Maricopa County
Ryan White Part A Program
Policy and Procedures
Eligibility Policy

Effective Date: 05/15/2013
Revised Date: 03/01/2016
Reviewed Date: 03/01/2016

1. PURPOSE:

To guide the administration of the Ryan White Part A Program to provide a standard and centralized system to determine client eligibility within the Ryan White Part A continuum of care.

2. ELIGIBILITY POLICIES:

2. A. Determining Client Eligibility and Documentation

All persons seeking services must be determined "eligible" to receive services under the Ryan White Part A (RWPA) program. All eligibility must be reviewed every 6 months. At the beginning of the eligibility year, all residency, income and other payer source support documentation must be collected and reviewed. At the midpoint of the eligibility year, clients may provide an attestation of no change, if appropriate. If changes have occurred, related support documentation must be collected. To be or remain eligible for the Part A program, a client must meet and have on file verification of the following conditions:

- HIV Positive Diagnosis;
- Residency within the Phoenix EMA;
- Current household income within the appropriate range for services, as defined in the menu of services;
- Other payer source/insurance; and
- Current linkage to and/or retention in care.

Exceptions to standard eligibility requirements occur within the Conditional Eligibility process defined in section 2. G. and the Pre-Approved Eligibility process defined in section 2. H.

2. B. Documenting Verification of HIV Positive Diagnosis (Medical Eligibility):

Once an acceptable HIV status document is collected and available for review, an HIV status document does not need to be collected again, unless otherwise identified by the funding source. The following documentation has been deemed acceptable within Federal and County guidelines:

Authenticated Lab Reports:

According to the Clinical Laboratory Improvement Amendments (CLIA) regulation found at 42 CFR part 493.1291(c), authenticated test reports must include the following:

1. For positive patient identification, either the patient's name and identification number, or a unique patient identifier and identification number;
2. The name and address of the laboratory location where the test was performed;
3. The test report date;
4. The test performed;
5. Specimen source, when appropriate;
6. The test result and, if applicable, the units of measurement or interpretation, or both; and
7. Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability.

Acceptable lab results provided to Case Management or Central Eligibility from a client's electronic medical record are an acceptable proof of HIV positivity. Acceptable labs include:

- HIV quantitative viral load by bDNA or PCR showing detectable virus level with the client's name imprinted on the authenticated laboratory report;
- Un-named authenticated ADHS lab result accompanied by named lab slip, ensuring that the lab slip number appears on both documents as a cross reference;
- Authenticated lab report of positive HIV antibody reactivity with client's full name;
- Authenticated CDC lab report with client's full name;
- State Number confirmed in CAREWare, which is issued by the state after confirmation of HIV positive diagnosis;
- Two positive HIV immunoassays by different assays based on different antigens or different principles.

2. C. Documenting Verification of Residency within the Phoenix EMA

A recipient of Part A services must be a resident of Maricopa or Pinal County, with documentation in the client chart. Proof must be current and issued within timeframes described in the chart below. The items in the chart below contain document types which may be considered for use by Part A contractors when determining EMA residency.

Any one of the documents listed below (Chart 1) will be accepted as proof of residency as long as the address is a land address, not a P.O. Box, not expired,

and is the same as the client's stated name and address on intake/application documents. Such official documents with address present include:

Chart 1: Acceptable Residency Support Documentation

Residency Document	Examples/ Rules	Timeframe
Annual Award Letter	SSI Disability Annuities Pension Tribal VA	Award coverage within current eligibility period
Variable Public Assistance Programs	Food stamps TANF Unemployment	Assistance coverage within current eligibility period
Mortgage or Lease Agreement	Mortgage billing statement or Rental contract	Dated within current eligibility period
Home Owner's Association (HOA) Statement	Maricopa or Pinal County property	Dated within current eligibility period
Driver's License	Arizona	Dated within current eligibility period
State Issued ID Card	Arizona	Dated within current eligibility period
Immigration Identification Card	Must have address on it	Dated within current eligibility period
Official Mail *Official mail is mail sent from, or by, an authorized department of government, governmental agency or international organization and normally has some indication that it is official; a certifying cachet, return address or other means of identity, indicating its user.*	Must include client's name and postmark	Dated within current eligibility period
Paycheck stubs	Must show client name and home address	Dated within current eligibility period
Bank Statement	Must show client name and home address	Dated within current eligibility period
Utility Bills	Electric Water Gas Phone Cable, Etc	Dated within current eligibility period

Tax Forms	W-2 1099 Tax Bill Property Tax Statement Tax Assessment Statement Must be issued by the employer or government entity.	Current or most recent tax year
Billing Statements	Doctor's Office Department Store Cell Phone Credit Card	Dated within current eligibility period
Homeless service provider or case manager statement	Signed and dated on Agency's letterhead or RWPA application attachment	Dated within current eligibility period
Other, subject to grantee approval	Must mention the client by name with the address where they live	Dated within current eligibility period

2. D. Documenting Verification of Current Household Income

Client annual income must be documented in relation to current Federal Poverty Level (FPL) and documented to be eligible according to contract requirements. The FPL limits per service category are set by the Planning Council annually and are identified in the Menu of Services

Household income and size measurements reflect the current AHCCCS model. The specific income limitations may vary according to service category and are defined in the Menu of Services in the appendix. FPL information can be found at http://aspe.hhs.gov/2015-poverty-guidelines.

Clients must provide proof of income, with payee's name indicted, which is current, as defined below (Chart 2).

If income status is unchanged from the previous certification/determination and documentation is valid in date, the client should so attest at time of re-certification. If the client is unemployed, and not receiving any federal/state assistance such as General Assistance, SSI or SSDI, the client may use the non-traditional income form in the Ryan White Part A application to document the client's income every six months. In cases of intermittent or seasonal pay when the client does not have substantial payment documentation to meet the established proof of income requirements, clients should provide most recent, appropriate proof of income along with non-traditional income form and an explanation.

Proof of income includes all of the following types of documentation that apply to client and each member of his/her household.

Chart 2: Acceptable Income Support Documentation

Source of income	Types of Examples	Dated within	Non-Traditional Income Form?
Annual Award Letter	SSI Disability Annuities Pension Tribal VA	Award coverage within current eligibility period	No
Variable Public Assistance Programs	Unemployment Temporary Assistance for Needy Families (TANF) General Assistance	Assistance coverage within current eligibility period	No
Monthly Income	Paystubs Child Support Alimony/ Palimony Dividends	Most current month's receipt of deposit or proof	No
Non-Traditional	Cash No Income Family Support	See Non-Traditional Income form	Yes
Other	Self Employment/ Tax Record issued by employer W2	Last 3 months (self employment)/ Current or most recent tax year	No
Multiple Sources	Any combination (1 or more of the above)	See requirements for specific income source	Yes if one or more income source is Non-Traditional

2. E. Documenting Verification of Other Payer Source

Ryan White is the payer of last resort. Providers are responsible to ensure that clients are screened for ineligibility of other payer sources covered by Federal or State programs such as Medicare, Medicaid/AHCCCS, and all other forms of insurance or third party payers such as private and commercial insurance plans, COBRA, and other payers. Veterans Affairs and Indian Health Services eligibility do not preclude clients from receiving Ryan White services.

It is the responsibility of each Provider to develop an internal system/procedure to monitor this screening process and ensure that third party reimbursements are appropriately tracked, utilized, and accounted for. Agencies that provide Mental Health, Substance Abuse and/or Nutrition Services, but do not offer primary medical care may not have access to the same payer screening databases as primary medical care providers. All agencies providing services which may reasonably be covered by a third-party payer are required to document screening for 3rd party payers at every client visit. Documentation must be kept on file showing that every client from the billing month has been verified through a review of the AHCCCS database prior to submission of monthly bills. Individual service categories may have different requirements in terms of frequency of 3rd party payer screenings. This information is provided below (Chart 3).

If a client has inadequate insurance coverage, a secure email request to RyanWhitePartA@mail.maricopa.gov for additional Ryan White coverage may be submitted. The request should include:

1. Proof of medical, mental health, substance abuse or dental coverage that demonstrates allowable services and maximums (i.e. benefit sheet, insurance breakdown, etc.);
2. Copy of the treatment plan which identifies which activities are funded through existing coverage and which activities and costs remain unfunded;
3. Estimate of the total price of services being requested, as demonstrated in the treatment plan; and
4. Anticipated expiration date of client's RWPA eligibility.

The AA's office will review the documentation to determine the adequacy of coverage and issue an approval or denial for supplemental funds within five business days.

Central Eligibility Insurance Screening Requirements:
The Central Eligibility Office must screen every client for enrollment in the Arizona Health Care Cost Containment System (AHCCCS) at least annually at their annual/birthday renewal or at the client's half birthday renewal if the client indicates any income or household size changes that could indicate AHCCCS eligibility. Documentation for proving lack of payer for AHCCCS eligible services in the Phoenix EMA must be kept on file at the Central Eligibility Office, in the form of an AHCCCS denial letter dated within the year previous to the client's eligibility period.

Additionally, clients who are ineligible for AHCCCS services must be screened for other insurance eligibility, including Federal Marketplace plans and private insurance (i.e. employer insurance).

Special note on Medicare: Providers are responsible for identifying Social Security Disability Income (SSDI) clients and assisting them in the Medicare application process after they have been enrolled in and received SSDI benefits for two years. Medicare eligible clients are expected to enroll in all Medicare parts for which they are eligible at the time they become eligible. Failure to enroll in either Medicare Part B or Part D may result in client ineligibility for Ryan White funded services provided by Medicare Part B and/or Part D.

In cases where a client's existing insurance coverage appears to be inadequate, these cases may be submitted to the AA for review and approval for RWPA covered services. Documentation of applicable approvals must be maintained in client chart.

Chart 3: Third Party Payer Screening Requirements

Service Category	Screening frequency	Screening Method
Early Intervention Services	Not applicable	Not applicable
Food Bank/Home Delivered Meals	At intake and every six months thereafter	RWPA eligibility and Medical Nutrition Assessment
Health Education/Risk Reduction	Not applicable	Not applicable
Housing	Every assistance request	HOPWA application and approval process and RWPA eligibility
Health Insurance Premiums & Cost Sharing	Every premium payment	Confirmation of appropriate CE and income status. Review of insurance/COBRA benefits. Completed and signed FAP application.
Medical Case Management	At intake and every six months thereafter	ALTCS, HUD case management services
Medical Nutrition	Every visit	AHCCCS database, Magellan database, EMDEOM, private insurance
Medical Transportation	At intake and every six months thereafter	AHCCCS, transportation services
Mental Health	Every visit	AHCCCS database, MMIC database, EMDEON, private insurance
Non-medical Case Management	Intake and every six months there after	HUD case management services

Service Category	Screening frequency	Screening Method
Central Eligibility: **Non-medical Case Management**	Every six months	Central Eligibility Office to complete the Ryan White Part A Application and Health E Arizona Screening
Psychosocial Services	Intake and every six months there after	RWPA eligibility
Outpatient/Ambulatory Medical Care	Every visit	AHCCCS database, Magellan database, EMDEOM, private insurance
Oral Health	Every service request (in person or for insurance)	Private insurance
Substance Abuse	Every visit	AHCCCS database, MMIC database, EMDEON, private insurance
Treatment Adherence	At intake and every six months thereafter	RWPA eligibility

2. F. Documenting Verification of Current Linkage to and Retention in Care

Federal Ryan White HIV/AIDS Program goals emphasize linkage to and retention in medical care. In an effort to further the ultimate goal of viral suppression in all clients eligible for Ryan White funded services, clients must provide documentation of current linkage to and retention in medical care, regardless of the entity paying for that care.

Documentation must be dated within the previous six (6) months. The documentation may take one of two forms:

- HIV quantitative viral load by bDNA or PCR the client's name imprinted on the authenticated laboratory report which also meets the standards outlined in Section 2.B. Linkage and Retention documentation does not have to show a measurable level.; or
- The Medical Provider Page as required by the Arizona AIDS Drug Assistance Program.

2. G. Conditional Eligibility

The overarching goal of the Ryan White HIV/AIDS Program is to "quickly link persons with HIV into high quality medical care, consistent with the Early Identification of Individuals with HIV/AIDS as required in the Ryan White HIV/AIDS Program legislation (Sections 2603(b)(2)(a)(i-iii) and 2617(b)(8)(A-E) of the PHS Act) and the National HIV/AIDS Strategy[1]"

- A 60 day conditional eligibility period for all Ryan White services can be accessed by clients who are:
    - Newly diagnosed clients within the previous six months;

[1] Department of Health & Human Services Letter dated February 25, 2013

  - New to the Phoenix EMA and in need of medical services;
  - Engaging in care for the first time after being diagnosed for longer than six months;
  - Returning to medical care after an absence of six months or longer; and/or
  - Are in need of early intervention services .

- As the clients are being linked to services, providers should complete and submit the following documents to the Central Eligibility Office :
  - Release of Information for the client;
  - Completed Conditional Eligibility Worksheet; and
  - Copy of an initial unconfirmed HIV test or notice from previous HIV medical provider indicating client's HIV+ status. In cases where the client has received phone notification, the provider may indicate this information on the Conditional Eligibility Worksheet.

The conditional eligibility period will be effective as of the first date of service noted on the Conditional Eligibility Form, and will expire within 60 days plus the days until the end of the month. To prevent billing challenges, providers are encouraged to submit paperwork as soon as is possible and no later than 10 days prior to the close of the billing month of the first service. In order to maintain eligibility after the conditional eligibility period, the client is required to complete the standard new client eligibility application process. Agencies submitting Conditional Eligibility Forms are expected to facilitate standard client enrollment in RWPA.

2. H. Pre-approved Eligibility

The purpose for requiring viral load tests within the past six months is for data collection and health outcome monitoring and not to cause clients to fall out of care. The pre-approved eligibility period for all Ryan White services can be accessed by those clients who do not have a viral load test within the past six months or those who are awaiting results from a recent viral load test.

- Clients who are awaiting results or who need to schedule a viral load test will be granted pre-approved eligibility for one additional month past their eligibility due date.
- This policy applies only to clients who have completed all other requirements for eligibility.
- The Central Eligibility Office will be responsible for monitoring clients awarded the pre-approved eligibility status.
- If, at the end of the pre-approved eligibility period, a valid viral load test has not been submitted and entered into CAREWare, the client's eligibility will be updated to Not Eligible.

3. CENTRAL ELIGIBILITY POLICIES AND PROCEDURES

Central Eligibility allows the Central Eligibility Office in partnership with clients to establish and maintain a baseline eligibility status for use by all Ryan White Providers.

3. A. Eligibility Responsibilities for All Providers:

It is the responsibility of ALL providers to:

- Assure that Ryan White Part A funds are utilized as the payer of last resort as defined by HRSA and as outlined above under "Guidelines for Documenting Verification of Other Payer Source." This requirement may result in additional screening beyond the baseline eligibility established by the Central Eligibility Office.
- Distribute their agency-specific Grievance Policy and maintain on file proof that each Ryan White Part A client has received a copy of the policy.
- Utilize CAREWare to monitor the eligibility status and income level of each client prior to providing Ryan White Part A services. Only services for current or pending clients within the service's approved income range will be reimbursed. Clients in a "pending" status will be reimbursable until the end of the calendar month. See Appendix for Menu of Services.
- Utilize CAREWare custom reports to ensure that units provided during a client's ineligible period are not included in the billing submission. In cases where an ineligible unit appears, the provider must delete the ineligible service. Do NOT delete the client. Until all ineligible services are removed, the bill will not be considered complete and ready for processing and payment.
    - The custom reports will automatically review client's documented third party payer and billed services. This process is intended to ensure that the third party payer requirements are met. This process does NOT replace agency requirements for third party payer screening.
    - Description: Clients who demonstrate existing Medicaid, Medicare, Marketplace, or private insurance coverage during their RWPA eligibility process will be identified in CAREWare as having limited eligibility. The limited eligibility clients will be matched against monthly billing for RWPA medical, mental health, and substance abuse services. If any of these clients appear on the provider's CAREWare custom reports, the agency will be requested to remove the units or provide documentation of changes to client third party payer.

- Clients without Medicaid, Medicare, Marketplace, or private insurance will be identified as full eligibility and will be excluded from this screening process.
- This sub-section does not apply in the following instances:
  - Non-Medical Case Management services provided to ineligible clients by providers contracted to provide either Retention Specialist or Central Eligibility activities; or
  - Health Insurance Premium and Cost Sharing Assistance (HIPSCA) services provided during the period of ineligibility if the date of service for which HIPSCA is requested occurred while the client was eligible.

- Submit mid-eligibility cycle name, income, and residency changes to the Central Eligibility Office via the Ryan White Part A Change Form.
- Coordinate all written communications regarding central eligibility through the Central Eligibility office.

3. B. Eligibility Responsibilities for the Central Eligibility Office:

It is the responsibility of the Central Eligibility Office to review, process, and approve eligibility documents compliant with Ryan White Part A Policies and Procedures. The Central Eligibility Office is responsible for maintaining accurate and appropriate client files for any client who certifies/recertifies at their agency. The results of these efforts will be published in CAREWare as a baseline eligibility status for all clients within the Phoenix EMA.

It is the responsibility of the Central Eligibility Office to distribute, collect, and file the following required supplemental forms, as needed: Release of Information, Statement of Clients Rights and Responsibilities, and Notice of Privacy Practices. See appendix for copies of each form.

Eligibility must be completed in a timely manner.

- The Central Eligibility Office has a maximum of 30 calendar days to determine and update client status in CAREWare after the first logged contact with a new client.
- After receipt of a correct and complete Ryan White Application, the Central Eligibility Office has 7 business days to update client status in CAREWare.
- Returning clients with a “not eligible” status in CAREWare will follow the same timelines as new clients.
- Renewing clients with a “current” or “pending” status in CAREWare will have until the end of their final eligibility month to provide appropriate support documentation and have their status updated in CAREWare.

- Conditional Eligibility Forms must be entered into CAREWare within 2 business days of receipt.
- In cases when there is a timeline conflict regarding the updating of client status, the earliest timeline must be met.

The Central Eligibility Office is required to follow up on referrals, incomplete packets, client inquiries, and Ryan White Part A Change forms submitted from other providers. The minimum required follow up is one documented contact. If the first contact does not result in confirmed communication with the client, a second documented contact must be made. Communication attempts should be conducted in a confidential manner.

The Central Eligibility Office is required to follow up on documented client claims which are inconsistent and impact client eligibility. At a minimum, the completion of a Statement of Facts form must be solicited from the client. The Central Eligibility office will have 7 business days from the date received to clarify the claim and determine a decision regarding which information to use in the application. Requirements for the clarification process beyond the collection of the Statement of Facts form will be determined by the Central Eligibility Office. Clarification activities must be reasonable and lead towards documentation that clarifies the item of discrepancy. Activities may include but are not limited to requests for written statements from employers that pay cash, research in a Base Wage database, or requests for copies of bank statements.

The Central Eligibility Office is required to meet with new clients in person to complete the Initial HIV Case Management Acuity/Risk Assessment. High need areas identified during the interview require an offer of related referrals. An offer of Medical Case Management referral is mandatory for new clients and clients that have been out of primary medical care for 6 or more months.

A score of 16 – 24 on the Psychosocial or Medical Case Management sections of the Initial HIV Case Management Acuity/Risk Assessment requires an expedited referral to Medical Case Management by direct, telephone contact between Central Eligibility Office and the Medical Case Management agency. Expedited referrals must occur within 2 business days of documented eligibility completion and must be documented in the client chart. Expedited referrals entered into CAREWare should include a comment indicating that the referral is expedited.

Clients may select the agency to receive the client's referral based on review of the Phoenix EMA provider brochure or the client may refuse referrals at that time. Referrals will be recorded via the Client Choice Referral Form in the client chart and documented in CAREWare. The Ryan White Part A Office will monitor referrals.

3. C. Acceptable Paperwork and CAREWare Data Entry

All Providers are required to utilize the forms and process approved by the Administrative Office.

Standard Eligibility Forms include forms that relate directly to the processing and establishment of baseline eligibility to be shared through CAREWare:

- **Arizona Ryan White Programs Application:** Completed at time of application and recertification.
- **6 Month Renewal:** Support documentation for clients that have no income, residency, or insurance changes at the six month period of the renewal year. Final language to be determined by the Central Eligibility Office and the Administrative Agent.
- **Ryan White Part A Change Form:** Utilized when a client has a change in name, residency, or income. Must be submitted to the Central Eligibility Office for follow up.
- **Initial HIV Case Management Acuity/Risk Assessment:** Risk assessment that identifies potential referral needs. Assessment is to be administered by Central Eligibility office.
- **Client Choice Referral Form:** Documents the client's referral selections or refusal of referrals.
- **Conditional Eligibility Form:** Provides 60 day conditional eligibility period for linking newly diagnosed and early intervention service clients into care. This form is for completion by the Provider and is only available in English.

*See Eligibility Forms in the Appendix.

Some Standard Eligibility Forms require entry into the CAREWare database.

- **Arizona Ryan White Programs Application:** Information from the Application will be entered into related CAREWare form. Scanned copies will be uploaded, including related support documents. May include Physician letter confirming HIV status.
- **Permanent HIV Diagnosis:** Scanned and uploaded separately from the application. Does not include physician letter.
- **Initial HIV Case Management Acuity/Risk Assessment:** Scanned copy will be uploaded and data will be entered into corresponding CAREWare form.
- **Client Choice Referral Form:** Scanned copy will be uploaded.
- **Conditional Eligibility Form:** Information from the Conditional Eligibility form will be entered into the related CAREWare form. Scanned copy of the initial HIV test should be scanned and uploaded as an initial HIV result.

Supplemental Forms are required to be completed at the Central Eligibility Office or at each agency (see notation below) and filed in respective Ryan White Part A client charts:

- **Release of Information*:** To be collected annually at the Central Eligibility Office for all Ryan White Part A clients. Must be accompanied by the Central Eligibility Provider List/Brochure.
- **Grievance Forms*: Required** policy and forms are detailed in the Grievance portion of the Policy and Procedure manual. Must be collected annually at **each agency** for all Ryan White Part A clients.
- **Statement of Clients Rights and Responsibilities:** The Central Eligibility Office must include in the client file a signed acknowledgment of the receipt of a copy of the Ryan White Part A Statement of Client Rights and Responsibilities or an annotation referencing client's refusal to sign a statement.
- **Notice of Privacy Practices*:** The Central Eligibility Office must include in the client file a signed acknowledgement of the receipt of a copy of the Ryan White Part A Notice of Privacy Practices.

*See Release of Information and Grievance forms in Appendix.

All supporting documents must meet the requirements outlined in the Eligibility Policy.

Electronic submission of the Ryan White Programs Application should only occur after the application is completed and required eligibility documents are collected.

Providers that encounter potential duplicate clients in the CAREWare system will notify the Ryan White Part A Office with the two client URNs. Providers will also identify which URN is believed to be correct and why.

Regarding information on the demographic and annual review tabs in CAREWare, non-Central Eligibility Providers should only update phone numbers. Any other changes to the demographic tab or annual review tab in CAREWare should be routed to the Central Eligibility Office via the Change Form.

In cases where a client is homeless, the address for a Ryan White Part A funded case management provider may be entered as the mailing address in CAREWare.

In cases where a client does not wish to receive mail, the Central Eligibility Office should change the address fields to "No Mail" and enter the client's address in the common notes section of the demographic tab. If a non-CE provider receives information that the client does not want to receive mail and the client's address

appears in the address fields of the demographic tab in CAREWare, the provider should complete a Change Form indicating “no mail” and send the change form to the Central Eligibility Office.

Insurance indications in CAREWare should reflect the client’s insurance enrollments at time of application/renewal with the Central Eligibility Office.

3. D. AHCCCS Screening:

All clients who cannot demonstrate current enrollment in private or Marketplace insurance, Medicaid/AHCCCS, or Medicare must undergo AHCCCS screening every six months utilizing the Health-e Arizona screening tool. In the alternative, the client may supply an AHCCCS denial letter dated within the past six months. This screening does not replace the mandatory ongoing 3rd party screening for applicable providers, as outlined in the Documenting Verification of Other Payer Section of the Eligibility Policy.

3. E. Recertification

Client recertification includes completion of the Arizona Ryan White Programs Application during the client’s birthday renewal and submission of an attestation during the client’s half birthday renewal. If there are income changes which impact the services a client is eligible to receive, additional support documentation may be requested. Recertification is not required to be completed in person. Related communications from Ryan White Part A Providers must be transmitted in a confidential manner.

Renewing clients may request that their case manager represent the client during the eligibility process. The Case Manager and agency name will be reflected in the application. The Case Manager will act as the liaison between the client and Central Eligibility Office and all communications between the Central Eligibility Office and client will be directed through the designated Case Manager.

3. F. Disenrollment:

In some situations, a client may be determined ineligible for Part A services or have their eligibility status terminated.

Reasons for disenrollment from all Ryan White Part A services may include, but are not limited to:*

- Expiration of the client’s eligibility documentation.
- Relocation outside Maricopa or Pinal County.

- Changes in income status to above current Federal Poverty Level (FPL) qualifications for Ryan White Part A services.
- Information submitted to Maricopa County by the Provider and/or client is inaccurate, incomplete, or falsified.

  *Client may be reenrolled upon completion of a correct and complete application.

Reasons for disenrollment from a specific service category may include, but are not limited to:*

- A client becomes eligible for another payer source for the services provided.
- A client experiences a change in income or household size raising them above the required FPL for the services provided.

  *Client may be reenrolled upon demonstration of no other payer source and appropriate eligibility and income range for the service category.

Reasons for disenrollment from a specific agency may include, but are not limited to:*

- A Provider determination that the client exhibits violent or threatening behavior to an employee, volunteer, or fellow client of the Provider or Ryan White Part A program. The agency is required to notify the AA of the client disenrollment.

  *Client may be reenrolled at the discretion of the agency.