COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS

CONTRACTED COMMUNITY SERVICES
SUPPORT SERVICES SECTION
Residential Unit

RESIDENTIAL EXTENSION GUIDELINES AND CONTRACTOR REQUEST FORM

PURPOSE: To establish a structured process for Division of HIV and STD Programs (DHSP) funded HIV/AIDS Residential Care Facilities for the Chronically Ill (RCFCI) and HIV/AIDS Transitional Residential Care Facility (TRCF) agencies with the intent to request residential extensions for their clients.

Clients receiving residential services are eligible for residential extensions. Residential extensions will be based on the client's health status for RCFCI and the clients overall level of functioning for TRCF. A residential extension request will be required for clients after the twenty-four (24) month period.

All extensions require prior approval from the Chief of Contracted Community Services of DHSP or his/her designee. Residential extension requests must be submitted within a minimum of five (5) working days prior to reaching maximum stay limitations.

EXTENSION GUIDELINES

An extension can be made as long as the client continues to meet program eligibility requirements in accordance with Title 22 and DHSP current contract agreement:

RCFCI

- Adults eighteen (18) years of age or older with HIV/AIDS;
- Emancipated minors with HIV/AIDS;
- Family units with adults or children or both, living with HIV/AIDS;
- Have an HIV/AIDS diagnosis from a primary care physician;
- Be certified by a qualified health care professional to need regular or ongoing assistance with Activities of Daily Living:
- Have a Karnofsky score of 70 or less;
- Have an unstable living situation; and
- Be a resident of Los Angeles County.

TRCF

- Adults eighteen (18) years of age or older with HIV/AIDS;
- Have an HIV/AIDS diagnosis from a primary care physician;
- Have a Karnofsky score of 70 or higher;
- Be certified by a qualified mental health professional to have a score on the Global Assessment of Functioning of 65 or less;
- Be actively engaged/receiving medical care;
- Be certified by their medical care provider(s) to take prescription medications independently;
- Meet income eligibility requirements; and
- Be homeless.

EXTENSION REQUEST PROCEDURE

The contractor must submit the following documents to DHSP a minimum of five (5) working days prior to the client-reaching maximum stay limitations:

- A completed copy of Attachment I, the one-page residential extension request form.
- A copy of the last Individual Service Plan (ISP)
- A copy of the new/revised current ISP
- Letter or faxed memo addressed to the Chief of Contracted Community Services requesting an extension, indicating the client ID number, reason for the extension, and the length of the extension.

The contractor must maintain the following documents within the client's record for review upon DHSP's annual program monitoring visits:

- A copy of Attachment I, the one-page residential extension request form;
- The last ISP completed prior to the extension request;
- The new/revised/current ISP and progress notes outlining how the client completed their goals as a result of the extension;
- A copy of the letter/memo sent to DHSP requesting the extension;
- A copy of the approval/rejection letter from DHSP.

****Important Privacy and Security Guidelines for submitting Treatment Extension Requests****

All Treatment Extension Requests and accompanying document(s) MUST be submitted via secure facsimile to DHSP/Contracted Community Services Division Secure Fax Line: (213) 381-8022

- Please include fax cover letter indicating Agency name, Contract #, and Service Category.
- All documents containing Protected Health Information (PHI) must be transmitted in accordance with any applicable local, State and Federal laws and pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Request(s) submitted via alternative method(s) will not be accepted.

ATTACHMENT I

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
CONTRACTED COMMUNITY SERVICES

SUPPORT SERVICES SECTION – RESIDENTIAL EXTENSION REQUEST

Please Check the Modality of Treatment:

☐ **Transitional Residential Care Facility**
☐ **Residential Care Facilities for the Chronically Ill**

Agency's Name:	DHSP Contract #:	
Name of Requestor:	Agency Phone #:	
E-Mail Address:	Agency Fax #:	
Client's Casewatch #:	Client's Admission Date:	Client's Scheduled Discharge Date:
Length of extension requested:	**Extension Start Date**:	**Extension End Date**:

Client's Current Level of Functioning (Provide the following as Required for Residential Services): **Karnofsky Score** _____ **GAF Score** _____

Please Check the Appropriate Criteria Below:

☐ 1. The client is making progress, but has not yet achieved the goals articulated in the individualized service plan. Continued residential services are necessary to permit the client to continue to work toward his or her goals.

☐ 2. New problems have been identified that are appropriately addressed at the present level of care. Continued residential services are necessary to permit the client to address his or her new goals

State Goals Client Will Achieve During This Extension Period:

Program Acceptance of Conditions: I certify that the above information is true and accept the following conditions: **1)** Approval does not exempt the program from complying with all other applicable State, Federal and County laws and regulations. **2)** One time only extensions will be granted per client resident episode and, **3)** Documentation of extension request will be maintained in client record.

_____ _____ _____
Printed Name and Title **Signature** **Date**

DHSP Use Only

Date Received: _____ Contract #: _____ Agency: _____

_____ _____ _____ ☐ Denied ☐ Approved, # of months: _____
Program Manager's Signature Print Name Date

_____ _____ _____ ☐ Denied ☐ Approved, # of months: _____
Section Manager's Signature Print Name Date

If denied, please provide the reason for denial:

C:\Users\osortiz\Desktop\Support Services\Fillable form.docm

Print Form

Clear Form