F. Financial Services

Service Definition

Financial Services are a combination of three components that aim to help people living with HIV (PLWH) who are seeking support with short-term financial assistance, transportation to medical appointments, or help covering expenses related to accessing health care. These service components are described in more detail below:

Emergency Financial Assistance (EFA)

EFA provides limited one-time or short-term payments to assist a client with an urgent need for essential items or services necessary to improve health outcomes.

There are six types of EFA that are allowable, including:

- Utilities.
- Housing.
- Food (including groceries and food vouchers).
- Cleaning supplies and personal hygiene items (such as soap, face masks and other personal protective equipment [PPE]).
- Transportation.
- Medication not covered by the Wisconsin HIV Drug Assistance Program (HDAP).

EFA payments are short-term and limited in amount. After two instances of client requests for the same type of EFA, clients who are in need of more regularly occurring assistance should be referred to longer-term services such as housing assistance, food services, and medical transportation.

Recipients providing EFA must provide at least one of these types of EFA but are not required to provide any specific type or all types of EFA.

Health Insurance Premium and Cost Sharing Assistance (HIPSCA)

HIPCSA provides financial assistance to a client by covering the cost of expenses related to accessing health care.

Assistance types available under this service include:

- Paying for premiums for health insurance that provide full medical care and pharmacy benefits that cover a full range of HIV medications.
- Paying co-pays, coinsurance, and deductibles on behalf of the client.
- Providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs, the maximum amount they would need to spend each year on medications covered by their prescription

drug plan before they reach the "catastrophic" level of coverage. HIPCSA services funded by the Wisconsin HIV Care Unit may only be provided after it is determined the cost cannot be covered by the Wisconsin HDAP.

Medical Transportation (MT)

MT assistance provides non-emergency transportation services that promote client access to medical or support services related to their HIV care.

MT assistance may also be used to promote client access to HIV Prevention Services for people using PrEP.

MT can be provided through any of the following:

- Vouchers, tokens, or bus tickets.
- Contracts or organizational accounts with providers of transportation services (such as cab companies or app-based ride services).
- A recipient-owned or leased vehicle.
- Non-cash mileage reimbursement, such as gas cards.
- Volunteer or staff drivers.

MT must be reported as a support service in all cases, regardless of whether the client is transported to receive a medical service or a support service.

Recipients providing Financial Services are expected to comply with the Life Care and Early Intervention Services (LCEIS) Universal Standards of Care, as well as the standards outlined below.

Standard 1: Financial service providers ensure services are delivered in accordance with the Wisconsin LCEIS Eligibility and Recertification Policy and Procedures.

Providers are responsible for determining eligibility at enrollment and confirming eligibility annually.

Documentation

Client records must document that the client is eligible at initial enrollment and confirmed annually in accordance with the Wisconsin LCEIS Eligibility Policy.

F.1 Emergency Financial Assistance

Standard 2: EFA payments are carefully planned and monitored to ensure funding is exclusively used for allowable purposes, as a payer of last resort.

LCEIS funds are intended to be used as a last resort after all other potential sources of funding have been used. However, a client's urgent financial need may arise in a situation that does not allow a recipient to exhaustively search for alternative sources of funding. Recipients providing EFA are expected:

- To use their discretion in balancing the best interest of the client and the limited nature of LCEIS funding.
- To develop procedures to prevent mismanagement of these funds.
- To thoroughly document uses of EFA funding.
- To thoroughly document when EFA funding was not provided after client request.

Uses not allowed include:

- Direct cash payments to clients, family, or household members.
- Cash equivalent payments to clients, such as a pre-paid general-purpose credit card redeemable for cash.
- Payment for security deposits.
- Payments for storage of client belongings.
- Pre-Exposure Prophylaxis (PrEP).
- Payments for tobacco, firearms, alcohol, or other drugs taken without support of a licensed medical provider.
- Payments that duplicate other EFA requests or assistance from another funded service.
- Payments for other types of needs, such as dental or medical care.

Recipients must train providers, non-service provider staff, and volunteers on what costs are allowable under EFA and have a high level of oversight to ensure EFA is not used for purposes not allowed under the service.

Recipients must maintain receipts and evidence of payments made using EFA funds to verify that no direct cash payment was provided to the client and that funds were used for allowable costs.

Documentation

The client record will document:

- The need for EFA.
- Dates when EFA funds were requested and provided.
- The purpose of the EFA funds.
- The amount of EFA funds given to the client.
- The method of providing EFA (i.e., voucher, direct payment to agency, direct payment to landlord, etc.).
- The number of times and amount of time EFA was provided. If the payment is one-time and another payment is not planned, this must be noted.

- Any circumstances when EFA funding was not provided after requested by the client.

If vouchers or gift cards are used, there must be a signed receipt for each distribution to the client, and a signed statement wherein the client acknowledges and agrees to the purpose(s) of and restrictions on the card or voucher.

Recipients will have written policies in place and made available to the Wisconsin HIV Care Unit on request. Policies must distinguish between EFA and other service categories along with policies to prevent misuse of EFA funds. Recipients providing EFA must have a way to track and report the amount of EFA provided by EFA type.

Standard 3: EFA is equally accessible to all clients of a recipient.

All clients receiving any other services at the recipient organization must be equally eligible to receive EFA.

Documentation

The recipient must have a procedure in place that outlines how a client applies for EFA and what criteria is used to review their application.

Standard 4: EFA is provided based on an assessment of client needs.

Providers will review the client's EFA request and assess if the client need has been well described and supported. Providers will plan for the delivery of EFA and will inform clients of the amount of assistance that will be provided, the timeframe in which EFA will be provided, and any restrictions on the EFA.

If EFA is used for a utility payment, temporary housing assistance, or medications not covered by HDAP, providers must maintain proof of amount due, such as a utility bill for the month being paid or an invoice or statement from landlord or pharmacist.

Documentation

The client record must contain documentation that the client's EFA request was reviewed, and the client was informed about the amount of assistance provided, the timeframe in which EFA will be provided, and restrictions on EFA.

The client record must contain proof of amount due, such as a utility bill for the month being paid or an invoice or statement from landlord or pharmacist.

Standard 5: EFA is used for allowable types of assistance and complies with limits.

EFA is provided in accordance with the allowable costs and amounts in the table below:

EFA Type	Allowable Uses of EFA	EFA Limits
Utility Assistance	To maintain client access to needed utilities, prevent shutoff, or restore utility service terminated due to failure to pay. Needed utilities are defined as heat, gas, electricity, water, internet, and mobile or land-based telephone.	• The EFA limit for a current, single utility charge is $500. • The EFA limit for a buildup of previous utility charges (back pay) is $1,000.
Housing Assistance	To maintain a client in current housing, prevent eviction, or help transition to housing that is more suitable for client needs. Housing EFA can be used for: • A single month's rent for current housing or first month's rent for new housing. • A temporary, emergency stay in a hotel or motel. • Another service or cost necessary to keep or obtain housing (such as a housing application fee, hazardous home cleaning, or moving expenses).	• A payment for a single month's rent or first month's rent cannot exceed $1,500. • Temporary emergency hotel or motel stays are capped at 14 nights in a rolling one-year period. • Other necessary services are capped at $500 per instance of EFA.
Food Assistance	To help clients access to food on an emergency basis.	• Food voucher and grocery store gift cards cannot exceed $250, and clients can receive no more than two vouchers or food gift cards in a rolling one-year period. • For clients with dependents, an additional $100 is allowable per dependent, up to four dependents.
Transportation Assistance	To help client access to services that are essential to their medical care or maintenance of health. The allowable uses of transportation EFA are broader than those for medical transportation and may include transportation to critical legal or social service appointments.	One instance of round-trip travel cannot exceed $250, and clients can receive no more than two instances of transportation EFA in a rolling one-year period.
Medication Assistance	To help client access to essential medications that are not otherwise available through HDAP or other means. Payments for health insurance premiums, co-pays, co-insurance, or deductibles that occur more than once or on a regular basis should be provided according to the Health Insurance Premium and Cost-Sharing Assistance standards of care.	Medication EFA is capped at a 90-day supply, and clients can receive no more than two instances of medication assistance EFA in a rolling one-year period.

Documentation

The client record must contain documentation of the amount and value of EFA provided in each instance.

Standard 6: EFA is provided on a short-term, limited basis.

EFA spending is capped at two payment instances of each EFA type in a rolling one-year period. If a client requires more than two instances of any single EFA type, the client should receive assistance through other LCEIS services as allowable such as housing assistance, food services, and medical transportation.

Documentation

The client record must include documentation of all instances of EFA provided to the client. Upon second instances of any type of EFA, the client record must document information-sharing about other assistance programs.

Standard 7: The total value of all types of EFA a client receives in a rolling one-year period does not exceed $5,000.

Recipients must track utilization of assistance of all types to ensure the client does not exceed the combined maximum fiscal year amount of assistance of $5,000. The recipient must track use of assistance funds under each type of EFA and in combination.

In some circumstances, clients with extensive needs may appeal to the Wisconsin HIV Care Unit for an exception to the limitation on amount if the cap would jeopardize the client's ability to access medical care.

To be approved for an exception from the Wisconsin HIV Care Unit, a client or provider must submit the following information:

- An exception request to the Wisconsin HIV Care Unit demonstrating that Limitation on Amount guidelines would endanger the client's ability to remain in and access medical care.
- Evidence of need (such as loss of income, increased medical expenses, or unexpected emergency).
- A detailed plan to establish financial stability to eliminate the need for emergency assistance services.
- An update when progress is made.

Requests will be approved for one month at a time.

Documentation

The recipient must have a tracking system in place to review combined EFA amounts provided to each client.

The client record must document any exceptions approved by the Wisconsin HIV Care Unit, including evidence of a plan to establish financial stability, and documentation of outcomes and progress made towards the financial plan for each month funding is requested.

Standard 8: Clients are informed when they are no longer eligible to receive EFA.

When a client meets the limits for any type of EFA assistance or the combined EFA limit, providers must inform the client of which services they are no longer eligible for and when the client will again be eligible for services.

Documentation

The client record must show that client was informed when their EFA caps are met.

Standard 9: After due process and notice, a client may be permanently ineligible from receiving EFA.

In rare cases, after documenting a repeated pattern of misuse of EFA funds and informing the Wisconsin HIV Care Unit, recipients can choose to deny a client from receiving EFA.

Documentation

The client record must show a repeated pattern of misuse of EFA funds.

The recipient must provide the Wisconsin HIV Care Unit with written documentation explaining the situation.

The client record must show that the client was informed, preferably in a face-to-face meeting, that they are permanently barred from receiving EFA.

F.2 Health Insurance Premium and Cost Sharing Assistance

Standard 10: HIPCSA payments cannot duplicate HDAP/Insurance Assistance Program (IAP) payments.

Clients with income under or equal to 300% of the federal poverty level (FPL) must be assessed for eligibility for the Wisconsin HIV Care Unit's HDAP and IAP.

The recipient can provide HIPSCA services if the client is not eligible for the HDAP/IAP programs or if the cost is not HDAP allowable.

The recipient must assist the client, as needed, with applying to HDAP/IAP as soon as possible and coordinate assistance to the client in the interim.

Documentation

Client record must document determination that costs were not HDAP allowable or that the recipient organization was taking steps to assist client with applying for HDAP as soon as possible.

Standard 11: Payments for HIPCSA services are made only as a payer of last resort.

The HIPCSA service category is meant to supplement the Wisconsin HDAP and IAP.

The recipient must ensure that HIPCSA funds are used only to make payments for services where **both** of the following criteria are met:

- The client meets appropriate eligibility requirements as identified by the Wisconsin HIV Care Unit.
- The services for which payments are made are not eligible for payment by Medicaid or a third-party payer and have not been paid for.

Documentation

Client records related to claims paid must include documentation that no other payer sources (insurance or other programs) were available, or if available, that they were billed as the primary payer source.

The HIV Care Unit must be repaid for any improper payments made by the HIPCSA provider within 60 days of discovery.

Standard 12: HIPCSA payments for health insurance premiums must meet allowable coverage and cost requirements.

The recipient must have a system in place to assess health insurance coverage for adequate coverage and cost requirements prior to making payments.

Adequate coverage is defined by HRSA guidelines as:

- Providing at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient or ambulatory health services,[1] as well as,
- An annual premium cost not exceeding $10,000.[2]

Documentation

Client and accounting records must document evidence that health insurance premiums meet allowable coverage and cost requirements as above.

[1]HRSA PCN 18-01, Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance, pp. 2-3.

[2]The Wisconsin HIV Care Unit may waive this cap on annual premium costs if the HIPSCA provider can demonstrate that the client has imminent need for the services covered under the plan and that the Wisconsin HIV Care Unit's cost of paying for the health insurance (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services. Waiver requests should be submitted to the Wisconsin HIV Care Unit on an individual basis and no premium payments should be made until the waiver is granted.

Standard 13: HIPCSA payments for Medicare and Medicaid must meet allowable cost sharing requirements.

To ensure sufficient health care coverage for clients, HIPCSA payments for Medicare Part B, C, or D premiums are allowable when made in combination with at least one additional type of Medicare or Medicaid.

For example, payments for Medicare Part B premiums must be made in combination with payments for Medicare Part D premiums.

If a client uses Medicaid health care coverage, HIPCSA funds may be used to pay for any remaining premium amounts not covered by Medicaid.

Note: While providers are required to ask clients using Medicaid for a co-pay (if the client has one), the provider cannot deny service if the client does not have funds for or refuses to pay for the co-pay. Therefore, LCEIS funds should not be used to pay co-pays for Medicaid clients.

Documentation

Client and accounting records must document HIPCSA payments made for Medicare and Medicaid meet allowable requirements.

Standard 14: HIPSCA services must not involve payments for inpatient care.

Funds cannot be used to pay premiums or cost sharing assistance for Medicare Part A, which exclusively covers inpatient care, or used to cover costs associated with the creation, capitalization, or administration of a liability risk pool or costs associated with Social Security.

Payments must not made for any bills that are considered "bad debt." If a bill has been sent to a private collection agency, the bill is considered a debt that has been determined to be uncollectable. It is therefore "bad debt" and is an unallowable cost for LCEIS funds. In some cases, the client or recipient providing HIPCSA may be able to work with the organization that originally issued the bill to have the bill removed from the collections agency and paid under the original billing party system. Patient Assistance Programs at the billing agency must be attempted to be utilized before using HIPSCA to pay these debts.

Documentation

Client and claim records must clearly document services were allowable. Client records must document other programs applied for when applicable.

Standard 15: Recipients must effectively monitor and manage expenditures.

Recipients must have a system in place to monitor and manage expenditures to ensure that funding will be available throughout the program year. Recipients must promptly report projected shortfalls or under-expenditure of grant funds to the Wisconsin HIV Care Unit.

The maximum amount a recipient can pay towards a client's medical bills cannot exceed $10,000 in a calendar year, and the maximum amount paid towards a single medical bill cannot exceed $5,000. There is no limit to the number of times a client can use this service in a calendar year. This cap applies only to medical bill payments, not to payments for insurance premiums.

Recipients cannot use a lower payment cap if the recipient medical bill payment program uses LCEIS funding.

In extenuating circumstances, a recipient can, at their discretion and in consultation with the Wisconsin HIV Care Unit, choose to pay more than $5,000 on a single medical bill or allow the client to exceed the $10,000 cap.

In deciding whether exceeding the cap is warranted, recipients are expected to use their discretion in balancing the best interest of the client and the limited nature of LCEIS funding and to thoroughly document the reasons.

The recipient must have a system in place to detect and address inaccurate claims. This error-detection system may include a required analysis of individual claims exceeding a predetermined dollar amount or analyzing a statistically significant sample of claims for accuracy and justification.

Documentation

Recipient claim records must document expenditures by instance and by client for the calendar year.

Communications with the Wisconsin HIV Care Unit regarding projected shortfalls or under-expenditure of grants funds and resolution must be documented.

Any identified excess spending situation must have documentation of consultation with the Wisconsin HIV Care Unit.

Documentation of how the error-detection system functions and results of all analyses must be available to Wisconsin HIV Care Unit staff upon request.

Standard 16: No payments can be made directly to clients, family, or household members.

The recipient must have systems in place that ensure that claims payments are made to appropriate service providers and not to clients or improper individuals.

Documentation

Policies and procedures must be in place to ensure that payments are made only to appropriate vendors.

Standard 17: HIPCSA funding must only be used solely for the costs of client assistance.

Recipients receiving funding for HIPCSA can bill the Wisconsin HIV Care Unit only for the amount spent directly on client assistance.

Staff time, agency operations, or other administrative costs associated with providing this service category are unallowable.

Documentation

Accounting records must document adherence to this requirement.

Standard 18: Properly submitted claims from participating and non-participating care providers must be paid in a timely manner.

All reasonable efforts are made to ensure that properly submitted claims from care providers are paid within 30 days of receipt or disputes/questions are sent to the care provider within 30 days of receipt.

Documentation

Claims data recorded by the recipient must include the date that that the claim was received and the date that payment was made.

Client records must contain evidence that claims payments were made within 30 days from the date that the claim was received.

Standard 19: Billing issues must be reported by service providers, case managers, or clients and are promptly resolved to ensure the client's access to services.

Recipients must make all reasonable efforts to assist, support, and cooperate in the event of claims processing or payment dispute. Technical assistance from the Wisconsin HIV Care Unit is available to resolve chronic or systemic billing problems, when identified.

Billing problems must be promptly communicated between the Wisconsin HIV Care Unit and the recipient and resolution will be expedited.

Documentation

Recipients must document communications with Wisconsin HIV Care Unit staff regarding billing problems and resolution thereof.

Standard 20: If a client is deemed ineligible for HIPCSA services, the client ineligibility must be documented.

For a client to be deemed ineligible for HIPCSA services, one of the following criteria must be true. The client:

- Reached the maximum dollar amount of assistance, and no waiver was requested or approved.
- Experienced a household income increase that rose above the limits.
- Failed to notify the program of changes in eligibility factors.
- Moved out of the region or jurisdiction.
- Submitted false or misleading information to the program*.
- Was otherwise unwilling to abide by the requirements of the program*. or
- Is deceased.

*Requires a warning and 30 days' notice.

Documentation

The client record must include documentation of criteria used to determine client ineligibility.

Standard 21: Clients may be discharged from HIPCSA for behavioral reasons or for violations of policies.

Removing clients from HIPCSA services for behavioral reasons or for violation of program policies must be used as a last resort. Clients cannot be removed from HIPCSA services for missing appointments or being out of medical care.

Prior to discharge, clients must receive a warning from the recipient, which involves the following steps:

1. Document that the client has a clear pattern of violation of HIPCSA guidelines.
2. Give the client notice that if they do not change this behavior, they may be removed from the program. This notice must be given verbally either in person or through a real-time phone conversation and offered in writing including specific information on what behavior the client is expected to change. All notices must be documented.
3. Inform the client's referring provider either over the phone or in person that the client is in danger of losing their HIPCSA assistance. This cannot be done through an email or voicemail—the provider must speak directly to the client's case manager.
4. Inform the Wisconsin HIV Care Unit that a client is in danger of being disenrolled and summarize the reason for the decision to disenroll the client.
5. If the pattern of behavior continues, the recipient must continue to document this information. After issuing this warning, the recipient must wait at least 30 days before proceeding to giving the client 30 days' notice as described below.

Prior to discharge, a client must be given 30 days' notice by the recipient, which involves the following steps:

1. Inform the client that their HIPCSA services will end 30 days from the date the client is informed. The recipient must inform the client through a face-to-face meeting or a real-time phone conversation and give the client a written document explaining they will be removed from the program.
2. Inform the client's referring provider either over the phone or in person that the client's HIPSCA services will be discontinued in 30 days. This cannot be done through an email or voicemail—the provider must speak directly to the client's case manager.

3. Inform the Wisconsin HIV Care Unit that the client is being disenrolled and summarize the reason for the decision to disenroll the client, including written confirmation from the client's case manager that the case manager received this information.

Documentation

The client record must document that discharge warning steps were followed and that the 30-day notice was provided, if required.

If the client refuses written documentation of the notice, recipient organizations must document this.

F.3 Medical Transportation (MT)

Standard 22: MT must be provided only to LCEIS allowable services.

Medical transportation must be provided only to LCEIS services.

Transportation to emergency rooms is not allowable.

Documentation

Each instance of MT is linked to one of the following LCEIS services:

A. HIV Prevention Services for people not living with HIV.
   - A.1 Clinical services and laboratory testing for people not living with HIV to obtain access to pre-exposure prophylaxis (PrEP Services)
   - A.2 PrEP Navigation

B. HIV Care Services for people living with HIV.
   - B.1 Outpatient/Ambulatory Health Services
   - B.2 Oral Health Services
   - B.3 Early intervention services
   - B.4 Financial services
   - B.5 Legal services
   - B.6 Social/Pastoral Services
   - B.7 Mental Health Services
   - B.8 Homecare services and supplies
   - B.9 Case management services

Standard 23: Each instance of medical transportation provided to the client is documented.

The recipient must maintain documentation of each instance of medical transportation provided to each client and must have a way to link the documentation of the medical transportation assistance to the client's records, and therefore the client's eligibility for LCEIS services.

Documentation

If the recipient keeps a physical or electronic medical transportation log that is separate from the client record, the medical transportation log must be linked back to the client file without compromising the client's personal health information (PHI) as defined by HIPAA. The log must be available for review by the Wisconsin HIV Care Unit upon request.

Standard 24: Use of medical transportation funds must be monitored to ensure funding is exclusively used for allowable purposes, as a payer of last resort.

LCEIS funds must be the medical transportation provider of last resort. If a client is eligible for medical transportation through Medicaid or private insurance, the recipient or client must try to use medical transportation services through their insurance first. If the client has a copay for medical transportation through their insurance, LCEIS funds can be used to cover the expense.

If a client is eligible for medical transportation services through their insurance and any of the following circumstances occur, LCEIS funds can be used for the client's medical transportation:

- Medical transportation through Medicaid is not available in the client's area.
- The provider is transporting the client or must accompany the client.
- The client needs to travel with children and the medical transportation service will not allow the client to bring children.
- The medical transportation service is late, or the client is in danger of missing their appointment.
- The client urgently needs non-emergency transportation and there is not enough time to notify the medical transportation service available through Medicaid.
- The medical transportation service available through Medicaid refuses to transport the client.
- The client is accessing a support service not otherwise covered by medical transportation services, such as accessing housing assistance, a food bank or pantry, or legal services.

Documentation

The reason for the use of LCEIS funds rather than other transportation services must be documented in the client record using a brief narrative.

Standard 25: Working collaboratively with the client, the provider assesses the client's transportation needs.

The provider assesses the client's transportation needs at the client's request or when there is an access barrier and must take reasonable steps to evaluate the appropriateness and eligibility of the type of transportation being requested by the client, including the eligible LCEIS services associated with each instance of transportation assistance (see table above).

Documentation

The client record must include evidence that the client's transportation needs were assessed, and evidence that the staff evaluated whether the transportation being requested might be ineligible.

Standard 26: Clients must receive safe, cost-effective, non-emergency transportation, allowing access to primary medical care or other LCEIS services.

Providers must evaluate and provide the medical transportation method best suited to meet the needs of the client. Safety, dependability, and cost effectiveness must be assessed as they are primary concerns. Allowable methods include:

- Vouchers, tokens, or bus tickets.
- Contracts with providers of transportation services, such as cab companies or app-based ride services.
- Recipient-owned or leased vehicle.
- Organization and use of volunteer drivers.
- Non-cash mileage reimbursement, such as gas cards.

Documentation

The client record must document that the client's need for transportation were evaluated, and an appropriate method of transportation was provided.

Standard 27: If providers, non-service provider staff or volunteers are used as drivers, the recipient must ensure that their MT program addresses liability issues.

If providers, non-service provider staff, or volunteers are used as drivers, the driver must demonstrate that they maintain the following:

- A current, valid driver's license, with a copy kept on file.
- Vehicle liability insurance coverage on their vehicle
    - Note: If provided by staff in a vehicle owned by the provider, the liability insurance maintained by the provider must meet State of Wisconsin guidelines.
- Proof the provider organization has insurance that allows volunteers or staff to transport clients in their own vehicles.
- Each vehicle used by the staff or volunteer maintains a current vehicle registration, and license plates.

If providers, non-service provider staff, or volunteers are reimbursed for mileage, the mileage reimbursement costs must be reported as part of the medical transportation service category and cannot be included as part of another service.

Providers, non-service provider staff and volunteers who transport clients should receive training on their responsibilities and obligations in the event of an accident, including the extent of their personal liability.

Documentation

Recipient records must include the following documentation:

- Evidence of valid driver's license.
- Evidence of vehicle liability insurance.
- Evidence of vehicle registration.

- Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each staff or volunteer that provides medical transportations.

Providers, non-service provider staff, or volunteers who provide medical transportation with mileage reimbursement, must still document each instance of medical transportation assistance and the appropriateness of each instance.

Standard 28: If vouchers, coupons, or bus passes are utilized, recipients must take reasonable steps to ensure that the resources are utilized for access to LCEIS services.

Each voucher, coupon, or bus pass should be correlated with one or more specific sessions or appointments for core medical or support services.

Documentation

If daily bus passes are utilized, the provider must document the cost effectiveness of a daily bus pass over tokens or coupons for individual rides, and a description of the need for multiple transportation instances, such as multiple medical appointments or support service appointments.

Standard 29: If contracts with cab or ride share services who provide transportation services are utilized, the recipient must document why this the most efficient mode of transportation available.

Recipients are encouraged to pursue other options before enlisting a cab or ride service, if possible. There may be instances where a cab ride is the best transportation option due to the client's geographic location, physical or mental health, or urgency of the situation.

If a recipient offers cab or ride services and other modes of transportation, the recipient must have an established policy that explains how the recipient determines which form of transportation assistance is used in different circumstances.

Documentation

Recipients must keep documentation of a policy that explains how the recipient determines which form of transportation assistance is used in different circumstances must be available for review by the Wisconsin HIV Care Unit upon request.

Standard 30: The recipient has a system in place to prevent unallowable uses of MT resources.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients.
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle.

- Any other costs associated with a privately-owned vehicle (such as lease; loan payments; and insurance, license, or registration fees).
- Transportation of clients to activities not related to HIV-related core medical or support services, such as grocery shopping, personal errands, banking, recreational or social events, employment, employment readiness training, employment searches, court appearances, or probation officer visits.

If gas gift cards are utilized, additional protections must be in place to prevent:

- Using the card to purchase alcohol, tobacco, illegal drugs, or firearms.
- Redeeming the card for cash.
- Exceeding the federal reimbursement rate for mileage.[3]

Examples of additional protections may include having clients sign a form attesting to the allowable uses of gas gift cards, or documentation of conversation with the client discussing the limitations of the gas gift card uses.

Gift cards for medical transportation must not be in the form of a pre-paid credit card and must have expirations dates.

Documentation

Client record must document receipt of gas gift card and that client was informed of the purpose(s) of and restrictions on the use of the card.

Standard 31: The recipient must have a thorough system to document each instance of MT assistance and the appropriateness of each instance.

The log or client record must document the following for every instance of medical transportation assistance:

- Unique identifier of client receiving assistance.
- Name of staff member arranging for transportation assistance.
- Type of service for which transportation is provided.
- Trip date.
- Trip origination and destination.
- Transportation method (bus pass, taxi voucher, use of provider vehicle, etc.).
- Documentation that the client utilized the assistance to attend an eligible session/appointment.
- Dollar value of the assistance provided.

Documentation

The provider must be able to demonstrate that every instance of medical transportation was appropriately documented, including all required elements.

[3] If using a reimbursement rate other than the federal reimbursement rate, recipients must establish a consistent and properly documented mileage reimbursement policy.

Standard 32: The provider must take reasonable steps to prevent misuse of MT funds.

Providing false or misleading information to providers in order to obtain medical transportation assistance is considered misuse and may result in temporary or permanent discharge from the program.

Recipients must have a documented policy in place for misuse of medical transportation funds and the action steps that follow.

It is recommended that recipients not be penalized or barred from future medical transportation services for first-time misuse or diversion of medical transportation assistance.

Documentation

Providers must document findings about misuse of medical transportation assistance and subsequent actions taken.