LATiNO
C'OMMUNITY SERVICES

Ryan White Part A
Medical Transportation Services/Latino Community Services
Program Protocols

Revised May 2023

Table of Contents

Transportation Overview

The Ryan White Part A: *Medical Transportation Services* includes the conveying of services to clients in order to access primary medical care and/or psychosocial support services. Services may be provided routinely or on an emergency basis to clients who access Ryan White CORE and/or NON-CORE service categories.

Latino Community Services' Medical Transportation Program will provide transportation services to Ryan White eligible individuals throughout the Greater Hartford Transitional Grant Area (TGA), to help facilitate more effective and therapeutic HIV primary medical care including monolingual Spanish speaking clients to achieve improved medical outcomes.

Mandates:

There are standards set in place by Latino Community Services, Contractor and the City of Hartford Department of Health and Human Services, funding entity, to deliver effective services within the Hartford Transitional Grant Area to HIV positive individuals requiring medical transportation services.

(1) Service Priorities:

A **Highest Priority**	**B** **To be provided if those requests listed as "A" have been fulfilled**
Medical & Dentist Appointments	Medical Case Management
Mental Health Sessions	Support Groups (If no medical appts. at the same time)
Substance Abuse Counseling	Food Pantry

(2) Types of Transportation Options available and rules of governing their use

Van Services:
These services are designed to be utilized by individuals with some kind of impairment who are ambulatory. They may also be for individuals in a geographic area with no bus line or for people who are going to an appointment out of bus line service. This may also be a temporary arrangement for persons who became ill and cannot take a bus during that period of time. If a client has a scheduled pickup for 12:00 PM, the van drivers will only wait 15 minutes for that client to come out (until 12:15 PM). Van drivers will not knock on doors; it is the responsibility of the client to be prepared for his/her scheduled pick up time. If a client is a "no show", standard protocols state that the Medical Case Managers will be informed

Requirements for Referral to the Medical Transportation Program

Referral system for Medical Case Managers

- Provider will submit referral and pertinent documentation to the medical transportation provider of LCS via fax (860-371-2235).

- Medical Transportation program will confirm that all documentation is complete and accurate and that releases have been signed and are not expired. Then begins relationship with client.

- Medical Transportation program will confirm with client of the pending appointment.

- Client will be given and explained the LCS Client Action Inquiry Procedure form for their records, client will be asked to sign the acknowledgement form and it will be placed in clients file.

- Medical Transportation program will drop off and pick up client from appointment and document all information on outcome of service and be placed in client folder including any follow up appointments, when appropriate.

- Medical Transportation program will communicate with Medical Case Manager as a courtesy phone call of outcome of client's appointment.

PLEASE NOTE: CLIENTS WILL NOT RECEIVE SERVICES UNTIL ALL REQUIRED DOCUMENTATION IS COMPLETED AND RECEIVED.

Medical Transportation provides transportation services five days per week Monday through Friday 8:00 AM - 3:00 PM

Requests for services must be made no later than **24 hours before the date of the service.** Service providers should communicate with their clients regarding scheduling. Although, a client may call to schedule an appointment with 24-hour notice, the slot may be already filled by another appointment. Therefore, it is strongly encouraged that clients call to schedule rides at least with a 24-hour notice. Transportation staff will try to make all the accommodations possible. Each client that is eligible rides (one round trip service is equivalent to one ride).

Winter Schedule: During the months of November through February, Medical Transportation will continue to follow normal operational hours however hours may be subject to change in consideration of the inclement weather. During these months, should inclement weather cause a delay or change in operations hours, program staff will make every effort to contact client and/or providers in order to inform them with ample notice. We ask that you also inform yourselves through WFSB, Channel 3 for potential agency closings and delayed openings.

The following are standard Terms of Service:

- Service units will be provided on a "first come, first serve basis."
- Service units will be provided only if space is available or client may need to negotiate with the Transportation Coordinator or Service Provider.
- Service units will be provided with the highest priority for services.
- Service units that are provided within the Tolland & Middlesex Counties are allotted an hour as opposed to the half hour allotted in the Hartford County.
- All service units will be monitored.
- Three no-shows without cancellation during the same calendar month as well as excessive cancellations will cause services to be suspended for one month. Both the provider and the client will be notified.

Checklist for Referring Provider

Providers, please be sure you complete and submit all of the forms listed in this checklist. This will allow for a more expeditious approval process.

Client CAREWare ID:			
Medical Case Manager or referring provider:			
Referring Agency:	*Phone:*	*Ext.*	*Fax:*
Email of referring provider:			

Required Checklist of approval process:

D **Providers submit electronic referrals via CAREWare**
☐ Ryan White Eligibility Worksheet & Income Verification
☐ Release of Information and Entire Network of Service Providers Signed
☐ RW Part A Transportation Service Assessment Form
☐ RW Part A Monthly Log of Service Form
☐ Signed Ryan White Consent and Statement
☐ Signed Ryan White Consent to Share for HIV/Hepatitis C & HOPWA

Notes:

RW Part A Transportation Services Assessment Form

CLIENT INFORMATION

Client ID:	**Name:**	**Age:**
Address:	***Phone number:**	**Gender:**
City: **Zip:**	**Primary language:**	**Race:**
Case Manager (if one is assigned to the client):		

**Individuals without a phone number cannot access Uber.*

Has client applied for other services: ◯ Yes ◯ No ◯ Veyo ◯ First Transit ◯ Other

APPOINTMENT INFORMATION

Referral Service Date:

Was CAREWare Referral completed? ◯ Yes ◯ No

Type of appointment:

Additional Notes:

If service was denied, explain why and how it was resolved:

If no show up or appointment cancelled, was Case Manager contacted: ◯ Yes ◯ No

Funds utilized for this need: ◯ RW Part A ◯ RW Part B

Case Manager Signature _____ **Date:**

RIDES for the Month of _____, 20____

TRANSPORTATION TYPE	AMOUNT OF BUS CARD	DATE OF RIDE	TIME OF RIDE	PICK- UP LOCATION FOR VAN/UBER	DROP-OFF LOCATION FOR VAN/UBER
Van Uber Bus Card					
Van Uber Bus Card					
Van Uber Bus Card					
Van Uber Bus Card					
Van Uber Bus Card					
Van Uber Bus Card					
Van Uber Bus Card					
Van Uber Bus Card					
Van Uber Bus Card					
Van Uber Bus Card					
Van Uber Bus Card					

Red de Proveedores de Servicios de Ryan White

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

Nombre del Cliente:.....

Fecha de Nacimiento:_____ Identificación del Cliente:_____

Esta agenda, **Latino Community Services,** es parte de una red de proveedores que han acordado en coordinar sus servicios para proveerle a usted cuidado de salud, servicios de administración de caso, servicios sociales y de apoyo, así como coordinaci6n en el cuidado familia/cliente.

Todos los clientes tienen derecho a redbir en todo momento un trato digno y humano, respetándose por completo la dignidad personal y el derecho a la privacidad. De conformidad con las leyes del Estado, todo expediente es confidencial. Toda la información de los clientes se hace disponible, sin previa autorización por escrito, a las agencias que proveen la ayuda económica, así como a sus representantes, para asegurar la calidad y cumplir así con el requisito de los informes. La información dada a las agendas de ayuda económica para asegurar la calidad y los requerimientos de información serán transferidas utilizando un sistema de identificación por código para cada cliente. Toda otra información del cliente se mantendrá en el local de la agencia que provee el servicio en un lugar seguro cuyo acceso será limitado únicamente a miembros del personal de la agencia proveedora y personal de las organizaciones de ayuda económica que resguardan la calidad en el servicio.

He leído esta declaración, o me ha sido leída, y se me ha dado la oportunidad de hacer preguntas y obtener sus respuestas, y manifiesto que entiendo su contenido. Entiendo que puedo revocar el presente Acuerdo de Consentimiento en cualquier momento. Si no fuera revocado por mí, este Acuerdo de Consentimiento es válido por el termino de veinticuatro meses a partir de la fecha en que fue firmado. De la misma forma, este acuerdo expirara en sesenta días después de la fecha de este documento.

_____

(Firma del cliente o representante legal) (Fecha de suscripción)

NOTA: Este documento NO autoriza la entrega de ninguna información del cliente. 9/19

Ryan White Service Provider Network

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

Client Name: _____

Date of Birth: _____

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

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

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

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

_____ _____

Signature of client or legal representative Date

_____

Signature of Witness

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

Revised 3/18/16;9/19

CAREWare Data Sharing Consent for

HIV, Hepatitis C and HOPWA Programs

Consent for the collection and sharing of patient information by and between service providers for individuals receiving care and/or benefits for Ryan White, Hepatitis C and/or Housing Opportunities for Persons with AIDS (HOPWA) Programs

Latino Community Services is mandated to collect certain personal information that is entered and saved in a database system called CAREWare and/or CaseWorthy database system(s). CAREWare and CaseWorthy records are maintained in an encrypted statewide database, in secure servers hosted by the City of Hartford and Nutmeg Consulting LLC, respectively. CAREWare and CaseWorthy aggregate reports may be used for advocacy, both statewide and federally, and any client information used will be done so without revealing names or other information that would identify any specific client.

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

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

I, _____ (**Print Client Name**) hereby provide my consent and authorization for **Latino Community Services** to enter my client-specific health, treatment, and support service information in the encrypted CAREWare and HOPWA database program which is hosted and maintained by the City of Hartford through its Health Department and Nutmeg Consulting LLC, respectively.

I further provide consent and authorization for the City of Hartford through its Health Department to allow the disclosure and sharing of the information entered into the encrypted CAREWare database program to _____ (**Name of agency that share request will be sent to**). This information will be shared for the purpose of informing and coordinating treatment and benefits I receive under the Ryan White and/or the HOPWA Programs. By signing this form, I further acknowledge that if I fail to show for scheduled medical and other support appointments, I may be contacted by an authorized representative of the above-referenced agency in order to re-engage and link me back to care.

A form needs to be completed for each agency that an entity is requesting data from. Universal sharing of client data is not permitted. Client data is shared client by client and Provider by provider.

This consent will expire twenty-four months from the date of this document.

_____	_____
Client Signature	Date
_____	_____
Witness Signature	Date

Developed by the State of CT RWA,C&D; rev by the City of Hftd. 3/15;9/15, 2/18s; 2/6/19; 10/19;4/23
Revised 04/20rw 03/2022

LATiNO COMMUNITY SERVICES

AUTHORIZATION TO RELEASE INFORMATION

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

_____ _____

(Name of agency) (Medical 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 "NIA", not applicable)*

___ Medical records, including HIV related information
___ Psychiatric, psychological, psychotherapy or other counseling records
___ Alcohol and/or drug treatment related information
___ Public assistance
___ Financial
___ Employment
___ Other

OF: _____ Date of Birth:_____

(Client name)

TO:_____ _____

(Name of agency/emergency contact) (Provider name)

_____

(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 §§ I9a-583. I understand that the records to be released may contain confidential HIV/AIDS related information. I understand that I may revoke this authorization for release at any time by notifying the above authorized person in writing, except to the extent that information has already been shared. If not revoked by me, I understand this release is valid for **twenty-four** months from the date it was signed. By signing this form, I further acknowledge that if I fail to show for scheduled medical appointments, I may be contacted by an authorized representative of the above-referenced agency in order to re-engage and link me back to care. This release shall be considered invalid without an attached a dated copy of network providers.

_____ _____

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

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

Revised 1/15

Ry an White Parte A

AUTORIZACIÓN PARA LA ENTREGA DE INFORMACIÓN

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

_____ _____

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

Para entregar una copia sobre la siguiente en su poder, incluyendo la divulgación verbal, que consiste en, pero no limitada a lo siguiente:

(INSTRUCCIONES: *Cliente necesita inicial al lado de lo que anhela o escribir "NO" a lo desaprobado. Todos los espacios en blanco deben ser llenados o marcados "N/A, No Aplica)*

___ Registros médicos, incluyendo la información relacionada con el VIH
___ Psiquiatría, psicológica, psicoterapia u otros registros de asesoramiento
___ Información relacionada con el tratamiento de alcohol y/o drogas
___ Asistencia Publica
___ Financiero
___ Empleo
___ Otro

DE: _____ Fecha de Nacimiento:_____

(Nombre del cliente)

PARA _____ _____

(Nombre de la agencia/contacto de emergencia) (Nombre de proveedor)

_____

(Dirección de la agencia)

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

Cliente necesita inicial al /ado de lo que aprueba o escribir "NO" a lo desaprobado.

_____Esta agencia solamente
_____Toda la red de proveedores de servicios (no válidos y sin lista adjunta de proveedores de servicios)
_____Otras agencias anotadas:_____
_____ Rechazar los servicios de intervención temprana

Todos los registros son confidenciales a conformidad con los estatutos generales de Connecticut I 9a-583. Entiendo que los expedientes puedan estar expuestos en libertad y puede contener información confidencial relacionada con el VIH / SIDA. Entiendo que puedo revocar esta autorización para la liberación en cualquier momento mediante notificación a la persona anteriormente autorizado por escrito, salvo en la medida en que la información que ya ha sido compartida. Si no revocado por mí, entiendo este comunicado es válido durante **veinticuatro meses** desde la fecha de su firma. *Al firmar esta forma, yo reconozco que,* si *no puedo mantener la cita de servicio médico y de otra, puedo ser contactado por un representante autorizado de/ programa de servicio de intervención con el fin de volver a participar en mi cuidado médico.* Este comunicado se considerará invalido y sin una copia fechada adjunta de proveedores de la red.

_____ _____

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

PROHIBICIÓN DE DIVULGACIÓN: Esta información se da a conocer a usted de los registros de las personas cuya confidencialidad está protegida por la ley federal y estatal. Leyes y reglamentos del Estado que prohíben hacer cualquier otra revelación de esta información sin el consentimiento expreso y por escrito de la persona a quien pertenece, o según lo permitido por dicha ley. Una autorización general para la divulgación de información médica o de otro no es suficiente para este propósito. Por favor honrar una copia mecánica reproducido de este comunicado.
Revisado 5/19 de Hartford TGA RW Parte A

	Client Initials	Client ID#	Client Initials
Advancing CT Together (ACT) 110 Bartholomew Ave Hartford, CT 06106		Hartford Hospital/ Brownstone Clinic 80 Seymour Street Hartford, CT 06102	
Hartford Gay & Lesbian Health Collective P.O. Box 2094 Hartford, CT 06145		Health Collective East 64 Church Street Manchester CT 06040	
St Francis Hospital/Burgdorf Clinic 131 Coventry Street, Hartford, CT 06112		Human Resources Agency of New Britain, Inc. 83 Whiting Street, New Britain, CT 06051	
CT AIDS Drug Assistance Program (CADAP) 410 Capitol Ave, **Mail stop** MS11APV, Hartford, CT 06106		Hispanic Health Council 175 Main Street Hartford, CT 06106	
Community Health Services, Inc. (CHS) 500 Albany Avenue Hartford, CT 06112		Latino Community Services 28 Grand Street 2nd Floor Hartford, CT 06106	
Community Health Center, Inc. (CHC) 33 Ferry Street Middletown CT 06457		Mercy Housing & Shelter 211 Wethersfield Avenue Hartford, CT 06114	
Community Renewal Team (CRT) 555 Windsor Avenue Hartford, CT 06120		Prospect Rockville Hospital 31 Union Street Rockville CT 06066	
University of CT Medical Health Center 263 Farmington Ave. Hartford, Ct 06106		THOCC-New Britain Campus 100 Grand Street New Britain, CT 06050	
CT Children's Specialty Group 282 Washington Street Hartford CT 06106		Charter Oak Health Center 21 Grand St Hartford, CT 06106	

Client Signature: _____ Date: _____

Witness: _____ Date: _____

Medical Transportation Services / Client Rights and Responsibilities

Client ID# _____

To be completed by the Client and primary staff providing medical transportation services
(When completed, give a copy to the client and place copy in the client's file)

Client accessing Medical Transportation services at LCS have the Right to the following Services:

- **Quality Care-to** receive services that are competent and offered by qualified personnel.
- **Personal Dignity-to** be treated with respect by all agency staff, and have the right to expect freedom from mental and physical abuse.
- **Non-Discrimination-services** will be provided to clients without discrimination as to Race, Color, Religion, Age, Disability, Sexual Orientation, Marital Status, Nationality or Ethnic origin, Cass and Physical or Mental ability.
- **Privacy and Confidentiality-The** Medical Transportation Department and LCS are designated by law and by professional ethics to maintain client confidentiality. The Medical Transportation Department will disclose no information about a client without the client's permission as documented in a current Release of information form, except as required by law
- **Disagreement/Grievance Procedure-Clients** have the right to express concerns without fear of repercussion. If the disagreement is not resolved to the client's satisfaction, the client will be given a copy of the agency grievance policy that explains the procedures for further action.

Service may be terminated if a client:

- Refuses services and/or Request termination
- Moves out of service area
- Is verbally/physically abusive toward staff, visitors, and other clients
- Supplies the agency with misinformation in respect to any information, to determine eligibility
- Is duplicating services
- Has chronically missed (3 or more in one month) Transportation appointments without calling to cancel beforehand or to reschedule

Client/Medical Transportation Staff agrees to the terms of this document as signed below

_____ _____
Client Signature **Date**

_____ _____
Transportation Driver Signature **Date**

Medical Transportation provides services to the listed cities within each County.

Hartford County

Avon
Berlin
Bloomfield
Bristol
Burlington
Canton
East Granby
East Hartford
East Windsor
Enfield
Farmington
Glastonbury
Granby
Hartford
Hartland
Manchester
Marlborough
New Britain
Newington
Plainville
Rocky Hill
Simsbury
South Windsor
Southington
Suffield
West Hartford
Wethersfield
Windsor
Windsor Locks

Middlesex County

Chester
Clinton
Cromwell
Deep River
Durham
East Haddam
East Hampton
Essex
Haddam
Killingworth
Middlefield
Middletown
Old Saybrook
Portland
Westbrook

Tolland County

Andover
Bolton
Columbia
Coventry
Ellington
Hebron
Mansfield
Somers
Stafford
Tolland
Union
Vernon
Willington