfa-2b (PEG-INTRON)		Ribavirin (Rebetol)
Antibiotics - 24		
Amoxicillin	Clarithromycin (Biaxin)	Neomycin Sulfate (Cortisporin)
Amoxicillin/Clavulanate pot. (Augmentin)	Clindamycin (Cleocin)	Nitrofurantoin Monohydrate ((Macrobid)
Ampicillin	Dicloxacillin	Ofloxacin (Floxin)
Azithromycin (Zithromax)	Doxycycline Hyclate	Paromomycin (Humatin)
Cefditoren Pivoxil (Spectracef)	Gatifloxacin (Tequin)	Penicillin G Benzathine (Bicillin)
Cefuroxime	Gentamicin	Penicillin V Potassium (Veetids)
Cephalexin (Keflex)	Levofloxacin (Levaquin)	Rifabutin (Mycobutin)
Ciprofloxacin (Cipro)	Minocycline HCL (Dynacin)	Vancomycin
Anti-Fungal Agents – 9		
Amphotericin B (Fungizone B)	Itraconazole (Sporanox)	Terbinafine (Lamisil) – Topical / Tablet
Clotrimazole (Mycelex, Lotrimin)	Ketoconazole (Nizoral)	Terconazole (Terazol 3 & 7)
Fluconazole (Diflucan)	Nystatin	Voriconazole (Vfend)
Other Anti-Infective Agents - 12		
Dapsone	Oseltamivir Phosphate (Tamiflu)	Sulfadiazine
Ethambutol (Myambutol)	Pentamidine (Pentam 300, NebuPent)	Trimethoprim-sulfamethoxazole, TMP-SMZ
Mepron	Primaquine	Trimethoprim (Proloprim)
Metronidazole (Flagyl)	Pyrimethamine	Zanamivir (Relenza)
Analgesic Agents – 6		
Acetaminophen with codeine	Fentanyl Transdermal System (Duragesic)	Oxycodone HCL – CR (Oxycontin)
Oxycodone with APAP 5/325 (Percocet)	Oxycodone with APAP SLN (Roxicet)	Tramadol HCl (Ultram)
Decongestant & Expectorant Agents – 3		
Guaifenesin/Codeine PH (Tussi-Organidin S-NR)	Guaifenesin/pseudoephedrine (Entex PSE)	Guaifenesin/DM HBr (Tussi-Organidin DM-S-NR)
Anti-Inflammatory Agents (NSAID) – 4		
Celecoxib (Celebrex)	Ibuprofen	Naproxen (Naprosyn)
	Ketoprofen (Orudis)	

Anti-Hyperlipidemic Agents – 10		
Atorvastatin (Lipitor)	Ezetimibe (Zetia)	Pravastatin (Pravachol)
Cholestyramine (Questran)	Fenofibrate (Tricor)	Rosuvastatin Calcium (Crestor)
Clofibrate (Atromid-S)	Gemfibrozil (Lopid)	Fenofibric Acid (Trilipix)
Colesevelam HCl (Welchol)	Omega-3 Acid Ethyl Esthers (Lovaza)	
Dermatological Agents - 13		
Alclometasone Dipropionate (Aclovate)	Fluticasone Propionate (Cutivate)	Mupirocin Ointment. (Bactroban Ointment.)
Betamethasone (Diprolene)	Hydrocortisone Topical	Pimecrolimus (Elidel)
Clindamycin Gel (Cleocin T)	Ketoconazole 2% (Nizoral Shampoo)	Triamcinolone-Acetonide Topical
Clobetasol Propionate (Temovate)	Lactic Acid	
Fluocinonide (Lidex)	Metronidazole Cream (MetroCream)	
Anti-Hypertensive/Cardiac Agents - 18		
Amlodipine (Norvasc)	Furosemide	Metoprolol Succinate (Toprol-XL)
Atenolol (Tenormin)	Hydrochlorothiazide (HCT)	Minoxidil
Clopidigrel (Plavix)	Isosorbide Dinitrate	Nitroglycerin
Digoxin	Isosorbide Mononitrate (Imdur)	Spironolactone
Diltiazem HCL (Cardizem)	Labetalol HCL (Normodyne)	Valsartan (Diovan), Valsartan and HCT (Diovan HCT)
Enalapril Maleate (Vasotec)	Lisinopril (Prinivil, Zestril)	Verapamil (Covera HS)
Anti-Depressants / Psychotropic Agents - 28		
Alprazolam (Xanax)	Divalproex Sodium (Depakote)	Olanzapine (Zyprexa)
Amitriptyline HCL (Elavil)	Duloxetine (Cymbalta)	Paroxetine (Paxil)
Aripiprazole (Abilify)	Escitalopram Oxalate (Lexapro)	Prochlorperazine (Compazine)
Benztropine Mesylate (Cogentin)	Fluoxetine HCL (Prozac)	Quetiapine Fumarate (Seroquel)
Bupropion HCL (Wellbutrin)	Hydroxyzine HCL (Atarax)	Risperidone (Risperdal)
Buspirone (BuSpar)	Lamotrigine (Lamictal XR)	Sertraline (Zoloft)
Carbamazepine (Tegretol)	Lithium	Trazodone
Citalopram (Celexa)	Lorazepam	Venlafaxine (Effexor)
Clonazepam (Klonopin)	Mirtazapine (Remeron)	
Diazepam	Nortriptyline HCL	
Gastrointestinal Agents: Proton Pump Inhibitors (PPIs) - 6		
Esomeprazole (Nexium)	Lansoprazole (Prevacid)	Rabeprazole Sodium (Aciphex)
Famotidine (Pepcid)	Pantoprazole Sodium (Protonix)	Ranitidine HCL (Zantac)
Vaccines - 7		
Comvax	Pneumococcal Vaccine (individual doses)	Vaqta
Engerix-B	Recombivax HB	
Havrix	Twinrix	
Endocrine/Metabolic Agents (Steroids) - 9		
Nandrolone decanoate (Deca-Durabolin)	Prednisone	Testosterone (Androderm)
Oxandrolone (Oxandrin)	***Somatropin (Serostim)***	Testosterone-cypionate (Depo-Testosterone)
Oxymetholone (Anadrol-50)	Testosterone (Androgel)	Testosterone Gel (Testim 1%)
Bronchial Dilators/Respiratory Agents - 9		
Albuterol (Proventil)	Flunisolide (Aerobid)	Salmeterol (Advair Diskus)
Azelastine HCl (Astelin)	Fluticasone Propionate (Flovent)	Salmeterol Xinafoate (Serevent)
Budesonide (Rhinocort AQUA)	Ipratropium Bromide (Combivent)	Triamcinolone Acetonide (Nasacort AQ)
Diabetes Agents - 8		
Exenatide (Byetta)	Insulin NPH	Pioglitazone HCL (Actos)
Glipizide	Insulin Regular	Rosiglitazone Maleate (Avandia)
Glyburide	Metformin HCL (Glucophage)	
Miscellaneous - 27		
Alendronate Sodium/ Cholecalciferol (Fosamax Plus D)	Filgrastim (G-CSF, Neupogen)	Levothyroxine Sodium (Synthroid)
Chlorhexidine gluconate (Peridex)	Gabapentin (Neurontin)	Loperamide HCL (Imodium)
Dexamethasone	Granisetron (Kytril)	Megestrol Acetate (Megace)
Diphenoxylate HCL (Lomotil, Lonox)	Hydroxyurea	Mometasonefuroate monohydrate (Nasonex)
Dronabinol (Marinol)	Imiquimod (Aldara)	Ondansetron (Zofran)
Erythropoetin (Epogen, Procrit)	Lactulose (Kristalose)	Strovite; Forte / Plus D / Advance / One
Ferrous Sulfate (Repliva)	Leucovorin	Temazepam (Restoril)
Fexofenadine HCl / Pseudoephedrine HCl (Allegra / Allegra-D)	Levocarnitine/Oral (Carnitor)	Zolpidem Tartrate (Ambien / Ambien CR)

TOTAL Drugs on CADAP Formulary = 241

BOLD ITALICS denotes Prior Authorization required effective September 15, 2006; revised November 1, 2009 to 26-week supply in a one-year period maximum

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET * HARTFORD, CONNECTICUT 06106

Connecticut AIDS Drug Assistance Program (CADAP) Formulary **Effective July 1, 2011**

Generic Name in Alphabetical / Numerical Order

1. Abacavir (Ziagen)
2. Abacavir/Lamivudine/Zidovudine (Trizivir)
3. Acetaminophen with codeine
4. Acyclovir (Zovirax)
5. Albuterol (Proventil)
6. Alclometasone Dipropionate (Aclovate)
7. Alendronate Sodium/ Cholecalciferol (Fosamax Plus D)
8. Alprazolam (Xanax)
9. Amitriptyline HCL (Elavil)
10. Amlodipine (Norvasc)
11. Amoxicillin
12. Amoxicillin/Clavulanate Potassium (Augmentin)
13. Amphotericin B (Fungizone B)
14. Ampicillin
15. Amprenavir (Agenerase)
16. Aripiprazole (Abilify)
17. Atazanavir (Reyataz)
18. Atenolol (Tenormin)
19. Atorvastatin (Lipitor)
20. Azelastine HCl (Astelin)
21. Azithromycin (Zithromax)
22. Benztropine Mesylate (Cogentin)
23. Betamethasone (Diprolene)
24. Budesonide (Rhinocort AQUA)
25. Bupropion HCL (Wellbutrin)
26. Buspirone (BuSpar)
27. Carbamazepine (Tegretol)
28. Cefditoren Pivoxil (Spectracef)
29. Cefuroxime
30. Celecoxib (Celebrex)
31. Cephalexin (Keflex)
32. Chlorhexidine gluconate (Peridex)
33. Cholestyramine (Questran)
34. Cidofovir (Vistide)
35. Ciprofloxacin (Cipro)
36. Citalopram (Celexa)
37. Clarithromycin (Biaxin)
38. Clindamycin (Cleocin)
39. Clindamycin Gel (Cleocin T)
40. Clobetasol Propionate (Temovate)
41. Clofibrate (Atromid-S)
42. Clonazepam (Klonopin)
43. Clopidigrel (Plavix)
44. Clotrimazole (Mycelex, Lotrimin)
45. Colesevelam HCl (Welchol)
46. Comvax
47. Dapsone
48. Darunavir (Prezista)
49. Delavirdine (Rescriptor)
50. Dexamethasone
51. Diazepam
52. Dicloxacillin
53. Didanosine (ddI, Videx)
54. Digoxin
55. Diltiazem HCL (Cardizem)
56. Diphenoxylate HCL (Lomotil, Lonox)
57. Divalproex Sodium (Depakote)
58. Doxycycline hyclate
59. Dronabinol (Marinol)
60. Duloxetine (Cymbalta)
61. Efavirenz (Sustiva)
62. Efavirenz/Emtricitabine/Tenofovir (Atripla)
63. Emtricitabine (Emtriva)
64. Emtricitabine/Tenofovir (Truvada)
65. Enalapril Maleate (Vasotec)
66. Enfuvirtide, T-20 (Fuzeon)
67. Engerix-B
68. Entecavir (Baraclude)
69. Erythropoetin (Epogen, Procrit)
70. Escitalopram Oxalate (Lexapro)
71. Esomeprazole (Nexium)
72. Ethambutol (Myambutol)
73. Etravirine (Intelence)
74. Exenatide (Byetta)
75. Ezetimibe (Zetia)
76. Famciclovir (Famvir)
77. Famotidine (Pepcid)
78. Fenofibrate (Tricor)
79. Fenofibric Acid (Trilipix)
80. Fentanyl transdermal system (Duragesic)
81. Ferrous Sulfate (Repliva)
82. Fexofenadine HCl / Pseudoephedrine HCl (Allegra / Allegra-D)
83. Filgrastim (G-CSF, Neupogen)
84. Fluconazole (Diflucan)
85. Fluocinonide (Lidex)
86. Flunisolide (Aerobid)
87. Fluoxetine HCL (Prozac)
88. Fluticasone Propionate (Cutivate)
89. Fluticasone Propionate (Flovent)
90. Fosamprenavir (Lexiva)
91. Foscarnet (Foscavir)
92. Furosemide
93. Gabapentin (Neurontin)
94. Ganciclovir (Cytovene)
95. Gatifloxacin (Tequin)
96. Gemfibrozil (Lopid)
97. Gentamicin
98. Glipizide
99. Glyburide
100. Granisetron HCl (Kytril)
101. Guaifenesin/Codeine PH (Tussi-Organidin S-NR)
102. Guaifenesin/DM HBr (Tussi-Organidin DM-S-NR)
103. Guaifenesin/pseudoephedrine (Entex PSE)
104. Havrix
105. Hydrochlorothiazide (HCT)
106. Hydrocortisone Topical
107. Hydroxyurea
108. Hydroxyzine HCL (Atarax)
109. Ibuprofen
110. Imiquimod (Aldara)
111. Indinavir (Crixivan)
112. Insulin NPH
113. Insulin Regular
114. Ipratropium Bromide (Combivent)
115. Isosorbide Dinitrate
116. Isosorbide mononitrate (Imdur)
117. Itraconazole (Sporanox)
118. Ketoconazole

119. Ketoconazole 2% (Nizoral Shampoo)
120. Ketoprofen (Orudis)
121. Labetalol HCL (Normodyne)
122. Lactic Acid
123. Lactulose (Kristalose)
124. Lamivudine (3TC, Epivir, **Epivir HBV**)
125. Lamivudine/Abacavir (Epzicom)
126. Lamivudine/Zidovudine (Combivir)
127. Lamotrigine (Lamictal XR)
128. Lansoprazole (Prevacid)
129. Leucovorin
130. Levocarnitine/Oral (Carnitor)
131. Levofloxacin (Levaquin)
132. Levothyroxine Sodium (Synthroid)
133. Lisinopril (Prinivil, Zestril)
134. Lithium
135. Loperamide HCL (Imodium)
136. Lopinavir/Ritonavir (Kaletra)
137. Lorazepam
138. Maraviroc (Selzentry)
139. Megestrol acetate (Megace)
140. Mepron
141. Metformin HCL (Glucophage)
142. Metoprolol Succinate (Toprol-XL)
143. Metronidazole (Flagyl)
144. Metronidazole Cream (MetroCream)
145. Minocycline HCL (Dynacin)
146. Minoxidil
147. Mirtazapine (Remeron)
148. Mometasone furoate monohydrate (Nasonex)
149. Mupirocin Oint. (Bactroban Oint.)
150. Nandrolone decanoate (Deca-Durabolin)
151. Naproxen (Naprosyn)
152. Nelfinavir (Viracept)
153. Neomycin Sulfate (Cortisporin)
154. Nevirapine (Viramune, **Viramune XR**)
155. Nitrofurantoin Monohydrate (Macrobid)
156. Nitroglycerin
157. Nortriptyline HCL
158. Nystatin
159. Ofloxacin (Floxin)
160. Olanzapine (Zyprexa)
161. Omega -3 Acid Ethyl Ester (Lovaza)
162. Ondansetron HCl (Zofran)
163. Oseltamivir Phosphate (Tamiflu)
164. Oxandrolone (Oxandrin)
165. Oxycodone HCL controlled release (Oxycontin)
166. Oxycodone with APAP 5/325 (Percocet)
167. Oxycodone with APAP SLN (Roxicet SLN)
168. Oxymetholone (Anadrol-50)
169. Pantoprazole Sodium (Protonix)
170. Paromomycin (Humatin)
171. Paroxetine (Paxil)
172. PEG-Interferon alfa-2a (Pegasys)
173. PEG-Interferon alfa-2b (PEG-INTRON)
174. PEG-Interferon alfa-2b (PEG-INTRON REDIPEN)
175. Penicillin G Benzathine (Bicillin)
176. Penicillin V Potassium (Veetids)
177. Pentamidine (Pentam 300, NebuPent)
178. Pinecrolimus (Elidel)
179. Pioglitazone HCL (Actos)
180. Pneumococcal vaccine (individual doses)
181. Pravastatin (Pravachol)
182. Prednisone
183. Primaquine
184. Prochlorperazine (Compazine)
185. Pyrimethamine
186. Quetiapine Fumarate (Seroquel)
187. Rabeprazole Sodium (Aciphex)
188. Raltegravir (Isentress)
189. Ranitidine HCL (Zantac)
190. Recombivax HB
191. Ribavirin (Copegus)
192. Ribavirin (Rebetol)
193. Rifabutin (Mycobutin)
194. **Rilpivirine (Edurant)**
195. Risperidone (Risperdal)
196. Ritonavir (Norvir)
197. Rosiglitazone Maleate (Avandia)
198. Rosuvastatin Calcium (Crestor)
199. Salmeterol (Advair Diskus)
200. Salmeterol Xinafoate (Serevent)
201. Saquinavir (Fortovase)
202. Saquinavir mesylate (Invirase)
203. Somatropin (Serostim) *
204. Sertraline (Zoloft)s
205. Spironolactone
206. Stavudine (d4T, Zerit)
207. Strovite
208. Strovite Advance
209. Strovite Forte
210. Strovite One
211. Strovite Plus Vitamin D
212. Sulfadiazine
213. Terbinafine (Lamisil) **
214. Temazepam (Restoril)
215. Tenofovir DF (Viread)
216. Terconazole (Terazol 3&7)
217. Testosterone (Androderm)
218. Testosterone (Androgel)
219. Testosterone-cypionate (Depo-testosterone)
220. Testosterone Gel (Testim 1%)
221. Tipranavir (Aptivus)
222. Tramadol HCl (Ultram)
223. Trazodone
224. Triamcinolone Acetonide (Nasacort AQ)
225. Triamcinolone-acetonide Topical
226. Trimethoprim (Proloprim)
227. Trimethoprim-sulfamethoxazole, TMP-SMZ
228. Twinrix
229. Valacyclovir (Valtrex)
230. Valganciclovir (Valcyte)
231. Valsartan (Diovan)
232. Valsartan and HCT (Diovan HCT)
233. Vancomycin
234. Vaqta
235. Venlafaxine (Effexor)
236. Verapamil (Covera HS)
237. Voriconazole (Vfend)
238. Zalcitabine (ddC, Hivid)
239. Zanamivir (Relenza)
240. Zidovudine (AZT, Retrovir)
241. Zolpidem Tartrate (Ambien / Ambien CR)

*** denotes Prior Authorization required effective September 15, 2006**
**** denotes 250mg tablet only effective October 1, 2008**

Section 4.

Ryan White Title I Program have developed Performance Standards for each of the services funded by Ryan White Title I funds. The Performance Standards that CARC pledges to meet for each of our programs is found in this section.

Performance Standards: Housing Assistance Fund

Performance Standards: Medical, Medication Reimbursement, Insurance Continuation

Performance Standards: Direct Financial assistance (Utilities, Babysitting, Food Vouchers)

See attached performance standards.

Greater Hartford Ryan White Title I
PERFORMANCE STANDARDS

RENTAL ASSISTANCE AND EMERGENCY HOUSING ASSISTANCE

Objectives: **>To provide regular monthly rental assistance.**
>To provide emergency rental assistance and first month rental subsidies.

Eligibility and Access

1.1 Provider agency will ensure that all clients accepted for services meet the minimum eligibility requirements defined by HRSA and the Hartford EMA.
1.2 Provider agency will ensure that Ryan White funds are funds of last resort and will only provide services when such services are otherwise unavailable.
1.3 Provider agency will accept and process only requests for rental assistance that are submitted by case managers.
1.4 Provider agency will provide case managers with easy to understand information about the following:
Hours of operation
Telephone numbers
Documentation that must be submitted with initial application for assistance
Documentation that must be submitted with 6 month reapplication.
Procedure for appealing a denied request
1.5 Eligibility for rental assistance will be reevaluated every 6 months

2. Quality of Care

2.1 Provider agency will have clearly stated, written guidelines that list all of the criteria, including allowable extenuating circumstances, that are used to determine if a client is eligible for rental assistance.
2.2 Provider agency will follow the written guidelines, without exception, for all requests for rental assistance.
2.3 Provider agency will ensure that staff are fully trained to implement the written guidelines.
2.4 Provider agency will send monthly checks for short-term rental assistance to the client's case manager at least 7 days before the rent is due. In the case of a new client, the first check may be sent within 7 days of an approved application
2.5 Provider agency will send checks for one time rental assistance within 7 days of an approved application.

3. Information Management

3.1 Provider agency will have a client record system that includes consistent and standardized ways of collecting and maintaining information about client demographics, requests for payment, service and other pertinent information and that assures confidentiality within parameters of state and federal law.

3.2 Provider agency will use the software application designated by the City of Hartford to maintain Ryan White Title I client information and will comply with the protocols published by the grantee regarding the use of the software.

3.3 Provider agency will have written policies for client confidentiality and release of information that are in accordance with state and federal laws. As part of the confidentiality policy, all agencies will have a "release of information" form describing under what circumstances client information can be released (name of agency/individual with whom information will be shared, information to be shared, duration of the release consent, and client signature).

3.4 Provider agency will make available to anyone who requests them the written guidelines and criteria for rental assistance.

4. <u>Quality Management</u>

4.1 Provider agency will have written policies for a client Grievance Procedure. The policy will identify the steps a client should follow to file a grievance and state how the grievance will be handled.

4.2 Provider agency will document that case managers have been informed of grievance procedures.

4.3 Provider agency will document service outcomes.

4.4 Provider agency will have a continuous quality improvement process that identifies areas requiring review, develops and implements changes in procedures, and documents the results to the changes.

4.5 Provider agency should consider using client satisfaction surveys as a means of gathering information about the response to and efficacy of services.

Greater Hartford Ryan White Title I
PERFORMANCE STANDARDS

DIRECT FINANCIAL ASSISTANCE

Objectives: **> To provide payment for emergency expenses, baby sitting and food vouchers.**

Eligibility and Access

1.1 Provider agency will ensure that all clients accepted for services meet the minimum eligibility requirements defined by HRSA and the Hartford EMA.

1.2 Provider agency will ensure that Ryan White funds are funds of last resort and will only provide services when such services are otherwise unavailable.

1.3 Provider agency will accept and process only requests for financial assistance and vouchers that are submitted by case managers.

1.4 Provider agency will provide case managers with easy to understand information about the following:

Hours of operation (including accessibility during evening and weekends)
Telephone numbers(including number to call for emergency assistance)
Documentation that must be submitted with requests
Procedure for appealing a denied request

1.5 Provider agency will make a presentation annually and/or as needed to case managers at a Care Coordinators meeting explaining the protocols, eligibility criteria, and other guidelines for obtaining financial assistance or vouchers.

2. Quality of Care

2.1 Provider agency will have clearly stated, written guidelines that list all of the criteria, including allowable extenuating circumstances, that are used to determine if a client is eligible for financial assistance.

2.2 Provider agency will follow the written guidelines, without exception, for all requests for financial assistance.

2.3 Provider agency will provide comprehensive orientation for new staff members and ensure that staff are fully trained to implement the written guidelines.

2.4 Provider agency will pay routine requests for payment within 14 days.

2.5 Provider agency will pay emergency requests for payment within 48 hours.

2.6 Provider agency will send notice to case manager that payment has been made within five days after check is sent.

3. Information Management

3.1 Provider will have a client record system that includes consistent and standardized ways of collecting and maintaining information about client demographics, requests for payment, service and other pertinent information and that assures confidentiality within parameters of state and federal law. The client record system must allow for the aggregation of client information.

3.2 Provider will use the software application designated by the City of Hartford to maintain Ryan White Title I client information and will comply with the protocols published by the grantee regarding the use of the software.

3.3 Provider will have written policies for client confidentiality and release of information that are in accordance with state and federal laws. As part of the confidentiality policy, all agencies will have a "release of information" form describing under what circumstances client information can be released (name of agency/individual with whom information will be shared, information to be shared, duration of the release consent, and client signature).

3.4 Provider will make available to any one who requests them the written protocols and guidelines for the delivery of services.

4. Quality Management

4.1 Provider will have written policies for a client Grievance Procedure. The policy will identify the steps a client should follow to file a grievance and stating how the grievance will be handled.

4.2 Provider will document that case managers have been informed of Grievance Procedures.

4.3 Provider will document service outcomes.

4.4 Provider will have a continuous quality improvement process that identifies areas requiring review, develops and implements changes in procedures, and documents the results to the changes.

4.5 Provider should consider using client satisfaction surveys as a means of gathering information about the response to and efficacy of services.

Greater Hartford Ryan White Title I
PERFORMANCE STANDARDS

MEDICAL FEE-FOR-SERVICE PAYMENTS; MEDICATION REIMBURSEMENT; INSURANCE CONTINUATION

Objectives: **>To reimburse fee-for-service medical providers for patient care;**
>To pay HIV related medication expense;
>To pay insurance premiums to continue insurance coverage.

1. **Eligibility and Access**

1.1 Provider agency will ensure that all clients accepted for services meet the minimum eligibility requirements defined by HRSA and the Hartford EMA.
1.2 Provider agency will ensure that Ryan White funds are funds of last resort and will only provide services when such services are otherwise unavailable.
1.3 Provider agency will accept and process only requests for direct financial assistance that are submitted by case managers.
1.4 Provider agency will provide case managers with easy to understand information about the following:
Hours of operation (including accessibility during evening and weekends)
Telephone numbers(including number to call for emergency assistance)
Documentation that must be submitted with requests
Procedure for appealing a denied request
1.5 Provider agency will make a presentation annually and/or as needed to case managers at a Care Coordinators meeting explaining the protocols, eligibility criteria, and other guidelines for obtaining medical, medication and insurance reimbursements.

2. **Quality of Care**

2.1 Provider agency will have clearly stated, written guidelines that list all of the criteria, including allowable extenuating circumstances, that are used to determine if a client is eligible for direct financial assistance.
2.2 Provider agency will follow the written guidelines, without exception, for all requests for direct financial assistance.
2.3 Provider agency will provide comprehensive orientation for new staff members to ensure that staff are fully trained to implement the written guidelines.
2.4 Provider agency will pay routine requests for payment within 14 days
2.5 Provider agency will pay emergency requests for payment within 48 hours
2.6 Provider agency will send notice to case manager that payment has been make within five days after check is sent.

3. **Information Management**

3.1 Provider agency will have a client record system that includes consistent and standardized ways of collecting and maintaining information about client *demographics, requests for payment, service and other pertinent information and that assures confidentiality within parameters of state and federal law. The client record system must allow for the aggregation of client information.*

3.2 Provider agency will use the software application designated by the City of Hartford to maintain Ryan White Title I client information and will comply with the protocols published by the grantee regarding the use of the software.

3.3 Provider agency will have written policies for client confidentiality and release of information that are in accordance with state and federal laws. As part of the confidentiality policy, all agencies will have a "release of information" form describing under what circumstances client information can be released (name of agency/individual with whom information will be shared, information to be shared, duration of the release consent, and client signature).

3.4 Provider agency will make available to any one who requests them the written protocols and guidelines for the delivery of services, including these Performance Standards.

4. Quality Management

4.1 Provider agency will have written policies for a client Grievance Procedure. The policy will identify the steps a client should follow to file a grievance and stating how the grievance will be handled.

4.2 Provider agency will document that case managers have been informed of Grievance Procedures.

4.3 Provider agency will document service outcomes.

4.4 Provider agency will have a continuous quality improvement process that identifies areas requiring review, develops and implements changes in procedures, and documents the results to the changes.

4.5 Provider agency should consider using client satisfaction surveys as a means of gathering information about the response to and efficacy of services.