SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2024 – February 28, 2025
Service Category:	`Early Intervention Services
Service Goal:	Quickly link HIV infected individuals to testing services, core medical services, and support services necessary to support treatment adherence and maintenance in medical care. Decreasing the time between acquisition of HIV and entry into care and decrease instances of out-of-care facility access to medications, decrease transmission, and improve health outcomes.
Service Health Outcomes:	If RW-funded test: maintain 1.1% positivity rate or higher (targeted testing) Link newly diagnosed HIV+ medical care in 30 days or less Improve retention in care (at least 1 medical visit in each 6 month period) Improve viral suppression rate

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**24/25 TOTAL**
Proposed Number of Clients	60	30	0	10	190	10		**300**
Proposed Number of Visits = Regardless of number of transactions or number of units	240	180	0	60	1140	60		**1800**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	1340	570	0	190	3610	190		**5900**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
Not applicable								

Planned Service Delivery and Implementation Activities	**Service Area**	**Timeline**	**Process Outcomes**

Element #1: Outreach Encounters • **Activities:** Early Intervention Services Case manager (EISCM) will conduct one-on-one, in-depth encounters with members of targeted populations at risk and provide referral to HIV Testing and Counseling (HCT), Pre-exposure prophylaxis navigation, Sexually Transmitted Infections testing among others.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will evidence encounters in case notes entered in ARIES Anonymous Encounter module and on outreach logs
Element #2: Community Collaboration • **Activities:** EISCM will Coordinate with local HIV Prevention Programs including surveillance activities of the Data to Care program from county public health departments. • EISCM will participate in the End of HIV Epidemic (EHE) of Riverside and San Bernardino County.	1,2,4,5,6	3/1/2024- 2/28/2025	FAP maintain collaboration with Riverside and San Bernardino DPH and other local prevention programs to coordinate outreach activities. Documentation of outreach activities and attendance to prevention meetings is kept in program binder.
Element #3: Screening, Intake, Assessment • **Activities**: EISCM will conduct screening, intake and assess PLWH newly diagnosed or disengaged in care to identify and problem-solve barriers to care.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will evidence in case note entered in ARIES identification of barriers to care and plan to problem-solve such barriers via intake and assessment.

Element #4: • **Activities**: EISCM will develop with client a referral plan to medical care, and support services.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will evidence referrals to medical care and support services via the Referral Tracking Plan. Referrals to medical and support services along with their outcome will be documented in ARIES. Referrals to testing will be documented in outreach log and sign- in sheet.

Element #5: • **Activities**: EISCM will conduct HIV Testing and Counseling. Individuals who test HIV positive will be referred to confirmatory HIV testing and care should confirmatory test result is positive.	1,2,4,5,6	3/1/2024- 2/28/2025	HIV Testing and counseling and referrals documentation will be maintained following approved HIV testing and counseling quality assurance
Element #6: • **Activities**: EISCM will utilize Navigation model to connect newly diagnosed and reconnect those that have fallen out of care. Navigation is an evidence-based intervention from the Centers for Disease Control compendium. Navigation support relies on accompanying clients to medical appointments.	1,2,4,5,6	3/1/2024- 2/28/2025	FAP follow-up/no contact protocol includes mail, community, home visit, and phone contact. Client file will evidence attempts to contact, education and support provided to address barriers to care. Attempts and contact with client will be documented in ARIES.
Element #7: • **Activities** EIS CM will maintain formal linkages with traditional (prisons, homeless shelters, treatment centers, etc) and non-traditional (faith- based organizations, community centers, hospitals, etc.) entry points	1,2,4,5,6	3/1/2024- 2/28/2025	Memoranda of Understanding (MOU) are kept at Administration. Staff maintain a List of Collaborators (traditional and non-traditional) which depicts the name of the agency collaborating, the target population, the type and frequency of outreach activity to be provided at the site.

Element #8: • **Activities:** EISCM Provide education/information regarding availability of testing and HIV care services to HIV+ those affected by HIV, and caregivers. *Activities that are exclusively HIV*	1,2,4,5,6	3/1/2024- 2/28/2025	Encounter file will evidence education of the HIV system of care in case note entered in ARIES ACE module. Sign-in sheets document location as well as attendees information for outreach activities.
Element #9: • **Activities**: EISCM will utilize standardized, required documentation to record encounters, progress regarding linkage of referrals	1,2,4,5,6	3/1/2024- 2/28/2025	Client will file evidence use of standardized, required documentation to include EIS Consent form, Enrollment form and Progress report form among others.
Element #10: **Activities**: EISCM will maintain update, quantifiable, required documentation to accommodate reporting and evaluation.	1,2,4,5,6	3/1/2024- 2/28/2025	Encounters are documented in ARIES. Referrals and their outcome are documented in ARIES. Outreach activities are documented in sign-in sheets and in the ARIES Anonymous Contact dashboard. Case Manager will track health outcomes (viral load and CD4 as well as access to medical care services data.

Element #11:Acitivities Eligibility worker will collaborate with Early Intervention Case Manager to conduct eligibility certification and re-certification every six	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will evidence documents supporting eligibility for services according to the IEHPC.
Element #12: Case Closure/Graduation • **Activities: EISCM will carry on case closure and transfer to another level of care according to standard.**	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will evidence date, reason for closure or transfer, referrals provided as appropriate in progress note entered in ARIES. Case Manager will complete Client Status form which will be placed in client file.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	Early Intervention Services - Minority AIDS Initiative
Service Goal:	Quickly link HIV infected ***Latinx and African-Americans*** to testing services, core medical services, and support services necessary to support treatment adherence and maintenance in medical care. Decreasing the time between acquisition of HIV and entry into care and decrease instances of out-of-care facility access to medications, decrease transmission, and improve health outcomes.
Service Health Outcomes:	• If RW-funded test: maintain 1.1% positivity rate or higher (targeted testing) • Link Latinx and African-American newly diagnosed HIV+ medical care in 30 days or less • Improve retention in care (at least 1 medical visit in each 6 month period) • Improve viral suppression rate

BLACK / AFRICAN AMERICAN	**SA1** West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 23/24 TOTAL**
Number of Clients	20	20	0	10	70	5		**125**
Number of Visits = Regardless of number of transactions or number of units	40	40	0	20	140	10		**250**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	310	310	0	155	1085	80		**1940**
HISPANIC / LATINO	**SA1** West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	SA6 San B Deser		**FY 23/24 TOTAL**
Number of Clients	80	40	0	20	120	15		**275**
Number of Visits = Regardless of number of transactions or number of units	160	80	0	40	240	30		550
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	1240	620	0	310	1860	230		4260
TOTAL MAI (sum of two tables above)	**SA1** West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B	**SA5** San B	**SA6** San B		**FY 23/24 TOTAL**

Number of Clients	100	60	0	30	190	20		**400**
Number of Visits = Regardless of number of transactions or number of units	200	120	0	60	380	40		800
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	1550	930	0	465	2945	310		**6200**

Group Name and Description (must be HIV+ related)	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
• Not Applicable								
•								
•								

Planned Service Delivery and Implementation Activities	Service Area	Timeline	Process Outcomes
Element #1: Outreach Encounters • **Activities:** Early Intervention Services Case manager (EISCM) will conduct one-on-one, in-depth encounters with members of the Latinx and African-American communities and provide referral to HIV Testing and Counseling (HCT), Pre-exposure prophylaxis navigation, Sexually Transmitted Infections testing among others.	1,2,4,5,6	3/1/2023- 2/29/2024	Client file will evidence encounters in case notes entered in ARIES Anonymous Encounter module and on outreach logs
Element #2: Community Collaboration • **Activities:** EISCM will coordinate with local HIV Prevention Programs including surveillance activities of the Data to Care program from county public health departments.	1,2,4,5,6	3/1/2023- 2/29/2024	FAP maintain collaboration with Riverside and San Bernardino DPH and other local prevention programs to coordinate outreach activities. Documentation of outreach activities and attendance to prevention meetings is kept in program binder.

• EISCM will participate in the End of HIV Epidemic (EHE) of Riverside and San Bernardino County.			
Element #3: • **Activities**: EISCM will conduct HIV Testing and Counseling. Individuals who test HIV positive will be referred to confirmatory HIV testing and care should confirmatory test result be positive.	1,2,4,5,6	3/1/2023- 2/29/2024	HIV Testing and counseling and referrals documentation will be maintained following approved HIV testing and counseling quality assurance
Element #4: Screening, Intake, Assessment • **Activities**: EISCM will conduct screening, intake and assess PLWH newly diagnosed or disengaged in care to identify and problem-solve barriers to care.	1,2,4,5,6	3/1/2023- 2/29/2024	Client file will evidence in case note entered in ARIES identification of barriers to care and plan to problem-solve such barriers via intake and assessment.
Element #5: • **Activities**: EISCM will develop with client a referral plan to medical care and support services.	1,2,4,5,6	3/1/2023- 2/29/2024	Client file will evidence referrals to medical care and support services via the Referral Tracking Plan. Referrals to medical and support services along with their outcome will be documented in ARIES.
Element #6: • **Activities**: EISCM will utilize Navigation model to connect newly diagnosed and reconnect those that have fallen out of care. Navigation is an evidence-based intervention from the Centers for Disease Control compendium. Navigation support relies on accompanying clients to medical and other support service appointments to ensure linkage.	1,2,4,5,6	3/1/2023- 2/29/2024	FAP follow-up/no contact protocol includes mail, community, home visit, and phone contact. Client file will evidence attempts to contact, education and support provided to address barriers to care. Attempts and contact with client will be documented in ARIES.

Element #7: • **Activities** EIS CM will maintain formal and informal linkages with traditional (prisons, homeless shelters, treatment centers, etc) and non- traditional (faith-based organizations, community centers, hospitals, etc.) entry points.	1,2,4,5,6	3/1/2023- 2/29/2024	Memoranda of Understanding (MOU) are kept at Administration. Staff maintain a List of Collaborators (traditional and non-traditional) which depicts the name of the agency collaborating, the target population, the type and frequency of outreach activity to be provided at the site.

Element #8: • **Activities:** EISCM Provide education/information regarding availability of testing and HIV care services to HIV+ those affected by HIV, and caregivers. *Activities that are exclusively HIV prevention education are prohibited*.	1,2,4,5,6	3/1/2023- 2/29/2024	Encounter file will evidence education of the HIV system of care in case note entered in ARIES ACE module. Sign-in sheets document location as well as attendees information for outreach activities.
Element #9: • **Activities**: EISCM will utilize standardized, required documentation to record encounters, progress regarding linkage of referrals	1,2,4,5,6	3/1/2023- 2/29/2024	Client will file evidence use of standardized, required documentation to include EIS Consent form, Enrollment form and Progress report form among others.
Element #10: **Activities**: EISCM will maintain update, quantifiable, required documentation to accommodate reporting and evaluation.	1,2,4,5,6	3/1/2022- 2/28/2023	Encounters are documented in ARIES. Referrals and their outcome are documented in ARIES. Outreach activities are documented in sign-in sheets and outreach logs and entered in the ARIES Anonymous Contact dashboard. Case Manager will track health outcomes (viral load and CD4 as well as access to medical care services data.
Element #11: **Activities** Eligibility worker will collaborate with Early Intervention Case Manager to conduct eligibility certification and re-certification every six months.	1,2,4,5,6	3/1/2023- 2/29/2024	Client file will evidence documents supporting eligibility for services according to the IEHPC.
Element #12: Case Closure/Graduation • **Activities:** EISCM will conduct on case closure and transfer to another level of care according to standard.	1,2,4,5,6	3/1/2023- 2/29/2024	Client file will evidence date, reason for closure or transfer, referrals provided as appropriate in progress note entered in ARIES. Case Manager will complete Client Status form which will be placed in client file.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2024 – February 28, 2025
Service Category:	Food Services
Service Goal:	The overall goal of food services is to supplement eligible HIV/AIDS consumer's financial ability to maintain continuous access to adequate caloric intake and balanced nutrition sufficient to maintain optimal health in the face of compromised health status due to HIV infection in the TGA.
Service Health Outcomes:	Improve retention on care (at least 1 medical visit in each 6-month period) Improve viral load suppression rate

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 24/25 TOTAL**
Proposed Number of Clients	169	154	0	0	342	160		**825**
Proposed Number of Visits = Regardless of number of transactions or number of units	1,690	1,540	0	0	3,420	1,600		**8,250**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	6,760	6,160	0	0	13,680	6,400		**33,000**

Group Name and Description (must be HIV+	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
Not Applicable								

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: ***Food Vouchers*** • **Activities:** To provide Food Vouchers Food assistance needs will be identified by staff during assessment/reassessment, which will be included in the individualized Care Plan (CP). Eligibility will be determined according to current financial eligibility guidelines in collaboration with Eligibility Worker. Eligible Clients will make appointment for picking up vouchers – whenever possible. Food vouchers will be distributed on a monthly to clients not to exceed a maximum of $80.00 monthly. Food vouchers will be kept in locked file cabinet in FAP's Administration offices and logged out to program using FAP's internal Food Voucher Request form. Food vouchers will be kept in locked file cabinet in FAP's program sites and logged out to eligible clients using FAP's internal Monthly Food Voucher Log.	1,2,4,5,6	03/01/2024 -02/28/25	Client file will evidence eligibility screening for Ryan White funds as well other party payors. Client file will document HIV status, proof of medical insurance, residence, and income according to standards. Client file will document evidence of certification and re-certification for service eligibility. Client file will contain Consent for Services; ARIES consent updated every three years, HIPAA Notification and Partner Services Acknowledgement form. Client file will evidence need for food assistance. Client file will contain proof of food assistance received as client signature on copy of food vouchers. Client file will contain evidence of referral to other sources of food assistance, as applicable. .

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2024 – February 28, 2025
Service Category:	Medical Transportation Services
Service Goal:	To enhance clients' access to health care or support services using multiple forms of transportation throughout the TGA
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period) Improve viral suppression rate

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 24/25 TOTAL**
Proposed Number of Clients	90	10	6	0	212	45	**363**
Proposed Number of Visits = Regardless of number of transactions or number of units	1080	120	72	0	2544	540	**4356**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	4320	480	288	0	10186	2160	**17434**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
Not Applicable								
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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: • **Activities: To provide *Bus passes*** CM in collaboration with Eligibility Worker will determine client eligibility: HIV diagnosis, residency, income, purpose of trips and screening for other party payors. CM will document services ordered in client file. Staff will provide bus pass to client and will enter service provided on Transportation Log. Transportation allowance is not to exceed $40.00 monthly. Medical Transportation services will be provided to access services according to standard.	1,2,3,5,6	03/01/2024 -02/28/25	Client file will evidence eligibility screening for Ryan White funds as well other party payors. Client file will document eligibility screening every six months and statement of need for bus pass. Client file will contain Consent for Services; ARIES consent updated every three years, HIPPA Notification and Partner Services. Transportation Log will evidence client signature acknowledging receipt of bus pass. Bus Pass assistance will be documented in ARIES.
Element #2: • **Activities: To provide *Taxi service*** CM in collaboration with Eligibility Worker will determine client eligibility: HIV diagnosis, residency, income, screening for other party payors, purpose and date of trip. CM will document services ordered in client file. Staff will order taxi service, notify client of time and need to be ready on time. Staff will enter service provided on Taxi Services Binder. Services will be provided to access services according to standard. Transportation allowance is not to exceed $40.00 monthly. Staff will document trip point of origin, destination and reason for trip.	1,2,3,5,6	03/01/2024 -02/28/25	Client file will evidence eligibility screening for Ryan White funds as well other party payors. Client file will document eligibility screening every six months and statement of need for urgent trip. Client file will contain Consent for Services; ARIES consent updated every three years, HIPPA Notification and Partner Services. Taxi Services Binder will evidence taxi request depicting point of origin and destination and statement of need for urgent trip. Services will be provided within San Bernardino County. Taxi assistance will be documented in ARIES.
Element #3: • **Activities:** To provide ***Gas cards*** CM in collaboration with Eligibility Worker will determine client eligibility: HIV diagnosis, residency, income, screening for other party payors, purpose and date of trip. CM will document service provided in client file. Staff will log voucher disbursement in Gas Card Log. Services will be provided to access services according to	1,2,3,5,6	03/01/2024 -02/28/25	Client file will evidence eligibility screening for Ryan White funds as well other party payors. Client file will document eligibility screening every six months and statement of need for gas voucher. Client file will contain Consent for Services; ARIES consent updated every three years, HIPPA Notification and Partner Services. Transportation log will evidence client signature

standard. Transportation allowance is not to exceed $40.00 monthly. Staff will document trip point of origin, destination and reason for trip.			acknowledging receipt of gas vouchers. Gas Voucher assistance will be documented in ARIES.
Element #3: **Activities:** CM in collaboration with Eligibility Worker will determine client eligibility: HIV diagnosis, residency, income, screening for other party payors, purpose and date of trip. CM and Mobility Manager will document service provided in client file. Mobility Manager and CM will document trip point of origin, destination, date, and reason for trip.	1,2,3,5,6	03/01/2024 -02/28/25	Client file will evidence eligibility screening for Ryan White funds as well other party payors. Client file will document eligibility screening every six months and statement of need for van trip. Client file will contain Consent for Services; ARIES consent updated every three years, HIPPA Notification and Partner Services. Excel Transportation log will evidence client signature acknowledging receipt of van trips which will be documented in ARIES.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2024 – February 28, 2025
Service Category:	Housing Services
Service Goal:	To provide shelter, on an emergency or temporary basis, to eligible clients throughout the TGA at risk for homelessness or with unstable housing to ensure that they have access to and/or remain in medical care.
Service Health Outcomes:	◦ Improve retention in care (at least 1 medical visit in each -month period) ◦ Improve viral suppression rate ◦ Improve stable housing rate

Emergency Housing

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 24/25 TOTAL**
Proposed Number of Clients	**2**	**0**	**0**	**0**	4	2		8
Proposed Number of Visits (application) = Regardless of number of transactions or number of units	**2**	**0**	**0**	**0**	**4**	**2**		**8**
Proposed Number of Units (nights) = Transactions or 15 min encounters	**74**	**0**	**0**	**0**	111	**71**		256

Housing Case Management

	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B West	SA5 San B East	SA6 San B Desert		FY 24/25 TOTAL
Proposed Number of Clients	12	0	0		72	14		**98**
Proposed Number of Visits = Regardless of number of transactions or number of units	120	0	0		720	140		**980**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	480	0	0		2,880	560		3,920

Group Name and Description (must be HIV+ related)	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
Not Applicable								

Planned Service Delivery and Implementation Activities	Service Area	Timeline	Process Outcomes
Service Delivery Element #1: Emergency Housing • **Activities:** Housing Case Manager (HCM) will provide Emergency housing assistance for a maximum of 90 nights (hotel/motel or rental assistance for up to 90 nights) per client t**o 3** eligible clients throughout the TGA based on current TGA standards.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will evidence housing intake and assessment activities, including comprehensive housing plan, eligibility screening, as well as insurance/third party payor. Client file will document HIV status, acknowledgement of Partner Services, and proof of insurance, income and residency according to IEHPC standards. Client file will contain Consent for Services, ARIES consent (updated every three years), HIPPA Notification and Partner Services Acknowledgement form. Client file will contain housing assistance vouchers and proof of payment, housing applications, leases, and any other required forms. Emergency housing assistance will be documented in progress note in ARIES.

Service Delivery Element #2: Housing Case Management ▪ **Activities:** HCM will provide case management to 65 eligible clients assessed at high acuity level based on current TGA standards. HCM will conduct intake and assess for housing needs and budgeting. ▪ HCM will conduct visit to clients in emergency housing on a weekly basis and number of contact with client will be determined according to acuity level.	4,5,6	3/1/2024- 2/28/2025	Client file will evidence housing intake and assessment activities, including comprehensive housing plan, eligibility screening, as well as insurance/third party payor. Client file will document HIV status, Acknowledgement of Partner Services, proof of insurance, income and residency according to IEHPC standards. Client file will contain Consent for Services, ARIES consent (updated every three years), HIPAA Notification and Partner Services, Acknowledgement form. Client file will contain housing assistance vouchers and proof of payment, housing applications, leases, etc. Emergency housing assistance will be documented in ARIES. Client file will contain Housing Service Plan signed by client and HCM. Client file will contain budgeting form completed in conjunction with client and HCM. Contact with and on behalf of client will documented in progress note entered in ARIES.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2024 – February 28, 2025
Service Category:	Emergency Financial Assistance
Service Goal:	To enable HIV service clients at risk of loss of utility services to remain connected, thus allowing them to maintain a stable living environment thereby improving quality of life and clinical health outcomes
Service Health Outcomes:	Improve retentions on care (at least 1 medical visit in each month period 6-month period) Improve viral load suppression rate

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 23/24 TOTAL**
Proposed Number of Clients	0	0	0	2	21	3	**26**
Proposed Number of Visits = Regardless of number of transactions or number of units	0	0	0	2	21	3	**26**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	0	0	0	2	21	3	**26**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
Not Applicable								

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2024 – February 29, 2025
Service Category:	Mental Health Services
Service Goal:	Minimize crisis situations and stabilize HIV clients' mental health status to maintain clients in the care system
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period) Improve viral suppression rate, improved or maintained CD4 cell count. Decreased level of depression post 12 individual sessions Decreased level of anxiety post 12 individual sessions.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 23/24 TOTAL**
Proposed Number of Clients	42	17	0	14	12	3		**88**
Proposed Number of Visits = Regardless of number of transactions or number of units	420	170	0	140	120	30		**880**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	2,640	1,640	0	1,520	1,440	1,080		**9,280**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**

Living Well with HIV Living Well with HIV/AIDS psychotherapy groups are facilitated by Mental Health clinicians. Focus of group sessions are psychological/emotional	1,2,3,4,5,6	Co-ed	Open	8	1.5 hr	1	On-going	Medical Visits Viral Loads Level of functioning

issues clients experience related to living with HIV/AIDS, relationships and other topics designated by group members.								
Young and Thriving Young and Thriving group is for clients age 30 and under. Group focuses on topics and activities that educate as well as equip youth with social skills for cultivating health relationships on the age of social media	1,2,3,4,5	Co-ed	Open	8	1.5 hr	1	On-going	Medical Visits Viral Loads Level of functioning
Rise and Grind This is group is a Co-ed, strength-based psycho-education group. The group is offered in 6 weeks segments with the topic/emphasis changing every new cycle.	4,5	Co-ed	Open	8	1.5 hr	1	On-going	Medical Visits Viral Loads Level of functioning

Aging Well This is a co-ed group which provides support to clients 50+ living with HIV. This group focuses on topics and activities that educate as well as equip social engagement, emotional welfare, and mental welfare which are often-overlooked challenges faced by aging people with HIV who can benefit from engaging in peer support, avoiding isolation, and maintaining open communication.	1,2,3,4,5	Co-ed	Open	8	1.5 hr	1	On-going	Medical Visits Viral Loads Level of functioning

Planned Service Delivery and Implementation Activities	Service Area	Timeline	Process Outcomes
Element #1: Initial Assessment and Re-assessment **Activities:** Initial individual mental health assessment(document mental health diagnosis) Client will meet with Mental Health Clinician (MHC) to complete initial assessment and reassessment. MHC will conduct eligibility for services along with screening for Third Party payer.	1,2,3,4,5,6	3/1/2024- 2/28/2025	Client file will document initial mental health assessment and reassessment to include DSMV diagnosis, and other outcome tracking data per program standards and entered in ARIES. Client file will document statement of screening and eligibility.
Element #2: Development of Treatment Plan **Activities:** Client and MHC will meet to develop treatment plan	1,2,3,4,5,6	3/1/2024- 2/28/2025	Client file will include initial and updated treatment plan and entered in ARIES.
Element #3: Individual counseling session **Activities**: Client will meet with MHC for individual session	1,2,3,4,5,6	3/1/2024- 2/28/2025	Client file will document session as case note and entered in ARIES.

Element #4: Group counseling session **Activities:** MHC will convene weekly support group to discuss issues relevant to HIV/AIDS. For individual attending group sessions only, file will include assessment, DSMV diagnosis, and treatment plan and documentation of group participation.	1,2,3,4,5,6	3/1/2024- 2/28/2025	Group counseling documentation will be maintained via sign-in sheets depicting group topic and entered in ARIES. Case Note will document attendance to group session
Element #5: Case Conferencing **Activities:** MHC will participate in case conference to discuss issues and needed referrals. MHC will discuss wrap-up around services regarding access to additional services including psychiatrists and other mental health professionals.	1,2,3,4,5,6	3/1/2024- 2/28/2025	Documentation of case conferencing is kept in program binder and entered in case in ARIES.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2024 – February 28, 2025
Service Category:	Substance Abuse Services
Service Goal:	Minimize crisis situations and stabilize client's substance use to maintain their participation in the medical care system.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period) Improve viral load suppression rate A clinically significant reduction in level of substance use/abuse (12) individual or group sessions

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 24/25 TOTAL**
Proposed Number of Clients	24	18	0	28	54	62	**186**
Proposed Number of Visits = Regardless of number of transactions or number of units	240	180	0	280	540	620	**1,860**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	1,440	1,200	0	1,600	2,640	2,960	**10,320**

Group Name and Description (must be HIV+ related)	**Service Area of**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
Circle of Truth **Nuevo Amenecer** • The support group goal is to identify the irrational beliefs and to refute tem. The irrational belief	1,2,3,4,5	English Co-ed Spanish-Speaking	Open Open	8 8	1.5 hr 1.5	1 2	On-going On-going	Medical visits Viral loads Substance use/abuse self-report and/or equivalent tool

would then be substituted with a more rational or accurate beliefs, which should have an impact on the emotional response. Social and problem solving skills will also be used to enable clients to develop non-substance use habits in order to adhere to their HIV care. HIV prevention risk-reduction including condom use as related to substance use is also discussed.								
Clean and Serene • This support group focuses on Cognitive Behavioral content with an emphasis on practicing new coping skills in maintaining sobriety	6	Co-ed	Open	8	1.5 hr	1 Weekly	On-going	• Medical visits • Viral loads • Substance use/abuse self-report and/or equivalent tool

Moving On • This group targets those who have lived with HIV for a number of years and who have a history of and/or current struggles with substance use.	4,5	Co-ed	Open	8	1.5 hr	1 Weekly	On-gong	• Medical visits • Viral loads Substance use/abuse self-report and/or equivalent tool

Planned Service Delivery and Implementation Activities	Service Area	Timeline	Process Outcomes
Element #1: Initial Assessment and Re-assessment • **Activities:** Initial individual substance abuse assessment Client will meet with Substance Use Disorder Counselor (SUDC) to complete initial assessment and reassessment. SUDC will conduct eligibility for services along with screening for Third Party payor.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will document initial substance abuse assessment and reassessment along with and other outcome tracking data per program standards and entered in ARIES. Client file will document statement of
Element #2: Development of Treatment Plan • **Activities:** Client and SUDC will meet to develop treatment plan	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will include initial and updated treatment plan and entered in ARIES. Treatment plan will be updated at least every 120 days.
Element #3: Individual Counseling Session • **Activities:** Client will meet with SUDC for individual session	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will document session as case note and entered in ARIES.
Element #4: Group Counseling • **Activities:** Group counseling session SUDC will convene weekly support group to discuss issues relevant to HIV/AIDS. For individual attending group sessions only, file will include assessment, and treatment plan.	1,2,4,5,6.	3/1/2024- 2/28/2025	Group counseling documentation will be maintained via sign-in sheets and entered in ARIES. For individual attending group sessions only, file will include assessment, and treatment plan.
Element #4: Case Conferencing • **Activities:** SUDC will participate in case conferencing to coordinate services and address identified issues	1,2,4,5,6.	3/1/2024- 2/28/2025	Documentation of case conferencing will be kept in program binder.
Element #5: Referrals • **Activities:** Referral to other mental health professionals SUDC will meet with client to identify needed	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will document referral(s) provided to include referral information and follow-up on the

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2024 – February 28, 2025
Service Category:	Psychosocial Support Services
Service Goal:	To provide psychosocial support services to person living with HIV/AIDS in the TGA in order to maintain them in the HIV system of care.
Service Health Outcomes:	Improve retention in care (at least 1 medical in each 6-month period) Improve viral suppression rate

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 23/24 TOTAL**
Proposed Number of Clients	8	4	15	6	6	3		**42**
Proposed Number of Visits = Regardless of number of transactions or number of units	80	40	150	60	60	30		**800**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	800	640	1,080	720	720	600		**4,560**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**

◦ Abriendo Caminos: Group provides a safe forum to learn about HIV self-management skill and healthy living while supporting each other	4.5	Spanish-Speaking	Open	8	1.5 hr	1	Open	Self-report of adherence to medical appointments, treatment regimen, knowledge about HIV disease and quality of life
◦ Healthy HIV self-management	4,5	Co-ed English	Open	8	1.5 hr	1	Open	Self-report of adherence to medical appointments, treatment regimen, knowledge about HIV disease and quality of life

Planned Service Delivery and Implementation Activities	Service Area	Timeline	Process Outcomes

Element #1: Assessment and Development of Psychosocial Support Plan **Activities:** Psychosocial Case Manager (CM) will meet with client to complete initial assessment and reassessment.	4,5	3/1/2024- 2/28/2025	Client file will evidence intake activities to include screening for eligibility as well as insurance/third party payor. Client file will document HIV status, proof of insurance, residence, and income according to IEHPC standards. Client file will evidence assessment of psychosocial needs and psychosocial support plan based on needs. Client file will contain Consent for Services, ARIES consent updated every three years, HIPAA Notification and Partner Services Acknowledgement form and any other required forms.
Element #2: Individual Psychosocial session • **Activities:** Individual support/counseling session Psychosocial CM will meet with client to provide individual session using Trauma-Informed care and psychosocial support approach	4,5	3/1/2024- 2/28/2025	Client file will evidence in progress note individual support session received.
Element #3: Coordination/Case Conferencing • **Activities:** Psychosocial Case Manager will case conference with Medical Case Manager, if applicable to discuss issues and problem-solve. • Psychosocial CM will participate in case conference to coordinate services, discuss issues and resolution to identified issues	4,5	3/1/2024- 2/28/2025	Client file will document linkage with Medical Case Management as applicable. Client file will document in progress note coordination with Medical Case Management to include issues discussed and resolutions identified.
Element #4: **Activities:** Group support/counseling session	4,5	3/1/2024- 2/28/2025	Client file will reflect in progress note participation in support group.

Psychosocial CM will convene weekly support group.			Group sign-in sheets will be maintained.
Element #5: **Activities:** Referral to Mental Health Professionals (MHP) Psychosocial CM will provide MHP referrals as needed.	4,5	3/1/2024- 2/28/2025	Client file will evidence referral to MPH. Referrals along with outcome will be entered in ARIES.
Element #6: **Activities:** Eligibility worker will collaborate with Psychosocial CM to conduct eligibility certification and re-certification every six months.	4,5	3/1/2024- 2/28/2025	Client file will evidence documents supporting eligibility for services according to the IEHPC Standards.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2024 – February 28, 2025
Service Category:	Case Management Services (Non-Medical)
Service Goal:	Facilitate linkage and retention in care through the provision of guidance and assistance with service information and referrals.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period) Improve viral suppression rate

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**24/25 TOTAL**
Proposed Number of Clients	61	23	0	14	73	27	**198**
Proposed Number of Visits = Regardless of number of transactions or number of units	610	230	0	140	730	270	**1,980**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	3,400	1,880	0	1,520	3,880	2,040	**12,720**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
Not Applicable								

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1:Intake and Eligibility • **Activities:** Intake/Screening for eligibility conducted within 10 days of referral for request and complete required consent forms, • Initial assessment conducted within 30 of first visit **Case Management collaborates with County Public Health HIV clinics, Borrego Health, AIDS HealthCare Foundation, Jerry L Pettis Veterans Hospital, Loma Linda Social Action Clinic Health System and with medical managed-care plans among others.* Case Manager will collaborate with Eligibility Worker to ensure service is delivered according eligibility standards. Eligibility will be conducted every six months	1,2,4,5,6	03/01/24-02/28/25	Client file will evidence intake activities including orientation to service, screening for eligibility as well as insurance/third party payor. Client file will document HIV status, proof of insurance, residence, and income according to standards. Client file will contain Consent for Services, ARIES consent updated every three years, HIPAA Notification and Partner Services Acknowledgement form and any other required forms. Client file will document evidence of certification and re-certification for service eligibility every six months.
Element #2: Assessment and Re-assessment of needs and acuity level • **Activities:** Initial and ongoing assessment of acuity level and of service needs. Case Manager will complete initial Acuity Level based on identified needs and assess new acuity level as needed.	1,24,5,6	03/01/24-02/28/25	Client file will evidence assessment and re-assessment of needs. Client file will evidence initial acuity level and on-going acuity level.
Element #3: Development of Individualized Comprehensive Care plan • **Activities:** Case manager will develop a comprehensive individualized Care Plan with client-centered goals and milestones. Care Plan will be re-evaluated every six months or as changes occur.	1,24,5,6	03/01/24-02/28/25	Client file will document Care Plan and disposition of objectives. Care Plan will be signed by client and Case Manager

Element #4: On-going monitoring of efficacy of Care Plan • **Activities:** Case Manager will monitor efficacy of care plan via on-going monitoring via face to face contact, phone contact and any other forms of communication deemed appropriate. Case Manager will work with client to identify tasks, interventions, assistance needed to access services, and anticipated time for each task/service.	1,24,5,6	03/01/24-02/28/25	Client file will document monitoring of Care Plan via progress notes and update of service objectives. Progress notes will be entered in ARIES.

Element #5: Assistance in accessing services and follow-up • **Activities:** Case Manager will work with client to determine barriers to access services and provide assistance in addressing identified barriers. • Case Manager will provide education, advice assistance in obtaining medical, social, community, legal, financial (e.g. benefits counseling), and other services from a trauma-informed approach. •	1,2,4,5,6	03/01/24-02/28/25	Client file will document in progress note contacts to provide education and advice on accessing medical, social, community, legal, benefits counseling, treatment adherence counseling and other services. Progress notes will be entered in ARIES. Client file will document entry of referrals provided and their outcomes in ARIES.
Element #6: Assistance with budgeting • **Activities:** Case Manager will discuss budgeting with clients to maintain access to necessary services. • CM will meet with client to complete Budgeting form and discuss budgeting issues as related to maintaining access to necessary services.	1,2,4,5,6	03/01/24-02/28/25	Client file will include Budgeting Form. Client file will document in progress note discussion regarding budgeting in order to maintain access to necessary services.
Element #7: Participation in case conference • **Activities:** Case Manager will participate in Case conferencing with Medical Case Management (MCM) and other disciplines on behalf of the client. • CM will present issues and discuss resolution to problem-solve identified issues.	1,2,4,5,6	03/01/24-02/28/25	Client file will evidence case conference as documented in progress notes entered in ARIES. As applicable, client file will reflect coordination of services with other medical providers and/or professionals.

Element #8: Case Closure/Graduation • **Activities:** Case Manager will carry on case closure/graduation according to standard whether it be agency initiated or self-disengagement or graduation.	4,5,6	03/01/24-02/28/25	Client file will evidence date, reason for closure, referrals provided as appropriate in progress note entered in ARIES. Case Manager will complete Client Status form which will be placed in client file.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	Foothill AIDS Project
Grant Period:	March 1, 2024 – February 29, 2025
Service Category:	Medical Case Management Services
Service Goal:	The goal of providing medical case management services is to ensure that those who are unable to self-manage their care, struggling with challenging barriers to care, marginally in care, and/or experiencing poor CD4/Viral load test results receive intense care coordinating assistance to support participation in HIV medical care.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period) Improve viral suppression rate

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 23/24 TOTAL**
Proposed Number of Clients	20	0	0	35	10	15	**80**
Proposed Number of Visits = Regardless of number of transactions or number of units	200	0	0	350	100	150	**800**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	800	0	0	1,400	400	600	**3560**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
HIV Education	1, 2,4,5,6	Clients engaged with MCM	Open	1,2,4,5,6	3/1/2024-2/28/2025	1 monthly	1.5 hr	Self-reported knowledge about HIV disease, treatment, and rating of importance of maintaining treatment adherence

Planned Service Delivery and Implementation Activities	Service Area	Timeline	Process Outcomes
Element #1: Initial and On-going Assessment • **Activities:** Medical Case Manager will conduct initial and on-going assessment of needs. *Medical Case Management will target clients who experience barriers in self-managing their HIV medical care; poor CD4 and viral load count; and do not have access to medical case management thru their medical homes, thus needing intense care coordination.*	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will evidence intake activities including screening for eligibility as well as insurance/third party payor. Eligibility certification will be conducted every six months. Client file will evidence initial and on-going assessment of needs.
Element #2: Development of Comprehensive Care Plan • **Activities:** Medical Case Manager (MCM) will develop a comprehensive, individualized care plan with the client and re-evaluation of plan (every six months). • MCM will rate areas of medical case management needs to measure acuity level.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will document individualized comprehensive care plan and acuity level that are to be re-evaluated every six months.
Element #3: Care Plan Implementation and Monitoring • **Activities:** MCM will monitor the plan efficacy, periodic re-evaluation and adaptation of the plan as necessary (6 months). • MCM will meet with client to assess progress and re-define objectives as needed.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will document in ARIES case note contacts to monitor progress and re-evaluation of plan every six months.
Element #4: Educational Group • **Activities:** MCM will facilitate group treatment adherence education, e.g. HIV health numeracy in respect to viral load.	1,2,4,5,6	3/1/2024- 2/28/2025	Group sign-in sheets will be kept in Treatment Adherence Group binder at respective FAP location.

Element #5: Advocacy • **Activities:** MCM will advocate and/or review of utilization of services, coordination and follow- up of medical treatments, communication between primary medical provider and HIV specialist among others	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will document specific advocacy, coordination and follow-up of services and medical treatments.

Element #6: Referrals • **Activities: MCM will** provide or refer clients for advice, support, counseling on topics surrounding HIV disease, treatments, medications, treatment adherence education, caregiver bereavement support, dietary/nutrition advice and education, and terms and information needed by client to effectively participate in his/her medical care.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will reflect service provided to include advice and counseling regarding treatment adherence, nutrition, and support to effectively participate in the system of care. As applicable, client file will reflect coordination of services with client's local managed-care plan. Performance Measures: 1) Care Plan 2) Gap in HIV medical visits
Element #7: Case Closure/Graduation • **Activities:** MCM will carry on case closure/graduation according to standard whether it be agency initiated or self- disengagement or graduation	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will evidence date, reason for closure, referrals provided as appropriate in progress note entered in ARIES.

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	Foothill AIDS Project
Grant & Period:	Part A Contract March 1, 2024 – February 28, 2025
Service Category:	Medical Nutrition Therapy
Service Goal:	Facilitate maintenance of nutritional health to improve health outcome or maintain positive health outcomes.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period) Improve viral suppression rate

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 23/24 TOTAL**
Proposed Number of Clients	**15**	**0**	**0**	**5**	**30**	**15**		**65**
Proposed Number of Visits = Regardless of number of transactions or number of units	**150**	**0**	**0**	**50**	**300**	**150**		**650**
Proposed Number of Units = Transactions or 15 min encounters	**750**	**0**	**0**	**350**	**1,350**	**750**		**3,200**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
Healthy Eating	1,2,4,5,6	PLWH engaged with MNT	Open	5	1.5 hr	1 monthly	On-going	Self-reported increased knowledge of foods for a healthy diet

Planned Service Delivery and Implementation Activities	Service Area	Timeline	Process Outcomes
\ **Element #1: Intake and Assessment** • **Activities:** Registered Dietician (RD) will conduct Intake/assessment of nutritional needs.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will evidence intake activities including screening for eligibility as well as insurance/third party payer. Eligibility certification and re-certification will be conducted every six months. Client file will document HIV status, proof of insurance, residence, and income according to IEHPC standards. Client file will document referral from medical provider. Client file will evidence assessment of nutritional needs signed and dated by Registered Dietician. Client file will contain Consent for Services, ARIES consent updated every three years, HIPAA Notification and Partner Services Acknowledgement form.
Element #2: Development of Nutritional Plan • **Activities:** RD will develop a nutritional plan with the client within 30 days of the initial assessment and re-evaluation of plan (every six months).	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will document individualized nutritional plan signed and dated by Registered Dietitian. Client file will document re- evaluation of the nutritional plan signed and dated by the Registered Dietitian every six months.

Element #3: Follow-up and Monitoring • **Activities:** RD will follow-up counseling with clients regarding medical nutritional recommendations, discuss barriers to implement recommendations and assess new nutritional needs as needed. • RD will provide nutritional supplements to clients without medical insurance or to those waiting for approval for nutritional supplements from their medical insurance.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will document follow-up counseling and re-assessment as needed. Notes will document progress towards nutritional plan goals and barriers to implement recommendation and interventions to address these barriers as recommended. Progress note will document nutritional supplements given to client.
Element #4: Nutritional Group • **Activities:** Provide nutrition group education to increase knowledge of healthy food choices and enhance strategies to accomplish nutritional goals, food/drug interactions and medications side effects associated with long-term pharmacotherapy.	1,2,4,5,6	3/1/2024- 2/28/2025	Group sign-in will be maintained in Nutrition Group binder at respective locations.
Element #5: Case Conferencing • **Activities:** Case conferencing with Medical Case Management (MCM) Staff and Primary Care Provider. RD will participate in case conference to discuss issues and problem-solve identified issues.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will reflect staff participation at case conference with MCM and Primary Care Provider, issues discussed and resolutions identified.
Element #6: Case Closure/Graduation • **Activities:** RD will carry on case closure/graduation according to standard whether it be agency initiated or self-disengagement or graduation.	1,2,4,5,6	3/1/2024- 2/28/2025	Client file will evidence date, reason for closure, referrals provided as appropriate in progress note entered in ARIES.