

Exhibit A
Scope of Work

1. Service Overview

Under the authority of the Federal Refugee Act of 1980, and as required by 42 Code of Federal Regulations (CFR), Part 440, Section 400.105, "In providing Refugee Medical Assistance (RMA) to refugees, a State must provide at least the same services in the same manner and to the same extent as under the State's Medicaid Program", the Department of Health Care Services (DHCS) agrees to provide the following services for the California Department of Public Health (CDPH).

Provide Refugee Medical Assistance (RMA) benefits (same as for a Medi-Cal eligibles), to all eligible persons who are admitted to the United States as refugees, asylees, Cuban and Haitian entrants, victims of trafficking, and other eligible entrants (henceforth referred to as "eligible new entrants") who are resettled in California.

2. Projects Representatives

A. The project representatives during the term of this agreement will be:

<p>California Department of Public Health Carlos Zavala Telephone: (916) 552-8252 Fax: (916) 552-8260 Email: Carlos.Zavala@cdph.ca.gov</p>	<p>Department of Health Care Services John Zapata, Contract Officer Telephone: (916) 552-9451 Fax: (916) 552-9477 Email: John.Zapata@dhcs.ca.gov</p>
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B. Direct all inquiries to:

<p>California Department of Public Health Refugee Health Section Attention: Beatrice Avis Mail Stop 5204 1616 Capitol Avenue P.O. Box 997377 Sacramento, CA 95899-7377</p> <p>Telephone: (916) 552-8009 Fax: (916) 552-8260 Email: Beatrice.Avis@cdph.ca.gov</p>	<p>Department of Health Care Services Medi-Cal Policy Division Administrative Support Unit Attention: Dalia Gouveia 1501 Capitol Avenue, MS 4612 P.O. Box 997413 Sacramento, CA 95899-7413</p> <p>Telephone: (916) 552-9599 Fax: (916) 552-9141 Email: Dalia.Gouveia@dhcs.ca.gov</p>
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C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this agreement.

3. Services to be Performed

A. DHCS shall reimburse healthcare providers, health/mental health agencies, fee-for-service providers, hospitals, county clinics, community clinics and other health and mental health providers, etc., for services provided to beneficiaries eligible for Refugee Medical Assistance (RMA), pursuant to the policies and procedures contained in the Medi-Cal Provider Manual, which can be accessed at the following DHCS link: http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp.

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B. All new eligible entrants must be determined ineligible for California Opportunity and Responsibility to Kids (CalWORKS), Healthy Families, Supplemental Security Income/State Supplementary Payment-based Medi-Cal or Medi-Cal only before they can be placed in RMA-based Medi-Cal. County Welfare Departments will determine eligibility based on guidelines provided by the Medi-Cal Eligibility Division (MCED) within DHCS. RMA benefits are time limited to eight months.

C. The DHCS/MCED shall:

1. Have oversight of the eligibility requirements of the Refugee Medical Assistance/Entrant Medical Assistance (RMA/EMA) Program.
2. Prepare All County Welfare Directors Letters to instruct counties on RMA/EMA requirements and procedures, as needed to address eligibility issues, changes or adjustments to federal regulations governing use of RMA, etc.
3. Prepare state regulations as needed.
4. Prepare any correspondence regarding RMA/EMA program eligibility requirements in response to inquiries from the federal Office of Refugee Resettlement (ORR), other states, local welfare departments, local health departments, etc., providing copies of such documents to the CDPH, Refugee Health Section (RHS) and the California Department of Social Services, Refugee Programs Bureau (CDSS/RPB).
5. Contribute to updating the annual State Refugee Plan with regard to RMA/EMA eligibility rules as needed.
6. Respond to county calls or other phone inquiries regarding RMA/EMA eligibility requirements.
7. Conduct annual RMA case monitoring/reviews on a sample basis in selected counties with large, medium, and small RMA population, to ensure compliance with RMA program rules and eligibility criteria. Prepare/submit a report to CDPH/RHS describing any county compliance issues, including corrective actions taken or planned to correct the issues identified. This activity requires onsite visits to counties and involves in-state travel.
8. Notify and collaborate with CDPH/RHS to resolve eligibility issues identified during RMA case reviews.
9. Respond to and resolve issues pertaining to RMA benefits irregularities identified by CDPH/RHS during monthly RMA beneficiary data reviews.
10. Implement enhancements to the DHCS Medi-Cal Eligibility Data System (MEDS) as needed to address changes in RMA eligibility requirements, changes in ORR regulations, and to obtain MEDS data for reporting purposes.
11. Provide to CDPH/RHS the most current available RMA enrollee data for reporting purposes. Data is due to CDHP/RHS as follows:

1st trimester (October, November, December, and January) due on February 10;

2nd trimester (February, March, April, and May) due on June 10;

3rd trimester (June, July, August, and September) due on October 10.

Exhibit A Scope of Work

12. Provide training on RMA/EMA program eligibility requirements to local welfare departments staffs as needed. This activity requires in-state travel.
13. Participate in Refugee Health Program in-service trainings, workgroup meetings, etc., as requested by CDPH/RHS, to provide RMA eligibility updates to county refugee health coordinators. This activity requires in-state travel.

D. The DHCS shall:

1. Process and pay RMA claims for RMA covered services.
2. Pay administrative fees for claims processing for RMA-based claims.
3. Provide technical assistance for problems relating to the RMA-based claims.
4. Process and pay RMA-based claims from Department of Mental Health and Department of Developmental Services.
5. Provide CDPH/RHS annual cost projections for RMA claims and appropriate administrative charges including proper detailed justifications for RMA Program Estimates. Projections are due to CDPH/RHS on August 1st of each year.
6. Immediately notify CDPH/RHS of any anticipated increases in annual cost projections that will exceed what is reported in the program estimates for any given federal fiscal year.

E. Funding Agency Responsibilities

The CDPH shall:

1. Reimburse DHCS for costs associated with the provision of health services to eligible new entrants. These costs shall include costs for all RMA claims; and RMA-related claims from the Department of Mental Health and Department of Developmental Services.
2. Reimburse DHCS for claims processing fees and other claims processing costs.
3. Reimburse DHCS for administrative costs associated with the oversight and monitoring of the RMA/EMA Program.
4. Reimburse DHCS for costs associated with implementation of enhancements to the MEDS.

The CDPH/RHS shall:

5. Process all RMA based claims received from DHCS and submit to CDPH accounting for payment.
6. Coordinate with the DHCS and CDPH accounting sections in the preparation of quarterly and annual financial status reports ensuring accuracy of expenditures prior to timely submissions to ORR.

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Scope of Work

7. Inform DHCS (MCED and Fiscal Forecasting) about any significant increases in RMA caseload in a given federal fiscal year.
8. Inform the DHCS/MCED about any pertinent meetings, information, publications, issues, legislation, and correspondence relating to the RMA/EMA program and/or refugees in California.

4. Information Sharing and Liaison

- A.** Each Department shall appoint a liaison to act in a monitoring capacity throughout the term of this Agreement.
- B.** DHCS/MCED and CDPH/RHS will share information and work together to assist each other in meeting the goals of the Refugee Resettlement Program and the Refugee Medical Assistance/Entrant Medical Assistance Program.

Exhibit B, Attachment I
 Budget
 Year 1
 (07/01/12 through 06/30/13)

Personnel

<u>Position Title and Number of each</u>	<u>Monthly Salary</u>	<u>FTE %</u>	<u>Annual Cost</u>
Staff Services Manager III (1)	\$ 7,474	10%	\$ 8,969
Staff Services Manager I (1)	\$ 6,127	25%	\$ 18,381
Associate Governmental Program Analyst (1)	\$ 5,348	100%	\$ 64,176

Subtotal Personnel \$ 91,526

Fringe Benefits (40.653% of Personnel) \$ 37,208

Total Personnel and Fringe Benefits \$ 128,734

Operating Expenses

General Expense (supplies, copying, etc.)	\$ 3,000
Communications (state standard cost for 1.35 FTE)	\$ 1,620
Facilities Operations (state standard cost for 1.35 FTE)	\$ 13,500
Consolidated Data Center (state standard cost for 1.35 FTE)	\$ 405

Total Operating Expenses \$ 18,525

Travel (conducts in-state audits and provides in-service training to counties) \$ 14,168

Other Costs

- RMA claims paid to health plans, fee-for service providers, county clinics, etc. \$8,423,524
- Department of Mental Health Services* \$ 143,388
- Department of Developmental Services* \$ 1,174,179
- Enhancements to MEDS \$ 20,000

Total Other Costs \$ 9,761,091

Total Direct Costs \$ 9,922,518

Indirect Costs (18.7% of Total Personnel and Fringe Benefits) \$ 24,073

Total Budget \$ 9,946,591

*To process and pay RMA-based claims for mental health and developmental services provided to refugees.

Support - \$185,500
 Local Assistance - \$9,761,091

Exhibit B, Attachment II
 Budget
 Year 2
 (07/01/13 through 06/30/14)

Personnel

<u>Position Title and Number of each</u>	<u>Monthly Salary</u>	<u>FTE %</u>	<u>Annual Cost</u>
Staff Services Manager III (1)	\$ 7,474	10%	\$ 8,969
Staff Services Manager I (1)	\$ 6,127	25%	\$ 18,381
Associate Governmental Program Analyst (1)	\$ 5,348	100%	\$ 64,176

Subtotal Personnel \$ 91,526

Fringe Benefits (40.653% of Personnel)

\$ 37,208

Total Personnel and Fringe Benefits \$ 128,734

Operating Expenses

General Expense (supplies, copying, etc.)	\$ 3,000
Communications (state standard cost for 1.35 FTE)	\$ 1,620
Facilities Operations (state standard cost for 1.35 FTE)	\$ 13,500
Consolidated Data Center (state standard cost for 1.35 FTE)	\$ 405

Total Operating Expenses \$ 18,525

Travel (conducts in-state audits and provides in-service training to counties)

\$ 14,168

Other Costs

- RMA claims paid to health plans, fee-for service providers, county clinics, etc. \$ 8,423,524
- Department of Mental Health Services* \$ 143,388
- Department of Developmental Services* \$ 1,174,179
- Enhancements to MEDS \$ 20,000

Total Other Costs \$ 9,761,091

Total Direct Costs \$ 9,922,518

Indirect Costs (18.7% of Total Personnel and Fringe Benefits)

\$ 24,073

Total Budget \$ 9,946,591

*To process and pay RMA-based claims for mental health and developmental services provided to refugees.

Support - \$185,500
 Local Assistance - \$9,761,091

Exhibit B
 Budget, Attachment III
 Year 3
 (07/01/14 through 06/30/15)

Personnel

<u>Position Title and Number of each</u>	<u>Monthly Salary</u>	<u>FTE %</u>	<u>Annual Cost</u>
Staff Services Manager III (1)	\$ 7,474	10%	\$ 8,969
Staff Services Manager I (1)	\$ 6,127	25%	\$ 18,381
Associate Governmental Program Analyst (1)	\$ 5,348	100%	\$ 64,176

Subtotal Personnel \$ 91,526

Fringe Benefits (40.653% of Personnel)

\$ 37,208

Total Personnel and Fringe Benefits \$ 128,734

Operating Expenses

General Expense (supplies, copying, etc.)	\$ 3,000
Communications (state standard cost for 1.35 FTE)	\$ 1,620
Facilities Operations (state standard cost for 1.35 FTE)	\$ 13,500
Consolidated Data Center (state standard cost for 1.35 FTE)	\$ 405

Total Operating Expenses \$ 18,525

Travel (conducts in-state audits and provides in-service training to counties)

\$ 14,168

Other Costs

- RMA claims paid to health plans, fee-for service providers, county clinics, etc. \$ 8,423,524
- Department of Mental Health Services* \$ 143,388
- Department of Developmental Services* \$ 1,174,179
- Enhancements to MEDS \$ 20,000

Total Other Costs \$ 9,761,091

Total Direct Costs \$ 9,922,518

Indirect Costs (18.7% of Total Personnel and Fringe Benefits)

\$ 24,073

Total Budget \$ 9,946,591

*To process and pay RMA-based claims for mental health and developmental services provided to refugees.

Support - \$185,500
 Local Assistance - \$9,761,091

Exhibit B
 Budget, Attachment IV
 Year 4
 (07/01/15 through 06/30/16)

Personnel

<u>Position Title and Number of each</u>	<u>Monthly Salary</u>	<u>FTE %</u>	<u>Annual Cost</u>
Staff Services Manager III (1)	\$ 7,474	10%	\$ 8,969
Staff Services Manager I (1)	\$ 6,127	25%	\$ 18,381
Associate Governmental Program Analyst (1)	\$ 5,348	100%	\$ 64,176

Subtotal Personnel \$ 91,526

Fringe Benefits (40.653% of Personnel)

\$ 37,208

Total Personnel and Fringe Benefits \$ 128,734

Operating Expenses

General Expense (supplies, copying, etc.)	\$ 3,000
Communications (state standard cost for 1.35 FTE)	\$ 1,620
Facilities Operations (state standard cost for 1.35 FTE)	\$ 13,500
Consolidated Data Center (state standard cost for 1.35 FTE)	\$ 405

Total Operating Expenses \$ 18,525

Travel (conducts in-state audits and provides in-service training to counties)

\$ 14,168

Other Costs

- RMA claims paid to health plans, fee-for service providers, county clinics, etc. \$ 8,423,524
- Department of Mental Health Services* \$ 143,388
- Department of Developmental Services* \$ 1,174,179
- Enhancements to MEDS \$ 20,000

Total Other Costs \$ 9,761,091

Total Direct Costs \$ 9,922,518

Indirect Costs (18.7% of Total Personnel and Fringe Benefits)

\$ 24,073

Total Budget \$ 9,946,591

*To process and pay RMA-based claims for mental health and developmental services provided to refugees.

Support - \$185,500
 Local Assistance - \$9,761,091

Exhibit B
 Budget, Attachment V
 Year 5
 (07/01/16 through 06/30/17)

Personnel

<u>Position Title and Number of each</u>	<u>Monthly Salary</u>	<u>FTE %</u>	<u>Annual Cost</u>
Staff Services Manager III (1)	\$ 7,474	10%	\$ 8,969
Staff Services Manager I (1)	\$ 6,127	25%	\$ 18,381
Associate Governmental Program Analyst (1)	\$ 5,348	100%	\$ 64,176

Subtotal Personnel \$ 91,526

Fringe Benefits (40.653% of Personnel)

\$ 37,208

Total Personnel and Fringe Benefits \$ 128,734

Operating Expenses

General Expense (supplies, copying, etc.)	\$ 3,000
Communications (state standard cost for 1.35 FTE)	\$ 1,620
Facilities Operations (state standard cost for 1.35 FTE)	\$ 13,500
Consolidated Data Center (state standard cost for 1.35 FTE)	\$ 405

Total Operating Expenses \$ 18,525

Travel (conducts in-state audits and provides in-service training to counties)

\$ 14,168

Other Costs

- RMA claims paid to health plans, fee-for service providers, county clinics, etc. \$ 8,423,524
- Department of Mental Health Services* \$ 143,388
- Department of Developmental Services* \$ 1,174,179
- Enhancements to MEDS \$ 20,000

Total Other Costs \$ 9,761,091

Total Direct Costs \$ 9,922,518

Indirect Costs (18.7% of Total Personnel and Fringe Benefits)

\$ 24,073

Total Budget \$ 9,946,591

*To process and pay RMA-based claims for mental health and developmental services provided to refugees.

Support - \$185,500
 Local Assistance - \$9,761,091



California Refugee Health Assessment

1. Identification

Alien Number
or VOT HHS Tracking Number

Demographic Data

Case Number

County Medical Record Number

Last Name

First Name

Male Female

Date of Birth (MM/DD/YYYY)

Age at Arrival

Email

Current Address

Contact Phone Numbers

Street

Apartment #

Home

City

ZIP Code

Cell

2. Arrival Data

Entry Status

Is a copy of I-94 in file? Yes Not applicable

Refugee

Asylee

Parolee

Victim of trafficking

Other

U.S. Arrival Date (I-94)
(MM/DD/YYYY)

U.S. Arrival /
Adjudication Date
(MM/DD/YYYY)

Paroled Date
(MM/DD/YYYY)

Certification Date
(MM/DD/YYYY)

U.S. Arrival Date
(MM/DD/YYYY)

Primary
 Secondary to State

Inside U.S.
 Outside U.S.

Cuba
 Haiti

Special Immigrant
Visa
 Amerasian
 Other

Specify State

Date to CA
(MM/DD/YYYY)

Voluntary Resettlement Agency Information

Voluntary Resettlement Agency Name

County

No Voluntary Agency

City

State

ZIP Code

Medi-Cal

Has Medi-Cal? Yes Pending No

Medi-Cal Number

Application Date (MM/DD/YYYY)

Reason

Interpreter

Was an interpreter used? Yes No

If yes, what type

In-Person Video
 Phone Other

3. Demographics

Country of Birth and Ethnicity		Languages		
Country of Birth _____	Ethnicity _____	Primary _____		
Education and Occupation		Secondary _____		
Not applicable <input type="checkbox"/>				
Years of Education _____	Previous or Current Occupation _____			
Residing Country Prior to U.S. (last 2 years)				
Not applicable <input type="checkbox"/>				
Country (most recent first)	Refugee Camp (if applicable)	Length of stay		
		Years	Months	Days

4. Assessment Disposition

Assessment Status	
<input type="checkbox"/> Started <u> / / </u> Date Started (MM/DD/YYYY)	<input type="checkbox"/> Not started Reason:
<input type="checkbox"/> Fully completed <input type="checkbox"/> Partially completed Reason:	<input type="checkbox"/> Used other provider <input type="checkbox"/> Moved to _____ <input type="checkbox"/> Unable to locate <input type="checkbox"/> Declined <input type="checkbox"/> Medi-Cal eligibility issue _____ <input type="checkbox"/> Deceased <input type="checkbox"/> Did not keep appointment <input type="checkbox"/> Other _____
<input type="checkbox"/> Used other provider <input type="checkbox"/> Moved to _____ <input type="checkbox"/> Unable to locate <input type="checkbox"/> Declined	<input type="checkbox"/> Medi-Cal eligibility issue _____ <input type="checkbox"/> Deceased <input type="checkbox"/> Did not keep appointment <input type="checkbox"/> Other _____

5. Overseas Medical Exam (DS-2053 or DS-2054)

Form DS-2053 or DS-2054	
DS-2053 or DS-2054 Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> Not available <input type="checkbox"/> Not applicable	
Classifications	
<input type="checkbox"/> No apparent defect, disease, or disability	
Class A Conditions (Check all that apply) <input type="checkbox"/> TB, active, infectious <input type="checkbox"/> Syphilis, untreated <input type="checkbox"/> Chancroid, untreated <input type="checkbox"/> Gonorrhea, untreated <input type="checkbox"/> Granuloma inguinale, untreated <input type="checkbox"/> Lymphogranuloma venereum, untreated <input type="checkbox"/> Hansen's disease, lepromatous or multibacillary <input type="checkbox"/> Addiction or abuse of specific substance without harmful behavior <input type="checkbox"/> Any physical or mental disorder with harmful behavior or history of such behavior likely to recur	Class B Conditions (Check all that apply) <input type="checkbox"/> TB, active, noninfectious <input type="checkbox"/> TB, inactive <input type="checkbox"/> Syphilis (with residual deficit), treated within the last year <input type="checkbox"/> Other sexually transmitted infections, treated within last year <input type="checkbox"/> Current pregnancy <input type="checkbox"/> Hansen's disease, prior treatment <input type="checkbox"/> Hansen's disease, tuberculoid, borderline, or paucibacillary <input type="checkbox"/> Sustained, full remission of addiction or abuse of specific substances <input type="checkbox"/> Any physical or mental disorder with harmful behavior or history of such behavior likely to recur <input type="checkbox"/> Other _____

6. Immunizations

	Overseas Immunization Status					Updated in RHAP Clinic				Referred Out	
	Completed	Not started	Series started	No records provided	Not applicable	Yes	No	Declined	Not applicable	Yes*	Not applicable
Diphtheria, Tetanus, and Pertussis (DPT/DTaP/DT/Tdap)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus (Td)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilus influenzae type b (Hib)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio (IPV/OPV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B (HBV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A (HAV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measles, Mumps, Rubella (MMR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicella (VAR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus (RV1/RV5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningococcal (MCV4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If referred out, where? _____

7. Tuberculosis

Overseas Chest X-Ray Findings

____/____/____ Normal Abnormal Not Available Not Applicable

X-Ray Date (MM/DD/YYYY)

U.S. IGRA

IGRA

____/____/____
Date Drawn (MM/DD/YYYY)

Results: + - Indeterminate
QFT _____IU

Results: + - Borderline
TSpot _____Spots

No IGRA

Reason:

Moved to _____

Lost to follow-up

Did not keep appointment

Declined

Deceased

TST Performed

Insufficient blood draw

Other _____

Tuberculosis (continued)

U.S. TST

TST Placed

____ / ____ / ____
Date Placed (MM/DD/YYYY)

____ / ____ / ____
Date Read (MM/DD/YYYY)

Results: + - _____ mm
Induration

Did not return for reading

No TST

Reason:

Moved to _____ Declined

Lost to follow-up Deceased

Did not keep appointment Other _____

IGRA performed

U.S. Chest X-Ray

U.S. Chest X-Ray Performed

____ / ____ / ____
Date (MM/DD/YYYY)

Result:

Normal

Abnormal (consistent with TB)

Abnormal (NOT consistent with TB)

Unavailable, reason _____

No U.S. Chest X-Ray Performed

Reason:

Moved to _____

Lost to follow-up

Did not keep appointment

Declined

Deceased

Pregnancy

Other _____

Disposition

Completed

Result:

TB Class 0 (No TB exposure, not infected)

TB Class I (TB exposure, no infection)

TB Class II (TB infection, no disease)

TB Class III (TB, clinically active)

TB Class IV (TB, not clinically active)

TB Class V (TB suspected, pending final diagnosis)

Reason for retaining TB V classification:

Moved to _____

Lost to follow-up

Work-up in progress

Deceased

Other _____

Not Completed

Reason:

Moved to _____

Lost to follow-up

Did not keep appointment

Declined

Deceased

Other _____

LTBI Treatment

LTBI Treatment

____ / ____ / ____
Started Date (MM/DD/YYYY)

____ / ____ / ____
Stopped Date (MM/DD/YYYY)

Reason LTBI treatment stopped:

Treatment completed

Moved to _____

Lost to follow-up

Did not keep appointment

Declined

Deceased

Active TB developed

Changed to outside provider

Adverse effect of medicine

Other _____

No LTBI Treatment

Reason:

Moved to _____

Lost to follow-up

Did not keep appointment

Declined

Deceased

Pregnancy

Changed to outside provider

Patient's age

Medical contraindication

Prior adequate treatment

Other _____

Comments

8. Laboratory Tests (Refer to RHAP protocol for specific guidelines)

If a lab test is not completed, provide reason in section 17.					
CBC with Differential	Hemoglobin	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Value _____	
	Hematocrit	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Value _____	
	Absolute Eosinophil Count	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Value _____	
Chlamydia		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not applicable	
Fecal Occult Blood		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not applicable	
Hepatitis B-Anti-HBc		<input type="checkbox"/> Reactive	<input type="checkbox"/> Non-reactive	<input type="checkbox"/> Not applicable	
Hepatitis B-Anti-HBs		<input type="checkbox"/> Reactive	<input type="checkbox"/> Non-reactive	<input type="checkbox"/> Not applicable	
Hepatitis B - HBsAg		<input type="checkbox"/> Reactive	<input type="checkbox"/> Non-reactive	<input type="checkbox"/> Not applicable	
Hepatitis C - Anti HCV		<input type="checkbox"/> Reactive	<input type="checkbox"/> Non-reactive	<input type="checkbox"/> Not applicable	
HIV		<input type="checkbox"/> Positive <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Negative	<input type="checkbox"/> Inconclusive	<input type="checkbox"/> Declined
Lipid Panel	Total Cholesterol	<input type="checkbox"/> Elevated	<input type="checkbox"/> Not elevated	<input type="checkbox"/> Not applicable	Value _____
<input type="checkbox"/> Random	HDL	<input type="checkbox"/> Elevated	<input type="checkbox"/> Not elevated	<input type="checkbox"/> Not applicable	Value _____
<input type="checkbox"/> Fasting	LDL	<input type="checkbox"/> Elevated	<input type="checkbox"/> Not elevated	<input type="checkbox"/> Not applicable	Value _____
	Triglycerides	<input type="checkbox"/> Elevated	<input type="checkbox"/> Not elevated	<input type="checkbox"/> Not applicable	Value _____
Malaria		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not applicable	
Pregnancy Test	<input type="checkbox"/> Urine <input type="checkbox"/> Serum	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not applicable	
		____ / ____ / ____ EDC Date (MM/DD/YYYY)			
Serum Glucose		<input type="checkbox"/> Elevated	<input type="checkbox"/> Not elevated	<input type="checkbox"/> Not applicable	Value _____
<input type="checkbox"/> Random					
<input type="checkbox"/> Fasting					
Serum Lead		<input type="checkbox"/> Elevated	<input type="checkbox"/> Not elevated	<input type="checkbox"/> Not applicable	Value _____
Syphilis VDRL or RPR		<input type="checkbox"/> Reactive*	<input type="checkbox"/> Nonreactive	<input type="checkbox"/> Not applicable	Value _____
*If Reactive, which test	<input type="checkbox"/> FTA-ABS <input type="checkbox"/> TPPA <input type="checkbox"/> TP-MHA	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not applicable	Value _____
Parasitic Infection	Value	Treated			
Stool Sample 1	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Yes <input type="checkbox"/> No - Reason: _____			
	Parasite 1 _____ Parasite 5 _____				
	Parasite 2 _____ Parasite 6 _____				
	Parasite 3 _____ Parasite 7 _____				
	Parasite 4 _____ Parasite 8 _____				
Stool Sample 2	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Yes <input type="checkbox"/> No - Reason: _____			
	Parasite 1 _____ Parasite 5 _____				
	Parasite 2 _____ Parasite 6 _____				
	Parasite 3 _____ Parasite 7 _____				
	Parasite 4 _____ Parasite 8 _____				
Serum Strongyloides	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No - Reason: _____			
Serum Schistosomiasis	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No - Reason: _____			

9. Patient Medical History

Medical Condition	No History	Check All that Apply	If applicable, what type(s)	Taking Medications for Condition
Allergies	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Anemia	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Cancer	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Cardiovascular Dz	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Hypertension	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Kidney Dz	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Liver Dz	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Lung Dz	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Mental/Emotional	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Stroke	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Surgery(ies)	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Thyroid Dz	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/> Current <input type="checkbox"/> Past		<input type="checkbox"/> Yes, specify <input type="checkbox"/> No

Supplements (Vitamins, Herbs, Etc.)

Are you taking supplements? Yes No

 If yes, supplements taken

Menstrual History Not applicable (pre-puberty)

Menstruating _____
 Date of LMP (MM/DD/YYYY)

Menopausal _____
 Age stopped menstruating

Pregnancy History Not applicable (pre-puberty)

 Gravida Para SAB TAB

Female Genital Cutting Declined

Female genital cutting Yes No
 Clitoridectomy Infibulation
 Excision Other _____

10. Family Medical History

Medical Condition	If applicable, what type(s)		
Cancer	<input type="checkbox"/> No history	Kidney Dz	<input type="checkbox"/> No history
<input type="checkbox"/> Mother		<input type="checkbox"/> Mother	
<input type="checkbox"/> Father		<input type="checkbox"/> Father	
<input type="checkbox"/> Maternal grandmother		<input type="checkbox"/> Maternal grandmother	
<input type="checkbox"/> Maternal grandfather		<input type="checkbox"/> Maternal grandfather	
<input type="checkbox"/> Paternal grandmother		<input type="checkbox"/> Paternal grandmother	
<input type="checkbox"/> Paternal grandfather		<input type="checkbox"/> Paternal grandfather	
<input type="checkbox"/> Sibling(s)		<input type="checkbox"/> Sibling(s)	
Cardiovascular Dz	<input type="checkbox"/> No history	Lung Dz	<input type="checkbox"/> No history
<input type="checkbox"/> Mother		<input type="checkbox"/> Mother	
<input type="checkbox"/> Father		<input type="checkbox"/> Father	
<input type="checkbox"/> Maternal grandmother		<input type="checkbox"/> Maternal grandmother	
<input type="checkbox"/> Maternal grandfather		<input type="checkbox"/> Maternal grandfather	
<input type="checkbox"/> Paternal grandmother		<input type="checkbox"/> Paternal grandmother	
<input type="checkbox"/> Paternal grandfather		<input type="checkbox"/> Paternal grandfather	
<input type="checkbox"/> Sibling(s)		<input type="checkbox"/> Sibling(s)	
Diabetes Mellitus	<input type="checkbox"/> No history	Mental/Emotional	<input type="checkbox"/> No history
<input type="checkbox"/> Mother		<input type="checkbox"/> Mother	
<input type="checkbox"/> Father		<input type="checkbox"/> Father	
<input type="checkbox"/> Maternal grandmother		<input type="checkbox"/> Maternal grandmother	
<input type="checkbox"/> Maternal grandfather		<input type="checkbox"/> Maternal grandfather	
<input type="checkbox"/> Paternal grandmother		<input type="checkbox"/> Paternal grandmother	
<input type="checkbox"/> Paternal grandfather		<input type="checkbox"/> Paternal grandfather	
<input type="checkbox"/> Sibling(s)		<input type="checkbox"/> Sibling(s)	
Hepatitis	<input type="checkbox"/> No history	Stroke	<input type="checkbox"/> No history
<input type="checkbox"/> Mother		<input type="checkbox"/> Mother	
<input type="checkbox"/> Father		<input type="checkbox"/> Father	
<input type="checkbox"/> Maternal grandmother		<input type="checkbox"/> Maternal grandmother	
<input type="checkbox"/> Maternal grandfather		<input type="checkbox"/> Maternal grandfather	
<input type="checkbox"/> Paternal grandmother		<input type="checkbox"/> Paternal grandmother	
<input type="checkbox"/> Paternal grandfather		<input type="checkbox"/> Paternal grandfather	
<input type="checkbox"/> Sibling(s)		<input type="checkbox"/> Sibling(s)	
High Cholesterol	<input type="checkbox"/> No history	Thyroid Dz	<input type="checkbox"/> No history
<input type="checkbox"/> Mother		<input type="checkbox"/> Mother	
<input type="checkbox"/> Father		<input type="checkbox"/> Father	
<input type="checkbox"/> Maternal grandmother		<input type="checkbox"/> Maternal grandmother	
<input type="checkbox"/> Maternal grandfather		<input type="checkbox"/> Maternal grandfather	
<input type="checkbox"/> Paternal grandmother		<input type="checkbox"/> Paternal grandmother	
<input type="checkbox"/> Paternal grandfather		<input type="checkbox"/> Paternal grandfather	
<input type="checkbox"/> Sibling(s)		<input type="checkbox"/> Sibling(s)	
Hypertension	<input type="checkbox"/> No history	Tuberculosis	<input type="checkbox"/> No history
<input type="checkbox"/> Mother		<input type="checkbox"/> Mother	
<input type="checkbox"/> Father		<input type="checkbox"/> Father	
<input type="checkbox"/> Maternal grandmother		<input type="checkbox"/> Maternal grandmother	
<input type="checkbox"/> Maternal grandfather		<input type="checkbox"/> Maternal grandfather	
<input type="checkbox"/> Paternal grandmother		<input type="checkbox"/> Paternal grandmother	
<input type="checkbox"/> Paternal grandfather		<input type="checkbox"/> Paternal grandfather	
<input type="checkbox"/> Sibling(s)		<input type="checkbox"/> Sibling(s)	

11. Lifestyle Assessment (13 years of age and older)

Health Behaviors	Declined to answer <input type="checkbox"/>	Not applicable <input type="checkbox"/>
Exercise		
During the last 30 days, did you exercise?	<input type="checkbox"/> Yes – Days per week _____ Minutes per day _____	<input type="checkbox"/> No
Smoking		
1. Have you ever smoked?	<input type="checkbox"/> Yes, age started _____	<input type="checkbox"/> No (skip to question 4)
2. Do you now smoke?	<input type="checkbox"/> Everyday	<input type="checkbox"/> Some days
	<input type="checkbox"/> No, age stopped _____	
3. On average, how many or how long do/did you smoke a day?	# of Cigarettes _____	# of Pipes _____
	# of Cigars _____	# of Other Tobacco _____
	# of minutes per day of Hookah, Shisha, Galyān, Narghile or Chillin _____	
4. Is smoking ever allowed inside your home?	<input type="checkbox"/> Yes, # of hours per day _____	<input type="checkbox"/> No
Alcohol		
1. During the past 30 days, have you had at least one alcoholic drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (skip questions 2 and 3)
2. During the past 30 days, how many days per month did you have at least one alcoholic drink?	# of Days/Month _____	
3. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?	# of Wine Drinks (3-5 oz) _____	# of Beer Drinks (10-12 oz or 1 bottle) _____
	# of Hard Liquor Drinks (1-1.5 oz) _____	
Health Education		
Was health education provided on health behaviors (exercise, diet/nutrition, smoking, and alcohol)?	<input type="checkbox"/> Yes –	<input type="checkbox"/> Written <input type="checkbox"/> Verbal
	<input type="checkbox"/> No	

12. Mental Health (16 years of age and older)

PTSD Screening Declined to answer Not applicable

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

	Yes	No
1. Have had nightmares about it or thought about it when you did not want to?	<input type="checkbox"/>	<input type="checkbox"/>
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	<input type="checkbox"/>	<input type="checkbox"/>
3. Were constantly on guard, watchful, or easily startled?	<input type="checkbox"/>	<input type="checkbox"/>
4. Felt numb or detached from others, activities, or your surroundings?	<input type="checkbox"/>	<input type="checkbox"/>

Generalized Anxiety Disorder Screening Declined to answer Not applicable

Over the past 2 weeks, how often have you been bothered by the following problems?

	Not at all (0)	Several days (1)	More than half of the days (2)	Nearly every day (3)
1. Feeling nervous, anxious or on edge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Depression Declined to answer Not applicable

Over the past 2 weeks, how often have you been bothered by the following problems?

	Not at all (0)	Several days (1)	More than half of the days (2)	Nearly every day (3)
1. Little interest or pleasure doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Traumatic Events (16 years of age and older)

Trauma Declined to answer Not applicable

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event tell me if: a) it *happened to you personally*, b) you *witnessed it happen to someone else*, c) you *learned about it happening to someone close to you*, d) it *doesn't apply to you*. Be sure to consider your entire life (growing up as well as adulthood) as I go through the list of events.

	Happened to me	Witnessed it	Learned about it	Doesn't apply
1. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb, land mine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war, forced labor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Sudden, violent death of a family member (for example, homicide, suicide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Serious injury, harm, or death you caused to someone else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Any other very stressful event or experience which caused you to experience intense fear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sudden move or loss of home and possessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Persecution Declined to answer Not applicable

Have you experienced any type of persecution? Yes No

If yes, check all that apply: Religious Political Ethnic Reproductive choices Military service escapee Other _____

16. Diagnosis

Findings				
<input type="checkbox"/> No overseas findings, and no U.S. findings.				
ICD10	Diagnosis	Findings	Follow-up	Date Seen by Outside Provider (optional)
		<input type="checkbox"/> Overseas findings <input type="checkbox"/> New, U.S. findings	<input type="checkbox"/> Problem addressed or treated at refugee clinic <input type="checkbox"/> Problem referred to primary care <input type="checkbox"/> Problem referred to specialty clinic <input type="checkbox"/> Problem referred to emergency care <input type="checkbox"/> Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	_____ Date (MM/DD/YYYY) <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Declined follow-up
		<input type="checkbox"/> Overseas findings <input type="checkbox"/> New, U.S. findings	<input type="checkbox"/> Problem addressed or treated at refugee clinic <input type="checkbox"/> Problem referred to primary care <input type="checkbox"/> Problem referred to specialty clinic <input type="checkbox"/> Problem referred to emergency care <input type="checkbox"/> Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	_____ Date (MM/DD/YYYY) <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Declined follow-up
		<input type="checkbox"/> Overseas findings <input type="checkbox"/> New, U.S. findings	<input type="checkbox"/> Problem addressed or treated at refugee clinic <input type="checkbox"/> Problem referred to primary care <input type="checkbox"/> Problem referred to specialty clinic <input type="checkbox"/> Problem referred to emergency care <input type="checkbox"/> Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	_____ Date (MM/DD/YYYY) <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Declined follow-up
		<input type="checkbox"/> Overseas findings <input type="checkbox"/> New, U.S. findings	<input type="checkbox"/> Problem addressed or treated at refugee clinic <input type="checkbox"/> Problem referred to primary care <input type="checkbox"/> Problem referred to specialty clinic <input type="checkbox"/> Problem referred to emergency care <input type="checkbox"/> Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	_____ Date (MM/DD/YYYY) <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Declined follow-up
		<input type="checkbox"/> Overseas findings <input type="checkbox"/> New, U.S. findings	<input type="checkbox"/> Problem addressed or treated at refugee clinic <input type="checkbox"/> Problem referred to primary care <input type="checkbox"/> Problem referred to specialty clinic <input type="checkbox"/> Problem referred to emergency care <input type="checkbox"/> Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	_____ Date (MM/DD/YYYY) <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Declined follow-up
		<input type="checkbox"/> Overseas findings <input type="checkbox"/> New, U.S. findings	<input type="checkbox"/> Problem addressed or treated at refugee clinic <input type="checkbox"/> Problem referred to primary care <input type="checkbox"/> Problem referred to specialty clinic <input type="checkbox"/> Problem referred to emergency care <input type="checkbox"/> Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	_____ Date (MM/DD/YYYY) <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Declined follow-up
		<input type="checkbox"/> Overseas findings <input type="checkbox"/> New, U.S. findings	<input type="checkbox"/> Problem addressed or treated at refugee clinic <input type="checkbox"/> Problem referred to primary care <input type="checkbox"/> Problem referred to specialty clinic <input type="checkbox"/> Problem referred to emergency care <input type="checkbox"/> Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	_____ Date (MM/DD/YYYY) <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Declined follow-up
		<input type="checkbox"/> Overseas findings <input type="checkbox"/> New, U.S. findings	<input type="checkbox"/> Problem addressed or treated at refugee clinic <input type="checkbox"/> Problem referred to primary care <input type="checkbox"/> Problem referred to specialty clinic <input type="checkbox"/> Problem referred to emergency care <input type="checkbox"/> Follow-up for this problem not currently available under current medical insurance (such as optometry, dental, etc.)	_____ Date (MM/DD/YYYY) <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Declined follow-up
Is VOLAG follow-up assistance needed?				
<input type="checkbox"/> Yes <input type="checkbox"/> No				

17. Reason for Not Completing Recommended Lab Test

18. Signatures

Physical Exam Performed By		
_____ Name (print)	_____ Signature	____/____/____ Date (MM/DD/YYYY)
Physical Exam Reviewed By		
<input type="checkbox"/> Same as above		
_____ Name (print)	_____ Signature	____/____/____ Date (MM/DD/YYYY)
Intake Interviewer 1		
_____ Name (print)	_____ Signature	____/____/____ Date (MM/DD/YYYY)
Intake Interviewer 2		
_____ Name (print)	_____ Signature	____/____/____ Date (MM/DD/YYYY)
Other Provider		
_____ Name (print)	_____ Signature	____/____/____ Date (MM/DD/YYYY)
_____ Role		

19. Notice of Privacy Practices Certification

I certify that a CDPH, Refugee Health Program Notice of Privacy Practices brochure was given to the client.

_____ Name (print)	_____ Signature	____/____/____ Date (MM/DD/YYYY)
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2012/2013 California State Plan for Refugee/Entrant Assistance and Services

Refugee Cash Assistance Requirements
and

California Department of Social Services Manual of Policies and Procedures (MPP)

SUBJECT	MPP SECTION
State will use the hearings standards and procedures as set forth in 45 CFR Section 400.83(b)	69-210 – Notices and Hearings (MPP Sections 69-200 through 69-306 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/spman.pdf)
Describe the elements of the TANF program which will be used in the RCA program. Determination of initial and on-going eligibility treatment of income and resources, budgeting methods, need standards. (45 CFR Section 400.66(a)(1)) Determination of benefit amounts/payment levels based on size of the assistance unit, income disregards. (45 CFR Section 400.66(a)(2)) Proration of shelter, utilities, and similar needs. (45 CFR Section 400.66(a)(3)) Any other State TANF rules relating to financial eligibility and payments. (45 CFR Section 400.66(a)(4))	69-206 – Income and Resources (MPP Sections 69-200 through 69-306 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/spman.pdf) 42-200 – Property (MPP Section 42-200 through 42-223 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/eas4.PDF and http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/5EAS.pdf) 44-100 - Income (MPP Section 44-100 through 44-133 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/10EAS.pdf) 44-200 – Assistance Unit Composition and Need (MPP Section 44-200 through 44-212 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/11EAS.pdf) 44-300 – Aid Payments (MPP Section 44-300 through 44-355 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/12EAS.pdf and http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/12EASa.pdf)
Will not consider resources remaining in the applicant’s country of origin. (45 CFR Section 400.66(b))	69-206.21 (MPP Sections 69-200 through 69-306 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/spman.pdf)
Will not consider a sponsor’s income and resources as accessible to the refugee solely because the person is serving as a sponsor. (45 CFR Section 400.66(c))	69-206.2 (MPP Sections 69-200 through 69-306 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/spman.pdf)
Will not consider any cash grant received by the applicant under the DOS or DOJ R and P program (45 CFR Section 400.66(d))	69-206.11 (MPP Sections 69-200 through 69-306 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/spman.pdf)

2012/2013 California State Plan for Refugee/Entrant Assistance and Services

Refugee Cash Assistance Requirements
and

California Department of Social Services Manual of Policies and Procedures (MPP)

<p>Will use date of application as the date RCA begins. (45 CFR Section 400.66(e))</p>	<p>69-205.211 (MPP Sections 69-200 through 69-306 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/spman.pdf)</p>
<p>Implementation must begin by 3/21/2002</p>	<p>69-200 Regulations became effective 2/1/02 (MPP Sections 69-200 through 69-306 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/spman.pdf)</p>
<p>Describes the criteria for exemption from registration for employment services, participation in employability service programs, and acceptance of appropriate offers of employment.</p>	<p>69-207.3 – Refugees Exempt from Registration, Employment and Employment-Directed Education/Training Requirements (MPP Sections 69-200 through 69-306 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/spman.pdf)</p>
<p>State will notify promptly local resettlement agency whenever refugee applies for RCA. (45 CFR Section 400.68(a))</p>	<p>69-203.2 – County Responsibilities (MPP Sections 69-200 through 69-306 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/spman.pdf)</p>
<p>State will contact applicant’s sponsor or local resettlement agency at time of application for RCA concerning offers of employment, etc. (45 CFR Section 400.68(b))</p>	<p>69-203.2 – County Responsibilities (MPP Sections 69-200 through 69-306 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/spman.pdf)</p>
<p>Describes safeguards for limited English proficient persons as required by 45 CFR Section 400.55</p>	<p>21-115 – Provisions for Services to Applicants and Recipients Who Are Non-English Speaking or Who Have Disabilities (MPP Sections 21-100 through 21-205 can be found at http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/3cfcman.pdf)</p>

CALIFORNIA STATE PLAN FOR REFUGEE/ENTRANT
ASSISTANCE AND SERVICES
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
MEDI-CAL ELIGIBILITY PROCEDURES MANUAL *ARTICLE 24*

ORR REQUIREMENT	MEPM SECTION
The state will base RMA/EMA on the applicant's income and resources on the date of application.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(4)
The state will use the 200 percent poverty option as an eligibility standard for RMA/EMA.	Article 24B-3, Section 2. RMA/EMA Eligibility Requirements, a.(2) and (3)
The state will allow refugees who do not meet the financial eligibility standards for RMA/EMA to spend down as is done for Medi-Cal.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(6)
The state will determine eligibility for RMA/EMA applicants as individuals and not as a family or assistance unit.	Article 24B-3, Section 2. RMA/EMA Eligibility Requirements, a.(1)
The state will not count the Reception and Placement grant, matching grant, or RCA when determining RMA/EMA eligibility on the date of application.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(5)
The state will not count any property remaining in the refugee's country of origin.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(5)
The state will not count any income earned after the date of application.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(4)
The state will not consider in-kind services and shelter provided by a sponsor or local resettlement agency when determining eligibility for RMA/EMA.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(5)
The state must comply with regulations governing applications, determination of eligibility and furnishing Medicaid (including opportunity for fair hearings).	Title 22, California Code of Regulations, Section 50257(b)(2); Article 24B-11, Section 9. Notice of Action
Notify the agency which provided for the initial resettlement of a refugee whenever the refugee applies for medical assistance.	Article 24B-5, Section 4. Resettlement Agency Identification
The state will transfer clients who lose eligibility for Medi-Cal due to employment during their first 8 months in the U.S. to RMA/EMA without an eligibility determination.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(9) and (10)
The state will not use denial or termination from RCA as criterion for eligibility for RMA/EMA.	Article 24B-4, Section 2. RMA/EMA Eligibility Requirements, a.(9)

**CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
WELFARE TO WORK DIVISION**

**Continuity of Government/Continuity of Operations (COG/COOP) Plan
Disaster Management Procedures – Pandemic Flu Preparation**

Task-Event/Activity	Responsible Team Member	Detail or Reference
Maintain telephone trees	WTW Management Team	Each manager responsible for his/her staff.
Conference Call Capability	WTW Management Team	Obtain conference call lines to be used as needed.
Dial-Up Access	WTW Branch Chiefs	If Dial-Up PC access becomes necessary, Branch Chiefs would work with managers to determine who needs access. ISD would then be requested to set up accounts.
Communication Plan for Stakeholders	WTW Deputy & Branch Chiefs	Inform stakeholders to refer to website for daily updates on issues. Branch Chiefs would review web content prior to posting.
Contact with Federal Government	WTW Deputy & Branch Chiefs	Keep federal officials informed of limitations by program and geographic area.
Request Waivers	WTW Management Team	If mandated program activities cannot be performed, e.g., face-to-face interviews, then waivers would be requested from federal entities.
Seek Executive Order	WTW Deputy Director	If State mandates cannot be carried out, e.g., fingerprint imaging, request an Executive Order to suspend mandate.
Alternative Operational Guidelines	WTW Management Team	Develop alternative program procedures for mandated activities that cannot be performed.

REFERENCES

Information by Government – U.S. Department of Health and Human Services
<http://www.pandemicflu.org>.

Pandemic Influenza Fact Sheet
<http://cdc.gov/flu/avian/gen-info/pandemics.htm>

California Department of Health Services
<http://www.dhs.ca.gov>

Governor's Office of Emergency Services
<http://www.oes.ca.gov>

World Health Organization
<http://www.who.org>

ACRONYMNS

ACIN -- All County Information Notice

ACL -- All County Letter

AREERA -- Agricultural Research, Extension and Education Reform Act

Cal EMA – California Emergency Management Agency

CalWORKs -- California Work Opportunity and Responsibility to Kids

CAPI -- Cash Assistance Program for Immigrants

CBO – Community-Based Organization

CDA -- California Department of Aging

CDDS -- California Department of Developmental Services

CDE -- California Department of Education

CDHCS – California Department of Health Care Services

CDMH -- California Department of Mental Health

CDPH – California Department of Public Health

CDSS – California Department of Social Services

CFR -- Code of Federal Regulations

COG – Continuity of Government

COOP – Continuity of Operations Plan

CRC – County Refugee Coordinator

CRHC – County Refugee Health Coordinator

CWD -- County Welfare Department

CWDA -- County Welfare Directors Association

DCDC – Division of Communicable Disease Control

DOJ -- Department of Justice

DOS -- Department of State

ECA -- Entrant Cash Assistance

EPO -- Office of Emergency Preparedness

ESL -- English-as-a-Second Language

FFP -- Federal Financial Participation

FFY -- Federal Fiscal Year

FSP -- Food Stamps Program

GA/GR -- General Assistance/General Relief

HFP -- Healthy Families Program

HHSA -- Health and Human Services Agency

JVCC -- Joint Voluntary Agencies Committee of California

LEP -- Limited English Proficient

MAA -- Mutual Assistance Association

MAP -- Maximum Aid Payment

MBSAC -- Minimum Basic Standard of Adequate Care

MEB -- Medical Eligibility Branch

MEDS -- Medi-Cal Eligibility Data System

MPP -- Manual of Policies and Procedures

OES -- Office of Emergency Services

ORR -- Office of Refugee Resettlement

PIPRP -- Pandemic Influenza Preparedness and Response Plan

PIWG -- Pandemic Influenza Work Group

PRWORA -- Personal Responsibility and Work Opportunity Reconciliation Act

R&P -- Reception and Placement

RCA -- Refugee Cash Assistance

RHA -- Refugee Health Assessment

RHEIS -- Refugee Health Electronic Information System

RHS – Refugee Health Section

RMA -- Refugee Medical Assistance

RPHDG -- Refugee Preventive Health Discretionary Grant

RPB – Refugee Programs Bureau

RRP -- Refugee Resettlement Program

RSS -- Refugee Social Services

SAC – State Advisory Council on Refugee Assistance and Services

SNAP – Supplemental Nutrition Assistance Program

SSA - Social Security Act

SSI/SSP -- Supplemental Security Income/State Supplementary Payment

TA -- Targeted Assistance

TANF -- Temporary Assistance to Needy Families

TB -- Tuberculosis

URM -- Unaccompanied Refugee Minors Program

U.S. -- United States

VOLAG – Voluntary Agency

W&I Code -- Welfare and Institutions Code

WTW – Welfare to Work