

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Health Resources and Services Administration**

HIV/AIDS Bureau  
Special Projects of National Significance Program

***Building a Medical Home for Multiply Diagnosed HIV positive Homeless  
Populations – Demonstration Sites***

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**FUNDING OPPORTUNITY ANNOUNCEMENT**

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# I. Funding Opportunity Description

## 1. Purpose

This funding opportunity announcement solicits applications for a new Special Project of National Significance (SPNS) multi-site initiative entitled *Building a Medical Home for Multiply Diagnosed HIV positive Homeless Populations – Demonstration Sites*. This initiative will award funds for up to five years to support organizations that will design, implement and evaluate innovative interventions to improve timely entry, engagement and retention in HIV care and supportive services for HIV positive homeless populations. The interventions are expected to implement models of care that build and maintain sustainable linkages to mental health, substance abuse treatment and HIV/AIDS primary care services to HIV positive individuals who are homeless or unstably housed. Funding for an evaluation and technical assistance center to coordinate the initiative will be made available under a separate announcement (HRSA-12-104).

Successful applicant organizations will implement and evaluate demonstration models of care for supporting homeless and unstably housed people living with HIV and co-occurring mental illness and substance use disorders. The purpose of all Ryan White HIV/AIDS Program funds is to ensure that eligible HIV-infected persons and families gain or maintain access to medical care. Given the transient and unstable lives of HIV infected homeless with co-occurring mental health or substance use disorders, it is important to strategically coordinate efforts to engage and retain individuals in care that meet their complex service needs and ensure adherence to treatment. The HIV/AIDS Bureau (HAB) is recommending demonstration site applicants under this initiative adopt a set of organizational structures characterized as having integrated or co-located strategies for service provision. In addition, demonstration site organizations will be expected to provide intensive coordination of care and service needs to ensure retention and adherence to care.

For the purposes of this initiative, integrated services will be broadly defined to include the management and delivery of HIV primary care, substance abuse and mental health treatment that assure homeless and unstably housed people living HIV receive a continuum of care according to their specific needs. In addition, successful applicants will be expected to include access to housing resources and services for their target population. This may be achieved through the co-location of services within an HIV primary care clinic; within a public housing facility that serves the target population or building a network of providers through the execution of memoranda of understanding or contracts. As such, the following section provides specific suggestions for the development of partnerships to improve the identification and coordination of HIV medical care and supportive services to meet the goals of this initiative. Eligible demonstration site applicants may adopt any of the following organizational structures described below.

- a. **Housing Partnership.** Applicants may choose to enter into a formal partnership with a U.S. Department of Housing and Urban Development (HUD) funded entity or housing assistance program to provide care and treatment to HIV positive homeless populations receiving services. It is not uncommon for health clinics to be located on-site in public housing developments or in homeless shelters, and it may be beneficial to offer supportive services, such as HIV medical care, mental

health or addictions counseling, on-site where housing is located. Refer to the HIV/AIDS Bureau's Housing Policy 11- 01 <sup>1</sup> for guidance on the allowable use of Ryan White program funds for housing referral services and short-term or emergency housing needs. HUD policy does not prevent Public Housing Authorities (PHA) or other grantees from voluntarily entering into agreements or contracts with health care, education and social service organizations to lease community space or other non-dwelling space to make services available at these housing sites.<sup>2</sup>

- b. System of Networked Services.** Effective partnership development begins with a mutual understanding of and agreement upon a clearly articulated division of roles, responsibilities, and expectations between partnering agencies. Applicants may develop a network of providers that will link the target population to primary care, substance abuse and mental health treatment and HUD supported programs such as Housing Opportunities for Persons with AIDS (HOPWA), homeless assistance and public housing. To this end, contracts or memoranda of understanding (MOUs) can be created outlining the specifics of the collaboration and any data sharing agreements. Such agreements ensure continuity of the relationship and the services provided, protecting the collaboration from being eroded due to turnover of staff at either agency. MOUs are typically used for non-binding agreements that do not involve the transfer of funds, personnel, property or services, whereas contractual agreements are binding and do involve such a transfer. Strong mechanisms must be developed to ensure the integrity and continuity of the partnerships or networks developed in the event of leadership changes or staff turnover at partnering agencies. The lead agency would be responsible for ensuring that all partners are trained and familiar with the services available across the network. In addition, the lead organization must develop systems and instruments to ensure eligible clients can be connected to available services across the network.
- c. System of Networked Services with a Dedicated Continuum of Care Coordinator/Network Navigator.** In addition to the formal network described above, applicants would include a dedicated position for the purposes of navigating patients through the system. This Continuum of Care Coordinator or Network Navigator would be supervised by a case manager. Like a patient navigator, this person could work with the client to assure access to all services based upon the case manager's needs assessment. Unlike a patient navigator, this staff would work across agencies to assure access to services outside their home organization. They would be able to connect clients to these providers through accompaniment and/or transportation where necessary. For example, an individual working in a outpatient clinic would be able to connect a client to mental health services in a different

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<sup>1</sup> See HRSA HAB Policy Notice 11-01, available from:  
<http://hab.hrsa.gov/manageyourgrant/files/policy1101.pdf.pdf>

<sup>2</sup> See HUD Notice of Funding Announcement FR-5500-N-13: Housing Opportunities for Persons with AIDS, available from: <https://apply07.grants.gov/apply/UpdateOffer?id=55170>

agency, substance abuse treatment in yet another agency and available housing assistance providers in the service area.

### **Key Definitions**

For purposes of this announcement, the following definitions will be used to describe the study population for inclusion in the SPNS multi-site evaluation. However, programs are required to serve all people of any race, ethnicity, sexual orientation or gender identity. Funds awarded under this grant may not be used for direct services or for duplication of existing services, but rather to fund activities designed to engage and retain people in quality HIV care. Direct HIV care is funded by other sources, such as the Ryan White HIV/AIDS Programs.

**Homeless/Unstably Housed.** The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining “Homeless” Final Rule published in the Federal Register on December 5, 2011, integrates the regulation for the definition of “homeless.” Specifically, the study population of interest for this initiative includes

- Literally homeless: an individual who lacks a fixed, regular, and adequate nighttime residence
- Unstably Housed individuals who:
  - Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to a homeless assistance application;
  - Have experienced persistent housing instability as measured by two moves or more during the preceding 60 days; and
  - Can be expected to continue in such status for an extended period of time.
- Fleeing domestic violence: Any individual who:
  - Is fleeing, or is attempting to flee, domestic violence;
  - Has no other residence; and
  - Lacks the resources or support networks to obtain other permanent housing.

**Multiply Diagnosed.** An HIV positive individual with one or more of the following co-occurring illnesses:

- Mental Illness: any illness that significantly interferes with the performance of major life activities, such as learning, working and communicating, including, but not limited to:
  - Anxiety disorders such as post traumatic stress disorder; and
  - Mood disorders such as major depression, bipolar disorder and dysthymia.
- Substance Use: any use of illicit drugs or the abuse of alcohol, prescription or over-the-counter drugs for purposes other than those for which they are indicated or in a manner or in quantities other than directed.

### **Available Resources**

SPNS funds require applicants to leverage existing resources and foster collaboration with organizations currently serving the target population. Significant Federal funds are expended through multiple agencies to provide housing related assistance to people living with HIV/AIDS

(PLWH). The U.S. Department of Housing and Urban Development (HUD), the Veterans Administration and Bureau of Prisons are three of the lead entities in the implementation of several housing related activities as part of the National HIV AIDS Strategy (NHAS). The bulk of Federal housing related resources are awarded through HUD. Additional funding is provided under the Ryan White HIV/AIDS Programs, which funds primary care and supportive services—including housing-related expenses—for under-served individuals living with HIV/AIDS. The Substance Abuse and Mental Health Services Administration funded grants support the treatment and prevention mental disorders, as well as, substance abuse treatment and recovery services.

The following resources may be consulted in designing your intervention models and preparing your applications. This is not an exhaustive list of resources and applicants are encouraged to locate other sources of local, regional or national relevance.

#### *Housing Opportunities for Persons with AIDS*

<http://www.HUDHRE.info/hopwa>.

Agencies may benefit from partnerships with nonprofits that have experience meeting the complex needs of clients living with HIV/AIDS. Health fairs and offering clinics in public housing communities can also promote HIV testing, education, and referrals to nearby health agencies for more complex care and treatment.

#### *United States Interagency Council (USICH) on Homelessness*

[http://www.usich.gov/opening\\_doors](http://www.usich.gov/opening_doors)

The Open Doors is the nation's first comprehensive strategy to prevent and end homelessness. Opening Doors serves as a roadmap for joint action by the 19 USICH member agencies along with local and state partners in the public and private sectors. The Plan presents strategies building upon the lesson that mainstream housing, health, education, and human service programs must be fully engaged and coordinated to prevent and end homelessness.

#### *Community and Supportive Services Web Site*

[http://portal.hud.gov/hudportal/HUD?src=/program\\_offices/public\\_indian\\_housing/programs/ph/hope6/css/resources](http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/ph/hope6/css/resources)

HUD has developed this web site to provide a central location for continually updated links to news, research, reports, guidance, best practices, and other materials related to the provision of community and supportive services for HUD-assisted households. Applicants may use this resource to learn from other organizations that have developed partnerships to enhance the access of their program participants to community resources.

#### *Homelessness Resource Exchange*

An additional HUD web site, <http://www.HUDHRE.info>, provides extensive guidance on serving individuals and families who are homeless or at risk of homelessness. This web site features a variety of tools, including service locators, maps, program guidance, and resources for organizational capacity building to form effective community coalitions and increase program participants' access to mainstream services and supports.

*Homelessness Resource Center*

<http://www.nrchmi.samhsa.gov>

The Substance Abuse and Mental Health Services Administration (SAMHSA) may provide useful information in developing plans and partnerships to serve persons with substance abuse and mental health service needs.

*U.S. Department of Veterans Affairs*

<http://www.va.gov/healthbenefits/>

<http://www.va.gov/homeless/>

Applicants are encouraged to assist eligible homeless veterans in accessing available services to maximize the use of existing treatment resources. The VA health care system provides a broad spectrum of medical and rehabilitative care for veterans. The VA also founded a National Call Center for Veterans who are homeless or at risk of becoming homeless, that provides free, 24/7 access to trained counselors.

**Demonstration Site Program Requirements and Expectations**

Demonstration sites are expected to implement interventions designed to provide coordinated or integrated care for multiply-diagnosed HIV positive homeless individuals, and to participate in the evaluation of those interventions. Applicants must propose intervention models that provide a comprehensive continuum of quality HIV care and ancillary services, specifically mental health, substance abuse treatment and housing resources that are grounded and informed by recent findings in the research literature. The successful applicant will clearly demonstrate how the proposed intervention will lead to the development of a medical home for the target population.

Successful applicants will propose innovative and previously untested interventions with strategies to integrate mental health services and substance abuse treatment in the context of Ryan White HIV primary care for the HIV positive homeless and unstably housed populations with co-occurring mental illness and/or substance use issues. The intervention may involve the significant improvement of an existing model or the creation of a new model to provide coordinated and integrated care. These models will be evaluated for effectiveness in the implementation of real-world settings in addressing the complex care and treatment needs for homeless and unstably housed individuals living with HIV and co-occurring mental illness and/or substance use. Successful applicants will propose interventions that demonstrate potential replicability in other similar localities. Specifically, the proposed interventions should address the following:

- Intensive care coordination
- Building sustainable partnerships
- Engagement in quality HIV primary care
- Retention once engaged in quality HIV primary care, mental health and /or substance use treatment
- Increasing access to stable/permanent housing

Optimum patient care results when grantees are knowledgeable about and coordinate with all available and accessible community resources. These resources may include federally-funded and non-federally-funded programs, such as shelters, transitional housing, substance abuse treatment, mental health treatment and other supportive services. At a minimum, applicants are expected to establish a formal integrated system where HIV infected multiply-diagnosed homeless individuals may receive coordinated care. Coordinated, integrated care may be achieved through the co-location of services within a setting that specifically serves the target population; within a clinic setting; or a combination of the two. Applicants must refer to and adopt any of the models of coordinated care described in the previous section of this funding opportunity announcement. Successful applicants will be expected to maximize access to available resources, including collaborating with Community Health Centers and other publicly funded primary care services; mental health and substance abuse treatment services, including those funded by the Substance Abuse and Mental Health Services Administration (SAMHSA); and research programs, including those funded by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC).

The ETAC will develop and maintain a website with a data submission portal, exclusively for this initiative. Demonstration sites will be expected to provide requested materials for inclusion on the Initiative's website in a timely manner.

Demonstration sites will be expected to collect and report relevant quantitative and qualitative outcome, process and cost measures for their interventions. This data may include but is not limited to client demographic characteristics; biomedical and behavioral health indicators; utilization of core medical and support services such as substance abuse and mental health and housing assistance; barriers to accessing treatment and services; medication adherence measures; and other outcome measures as defined by the ETAC. Demonstration sites must also facilitate the collection and reporting of relevant process data relating to the implementation of their intervention to the ETAC.

In the spring of 2012, the Office of HIV/AIDS Policy (OHAP) of the Department of Health and Human Services will issue guidance requiring use of a standard set of metrics to assure consistent outcome evaluation for the National HIV/AIDS Strategy. To assure expeditious translation of research into practice, sites will be required to incorporate these data standards where appropriate for the project.

The ETAC will also provide technical assistance to the demonstration sites during regular teleconferences; through its website and webinars; during site visits; and at the twice-a-year national meetings. The ETAC also will lead publication and dissemination activities, in collaboration with the demonstration sites and SPNS Program staff. Applicants should carefully read the requirements for the Evaluation and Technical Assistance Center under Announcement Number HRSA-12-104 to better understand the requirements of the national, multi-site evaluation.

In addition to the multi-site evaluation, demonstration sites must cooperate with the ETAC to conduct focused evaluation studies of interest to the initiative. Specific topics will be generated by the ETAC in collaboration with the demonstration sites and the SPNS program. These

focused evaluation studies may include case studies, qualitative studies, and cost analysis or cost-effectiveness studies (if feasible). Demonstration sites must agree to participate in publication and dissemination of program findings and lessons learned in collaboration with the ETAC and SPNS staff. Demonstration sites may opt to include a local evaluation with outcome measures that demonstrate achievement of individual sites' program goals and objectives and the impact of the program.

The SPNS program seeks to fund innovative interventions that inform current practice and advance the evidence base for best practices. The SPNS program will not provide funding beyond the 5-year project period for interventions developed under this initiative. Where possible, demonstration sites will be expected to explore other potential sources of funding to sustain those models that were found to be effective. Applicants should include a preliminary plan to sustain funding for the programs developed beyond the 5-year term of the SPNS initiative.

Demonstration sites will participate in hosting, at a minimum, one annual site visit conducted by the ETAC and the SPNS program. The ETAC will convene and host two grantee meetings per year in the Washington, DC/Metropolitan area. Successful applicants will be expected to attend these meetings. Funds for up to three staff members to attend these 2- to 3-day meetings must be allocated in the proposed project budget. Participants in these meetings generally include the principal investigator/project director and any combination of the data manager, evaluator or other key staff person.

Demonstration sites will be required to participate with the ETAC in the development of an Intervention Manual to document the implementation methodology of their project for purposes of replication. The manual will include, at minimum, the following: 1) a description of the intervention, 2) a refined logic model of the intervention(s) that depict the theoretical basis of the intervention, goals and objectives and the relationship between the target population and desired outcome, and 3) key considerations and recommendations for other programs looking to replicate the model.

Successful applicants will be required to submit the multi-site evaluation plan, any proposed local evaluation plan, data collection instruments and other related studies to their respective Institutional Review Boards (IRBs) for review and approval. Demonstration sites will be required to submit to SPNS and to the ETAC proof of IRB initial approvals and subsequent renewals for all client-level data collection instruments, informed consents and evaluation materials. Demonstration sites also must ensure the privacy and confidentiality of patients' medical records and their health-seeking efforts. Demonstration sites will be expected to conform to the regulations for human subjects research protection set forth in the Code of Federal Regulations.<sup>3</sup> Therefore, the principal investigator/project director and all key project personnel should take the National Institutes of Health (NIH) online Human Subjects Research Protections training.<sup>4</sup> Applicants must have a written plan in place to safeguard patients' privacy

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<sup>3</sup> See Code of Federal Regulations, Title 45, Part 46 Protection of Human Subjects, Revised January 15, 2009 Effective July 14, 2009. Available from: <http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html>

<sup>4</sup> See <http://phrp.nihtraining.com/users/login.php>

and confidentiality, in accordance with HIPAA regulations and human subjects research protections. Applicants must demonstrate they have documented procedures for electronically and physically protecting the privacy of patient information and data. All client-level data to be collected by demonstration sites in the multi-state evaluation must be electronically maintained and electronically transmitted to the ETAC's web-based data collection system.

Successful applicants will have personnel with the necessary skills to communicate project findings and lessons learned to local communities, state and national conferences, and to policymakers, and to collaborate in writing and publishing findings in peer reviewed journals.

## 2. Background

The Special Projects of National Significance (SPNS) Program is authorized by Section 2691 of the Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87) referred hereafter as the Ryan White HIV/AIDS Program. The SPNS Program supports the development of innovative models of HIV care to quickly respond to the emerging needs of clients served by the Ryan White HIV/AIDS Programs. SPNS evaluates the effectiveness of these models' design, implementation, utilization, cost, and health related outcomes, while promoting the dissemination and replication of successful models.

According to the Centers for Disease Control and Prevention (CDC), national HIV incidence in the United States is now relatively stable.<sup>5</sup> However, as many as one third of those previously diagnosed and aware of their HIV infection remain out of care,<sup>6</sup> often for years.<sup>7</sup> Timely entry into HIV care post-diagnosis has been found to have a number of benefits, including decreased morbidity, mortality and infectiousness,<sup>8</sup> as well as exposure to effective secondary prevention efforts through cost-effective clinical interventions.<sup>9,10</sup> There are many reasons why HIV positive persons may delay entering care upon diagnosis, including structural, financial and personal/cultural barriers arising from racial, ethnic and gender disparities.<sup>11</sup> Continuous retention in care has benefits similar to those of timely entry, and a number of strategies have

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<sup>5</sup> Prejean J, Song R, Hernandez A, et al. Estimated HIV Incidence in the United States, 2006-2009. *PLoS ONE*. 2011; 6 (8): e17502. E-published August 3, 2011.

<sup>6</sup> Fleming PL, Byers RH, Sweeney PA, et al. HIV Prevalence in the United States, 2000. Presented at the 9th Conference on Retroviruses and Opportunistic Infections, February 24-28, 2002, Seattle, WA

<sup>7</sup> Samet JH, Freedberg KA, Savetsky JB, et al. Understanding delay to medical care for HIV infection: the long-term non-presenter. *AIDS*, 2001 January, 15 (1): 77-85.

<sup>8</sup> Department of Health and Human Services, Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents, pages 27-32. Department of Health and Human Services. October 14, 2011. Available from:

<http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>

<sup>9</sup> Myers JJ, Shade SB, Rose CD, et al. Interventions Delivered in Clinical Settings are Effective in Reducing Risk of HIV Transmission Among People Living with HIV: Results from the Health Resources and Services Administration (HRSA)'s Special Projects of National Significance Initiative. *AIDS and Behavior*, 2010 June; 14 (3): 483-492.

<sup>10</sup> Marseille E, Shade SB, Myers J, & Morin S. The cost-effectiveness of HIV prevention interventions for HIV-infected patients seen in clinical settings. *Journal of Acquired Immune Deficiency Syndromes*, 2011 March; 56 (3): e87-e94.

<sup>11</sup> Tobias C, Cunningham WE, Cunningham CO, & Pounds MB. Making the Connection: The Importance of Engagement and Retention in HIV Medical Care. *AIDS Patient Care & STDs*, 2007; 21 (Supplement 1): S3-S8.

been developed to promote retention such as intensive case management, patient navigation, peer support groups, and mobile van outreach to find clients who were lost to follow-up.<sup>11, 12</sup>

Homeless persons living with HIV who also have persistent mental illness and substance use disorders present a formidable challenge for public health authorities seeking to engage and retain them in HIV primary care. The daily imperative of meeting subsistence needs (food, shelter, clothing, etc.) makes getting any form of medical care a secondary concern for most homeless people, until a medical issue becomes acute and warrants a visit to the emergency room and often, subsequent hospitalization. The authors of a study of homeless people in Los Angeles concluded that the subsistence needs of the homeless must first be addressed for efforts to address their health care needs to be successful.<sup>13</sup>

There is strong evidence that HIV infection is a serious concern among the homeless and unstably housed populations of the United States. According to the U.S. Department of Housing and Urban Development's Annual Homeless Assessment Report (AHAR), HIV/AIDS prevalence in its adult sheltered population of 649,917 was 3.9 percent in January 2010. Since less than 1 percent of all adults in the U.S. are living with HIV infection, adults living with HIV/AIDS are likely to be at greater risk of being or becoming homeless than the general population.<sup>14</sup> The AHARs also have found that African-American men between the ages of 31 and 50, and people with disabilities are all at a disproportionately higher risk of becoming homeless, compared to their numbers in both the overall U.S. and its poverty population.<sup>15</sup> A San Francisco study of 2,508 homeless and unstably housed adults found HIV prevalence to be 10.5 percent overall, with 29.6 percent among homeless men who have sex with men (MSM), 26 percent among homeless transgender persons, and 7.7 percent among homeless injection drug users (IDUs).<sup>16</sup> Homeless women living with HIV infection also must deal with gender differences that include poorer health, greater economic vulnerability and exchange sex.<sup>17</sup>

Significant disparities have been identified in research studies in HIV treatment access, retention and health outcomes between homeless and unstably housed persons living with HIV (PLWH) and PLWH who are stably housed. A New York City study of 1,851 PLWH found that 9 percent were unstably housed, and they were more likely to use emergency rooms and have been hospitalized, and less likely to have accessed outpatient care than those who were stably

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<sup>12</sup> Gardner L, Marks G, Metsch L, et al. Psychological and Behavioral Correlates of Entering Care for HIV Infection: The Antiretroviral Treatment Access Study (ARTAS) *AIDS Patient Care and STDs*, 2007; 21 (6): 418-425.

<sup>13</sup> Gelberg L, Gallagher TC, Andersen RM, & Koegel P. Competing priorities as a barrier to medical care among homeless adults in Los Angeles. *American Journal of Public Health*, 1997 February; 87 (2): 217-220.

<sup>14</sup> U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2010) *2010 Annual Homeless Assessment Report to Congress*. Retrieved from: <http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf> HUD, 2010 AHAR, p. 18

<sup>15</sup> HUD, 2010 AHAR, p. ii

<sup>16</sup> Robertson M, Clark R, Charlebois E, et al. HIV Seroprevalence Among Homeless and Marginally Housed Adults in San Francisco. *American Journal of Public Health*, 2004 July; 94 (7): 1207-1217.

<sup>17</sup> Riley ED, Gandhi M, Hare CB et al. Poverty, Unstable Housing, and HIV Infection Among Women Living in the United States. *Current HIV/AIDS Reports*, 2007 December; 4(4):181-186.

housed.<sup>18</sup> CDC used data drawn from its Supplement to HIV/AIDS Surveillance Project (2000-2003) to analyze comparisons between homeless and stably housed PLWH. Homeless PLWH had worse overall physical and mental health, were more likely to be uninsured, to have been hospitalized and have used emergency rooms. Homeless PLWH who also had lower CD4 counts, were less likely to receive or adhere to HAART medications. After controlling for other possible confounding factors, housing status remained a significant predictor of health and medication outcomes.<sup>19</sup> Another New York City study examining 1,661 PLWH over 12 years found that the need for housing posed significant barriers to consistent engagement in HIV primary care. After controlling for other factors, receipt of housing assistance over the 12 year time period was the strongest predictor of increased care access, retention in care, and improved care outcomes.<sup>20</sup>

Co-occurring substance abuse and mental illness problems, as well as physical and sexual violence, greatly complicate the care of homeless PLWH. The prevalence of substance abuse and mental illness among the homeless is much higher than the general population.<sup>21</sup> The 2010 AHAR also reported that 26.2 percent of its sheltered adults had a severe mental illness; 34.7 percent had a substance abuse problem; and 12.3 percent were survivors of domestic violence.<sup>22</sup> As with HIV, treatment for homeless people with mental health disorders and substance abuse problems poses an enormous challenge. A Los Angeles study of 1,563 homeless persons found that two-thirds were chemically dependent and 22 percent had mental health disorders, with significant overlap between the two groups. However, only one-fifth had received mental health or substance abuse treatment in the past 60 days.<sup>23</sup> A St. Louis study of 162 homeless persons with severe mental illness and substance abuse problems found not only HIV but also Hepatitis B & C prevalence, along with injection drug use, needle sharing to inject drugs, and exchange sex.<sup>24</sup> The economic vulnerability of runaway and homeless youth can predispose them to HIV risk factors that include exchange sex and substance abuse, and many of these youth also suffer poor mental health including depression and suicidality.<sup>25</sup>

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<sup>18</sup> Arno PS, Bonuck KA, Green J, et al. The impact of housing status on health care utilization among persons with HIV disease. *Journal of Health Care for the Poor and Underserved*, 1996; 7(1): 36-49.

<sup>19</sup> Kidder D, Wolitski R, Campsmith M, & Nakamura G. Health status, health care use, medication use, and medication adherence in homeless and housed people living with HIV/AIDS. *American Journal of Public Health*, 2007 December; 97(12): 2238-2245.

<sup>20</sup> Aidala A, Lee G, Abramson D, et al. Housing need, housing assistance, and connection to medical care. *AIDS and Behavior*, 2007 November; 11(6 - Supplement 2): S101-S115.

<sup>21</sup> Fischer PJ and Breakey WR. The epidemiology of alcohol, drug, and mental disorders among homeless persons. *The American Psychologist*, 1991 November; 46 (11): 1115-1128.

<sup>22</sup> HUD, 2010 AHAR, p. 18

<sup>23</sup> Koegel P, Sullivan G, Burnam A et al. Utilization of Mental Health and Substance Abuse Services Among Homeless Adults in Los Angeles. *Med Care*. 1999 Mar;37(3):306-17.

<sup>24</sup> Klinkenberg WD, Caslyn RJ, More GA, et al. Prevalence of human immunodeficiency virus, hepatitis B, and hepatitis C among homeless persons with co-occurring severe mental illness and substance use disorders. *Comprehensive Psychiatry*, 2003 July-August; 44(4): 293-302.

<sup>25</sup> Farrow JA, Deisher RW, Brown R, et al. Health and health needs of homeless and runaway youth. A position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*, 1992 December ;13 (8): 717-726.

The National HIV/AIDS Strategy (NHAS<sup>26</sup>) released in July 2010 by the White House Office of National AIDS Policy has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. The NHAS thus advocates adopting community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV. To ensure success, the NHAS requires the Federal government and State, tribal and local governments to increase collaboration, efficiency, and innovation. Therefore, to the extent possible, Ryan White program activities should strive to support the three primary goals of the National HIV/AIDS Strategy.

The second primary goal of the NHAS is to increase access to care and optimize health outcomes for people living with HIV, and includes an actionable step of *establishing a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV.*<sup>27</sup> To achieve this goal, the NHAS promotes increased collaboration among providers: *All levels of government should increase collaboration between HIV medical care providers and agencies providing HIV counseling and testing services, mental health treatment, substance abuse treatment, housing and supportive services to link people with HIV to care.*<sup>28</sup> Another actionable step of this second NHAS goal is *supporting people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.*<sup>29</sup> The following actions are recommended to realize this step:

*3.1 Enhance client assessment tools and measurement of health outcomes: Federal and State agencies should support case management and clinical services that contribute to improving health outcomes for people living with HIV and work toward increasing access to non-medical supportive services (e.g., housing, food, transportation) as critical elements of an effective HIV care system.*

*3.2 Address policies to promote access to housing and supportive services for people living with HIV: Federal agencies should consider additional efforts to support housing assistance and other services that enable people living with HIV to obtain and adhere to HIV treatment.*

Anticipated results of achieving this goal by 2015 include increasing the percentage of Ryan White clients with permanent housing from 82 percent to 86 percent (from 434,000 to 455,800 people). The Implementation Plan of the National HIV/AIDS Strategy also states that

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<sup>26</sup> Office of National AIDS Policy. National HIV/AIDS Strategy for the United States, July 2010. ONAP, The White House. See <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>

<sup>27</sup> NHAS, page 23.

<sup>28</sup> NHAS, page 25.

<sup>29</sup> NHAS, page 27.

*implementation of the National HIV/AIDS Strategy must entail integrating efforts to increase housing security for people living with HIV.*<sup>30</sup>

The Department of Housing and Urban Development operates the Housing Opportunities for People with AIDS (HOPWA) program to address the needs of homeless and unstably housed PLWH and their families.<sup>31</sup> HOPWA provides short-term, transitional and permanent housing for eligible households living with HIV. To be eligible for HOPWA assistance, individuals must be low income (defined as having an income below 80 percent of area median income) and have documented HIV positive status.<sup>32</sup> According to HOPWA's National Performance Profile for its 2009-2010 program year, the program served 61,582 households.<sup>33</sup> Other HUD programs provide housing assistance to persons who are homeless or at risk of homelessness, including many who also have mental health and substance abuse problems.<sup>34</sup>

Under the Ryan White HIV/AIDS Program legislation, outpatient substance abuse care and mental health services are included as core medical services, and housing assistance as a support service.<sup>35</sup> An analysis of client-level data collected in 1997 and 1998 from HRSA's Client Demonstration Project found that 17 percent of Ryan White clients received housing assistance. Recipients of housing assistance were a third more likely to receive primary medical care than those who did not receive it, but receipt of housing assistance had no impact on retention in care.<sup>36</sup> In May 2011, HRSA issued a final rule clarifying allowable expenditures for housing assistance to clients under the Ryan White HIV/AIDS program in a policy notice.<sup>37</sup> These include housing referral services; short-term emergency housing; housing services incorporating medical or support services including but not limited to residential substance abuse treatment or mental health services; and housing services that do not include medical or support services but are essential for access to and compliance with HIV-related medical care. Short-term or emergency housing assistance is defined as "transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable living situation. Such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term stable living situation" Such assistance cannot be in the form of direct cash payments and cannot be used for mortgage payments. Finally, the Ryan White HIV/AIDS Program may provide such housing assistance only as the payer of last resort.

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<sup>30</sup> Office of National AIDS Policy. National HIV/AIDS Strategy Federal Implementation Plan, July 2010, p.18. ONAP, The White House. Available from: <http://www.whitehouse.gov/files/documents/nhas-implementation.pdf>

<sup>31</sup> See [http://portal.hud.gov/hudportal/HUD?src=/program\\_offices/comm\\_planning/aidshousing](http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/aidshousing)

<sup>32</sup> See Administering HOPWA Housing Assistance Factsheet, available from: [http://portal.hud.gov/hudportal/documents/huddoc?id=DOC\\_12082.pdf](http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_12082.pdf)

<sup>33</sup> Department of Housing and Urban Development. HOPWA National Performance Profile 2009-2010 Program Year. Available from: [http://portal.hud.gov/hudportal/HUD?src=/program\\_offices/comm\\_planning/aidshousing](http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/aidshousing)

<sup>34</sup> HUD, 2010 AHAR, p. 18

<sup>35</sup> The Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87) , Section 2604. Available from: [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_public\\_laws&docid=f:publ087.111.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ087.111.pdf)

<sup>36</sup> Ashman J, Conviser R & Pounds M. Associations between HIV positive individuals' receipt of ancillary services and medical care receipt and retention. *AIDS Care*, 14 (Supplement 1): S109-S118.

<sup>37</sup> See HRSA HAB Policy Notice 11-01, in Federal Register, Volume 76, No. 92, May 12, 2011, 27649-27651. available from <http://hab.hrsa.gov/manageyourgrant/files/policy1101.pdf>

A variety of strategies to improve health care delivery to homeless populations have been described in the research literature. The Housing and Health Study, a collaboration between CDC and of the Department of Housing and Urban Development's Office of HIV/AIDS Housing, was a randomized trial examining the effects of HOPWA rental assistance among homeless and unstably housed PLWHA.<sup>38</sup> Although an independent difference could not be demonstrated between the two groups, the study did show the impact of housing assistance on improved health care access and outcomes, as well as significant reductions in risk behaviors.<sup>39</sup> Different types of outreach programs, including those that utilized physicians and nurses, also have had some success.<sup>40,41,42</sup> Other interventions reaching the homeless have included the use of mobile vans, street-side care, and shelter-based clinics.<sup>36,43</sup>

Integrated care models emerged during the HIV epidemic to deliver more effective care to the multiply-diagnosed living with HIV/AIDS. A 2004 review of integrated HIV care identified some programs that improved access or utilization of HIV primary care, mental health services and substance abuse treatment.<sup>44</sup> The HIV/AIDS Treatment Adherence Health Outcome & Cost Study (also called the HIV Cost Study) conducted from 1999 to 2003 was a collaborative project of the HIV/AIDS Bureau of HRSA, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the NIH's National Institutes on Drug Abuse, Mental Health and Alcohol Abuse and Alcoholism (NIDA, NIMH and NIAAA). The HIV Cost Study defined integrated care as combining "HIV primary care with mental health and substance abuse services into a single coordinated treatment program that simultaneously, rather than in parallel or sequential fashion, addresses the clinical complexities associated with having multiple needs and conditions."<sup>45</sup> The study also recognized the importance of affording access to ancillary services – including housing – in integrated care programs providing care for the multiply-diagnosed living with HIV/AIDS. The eight demonstration sites in the HIV Cost Study employed two integration strategies, which were co-location of mental health and substance abuse services with HIV/AIDS primary care; a coordinated network of care; or a hybrid of the two.<sup>46</sup> Evaluation of

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<sup>38</sup> Kidder DP, Wolitski RJ, Royal S et al. Access to housing as a structural intervention for homeless and unstably housed people living with HIV: rationale, methods, and implementation of the housing and health study. *AIDS and Behavior*, 2007 November; 11 (6 Supplement): S149–S161.

<sup>39</sup> Wolitski RJ, Kidder DP, Pals SL et al. Randomized trial of the effects of housing assistance on the health and risk behaviors of homeless and unstably housed people living with HIV. *AIDS and Behavior*, 2010 June;14 (3): 493-503.

<sup>40</sup> Cunningham CO, Shapiro S, Berg KM, et al. An evaluation of a medical outreach program targeting unstably housed HIV-infected individuals. *Journal of Health Care for the Poor and Underserved*, 2005 February; 16 (1): 127-138.

<sup>41</sup> Robb V. The hotel project. A community approach to persons with AIDS. *The Nursing Clinics of North America*, 1994 September; 29 (3): 521-531.

<sup>42</sup> Tommasello AC, Gillis LM, Lawler JT, and Bujak GJ. Characteristics of homeless HIV positive outreach responders in urban US and their success in primary care treatment. *AIDS Care*. 2006 November; 18 (8): 911-917.

<sup>43</sup> Nuttbrock L, McQuiston H, Rosenblum A, & Magura S. Broadening perspectives on mobile medical outreach to homeless people. *Journal of Health Care for the Poor and Underserved*, 2003 February; 14 (1): 5-16.

<sup>44</sup> Soto TA, Bell J, Pillen MB; et al. Literature on integrated HIV care: a review. *AIDS Care*, 2004; 16 (Supplement 1): S43-S55.

<sup>45</sup> Soto et al, p. S44.

<sup>46</sup> HIV/AIDS Treatment Adherence, Health Outcomes and Cost Study Group. The HIV/AIDS Treatment Adherence, Health Outcomes and Cost Study: conceptual foundations and overview. *AIDS Care*, 2004; 16 (Supplement 1): S6-S21.

one HIV Cost Study demonstration site using a culturally responsive integrated HIV primary and mental health care model found improvements in mental health and physical health, along with a reduction in substance abuse, among their participants.<sup>47</sup>

A promising means of addressing the many complexities involved in caring for the chronically ill is the medical home concept, first introduced by the American Association of Pediatrics (AAP) in 1967. In order to address the fragmentation of care provided to children, AAP called for the centralization of medical records in a medical home to improve care coordination.<sup>48</sup> AAP later expanded on the concept, defining it as “a partnership approach with families to provide primary health care that is accessible, family centered, coordinated, comprehensive, continuous, compassionate, and culturally effective.”<sup>40,49</sup> The medical home gained wider application to other patient populations, and in 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association, developed joint principles to describe the core elements of a medical home. These include a personal physician to provide continuous comprehensive care; physician directed medical practice; a whole person orientation; care that is coordinated and integrated across the complex care system; quality and safety as hallmarks; enhanced access to care; and payment that recognizes the added value provided to patients.<sup>50</sup>

Support for the medical homes model was included in the Patient Protection and Affordable Care Act (Public Law 111–148, March 23, 2010).<sup>51</sup> Section 2703 of the Affordable Care Act, entitled “State Option to Provide Health Homes for Enrollees with Chronic Conditions,” allows the States to add medical homes as an option under their Medicaid plans. CMS calls this provision “an important opportunity for States to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness.”<sup>52</sup> HRSA has supported the adoption of the medical home model by grantees in its Maternal and Child Health Bureau<sup>53</sup> and the Bureau of Primary Health Care (BPHC). In 2001 BPHC began its Patient-Centered Medical/Health Home (PCMHH) Initiative,<sup>54</sup> in which its

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<sup>47</sup> Winiarski MG, Beckett E, and Salcedo J. Outcomes of an inner-city HIV mental health programme integrated with primary care and emphasizing cultural responsiveness. *AIDS Care*, 2005 August; 17(6): 747-756

<sup>48</sup> Sia C, Tonniges TF, Osterhus E, and Taba S. History of the medical home concept. *Pediatrics*, 2004 May; 113 (5 Supplement):1473–1478.

<sup>49</sup> American Academy of Pediatrics. Policy Statement: The Medical Home. *Pediatrics*, 2002 July; 110 (1 Part 1): 184-186.

<sup>50</sup> American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. Joint Principles of the Patient-Centered Medical Home, March 2007. Available from <http://www.medicalhomeinfo.org/downloads/pdfs/jointstatement.pdf>

<sup>51</sup> The fulltext of PPACA is available from: <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>

<sup>52</sup> Center for Medicaid, CHIP and Survey & Certification. State Medicaid Director Letter 10-024, November 16, 2010. Centers for Medicare and Medicaid. Available from: <https://www.cms.gov/smdl/downloads/SMD10024.pdf>

<sup>53</sup> See Maternal and Child Health Bureau, Implementation of the Medical Home Program, available from: <http://mchb.hrsa.gov/programs/medicalhome/>

<sup>54</sup> See HRSA/Bureau of Primary Health Care Policy Assistance Letter 2011-01 available from: <http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html>

grantees are encouraged to gain accreditation as a medical home by the National Committee for Quality Assurance through participating in NCQA's medical home program.<sup>55</sup>

Early adoption of the medical home model by HIV providers funded under the Ryan White HIV/AIDS Program arose due to HIV stigma, and the need to co-locate as many HIV-related Ryan White services under one roof.<sup>56</sup> Ryan White-funded medical care providers have a history of providing multidisciplinary, comprehensive, consumer focused and culturally competent HIV primary care. The characteristics of Ryan White programs are marked by the provision of sound clinical care and adaptation of different models of care to racial/ethnic and gender characteristics of target populations. These programs present possibilities in the near future for wider adoption of the medical homes model for more Ryan White consumers.

The Ryan White HIV/AIDS Program complements the Affordable Care Act which supports the adoption of medical home programs. Ryan White grantees and providers also are encouraged to participate in and become accredited under the National Committee on Quality Assurance's Patient-Centered Medical Home (PCMH) 2011 initiative.<sup>57</sup> In 2011 HRSA's HIV/AIDS Bureau funded the University of Medicine and Dentistry, New Jersey under a cooperative agreement to provide training and technical assistance to Ryan White grantees that includes HIV/AIDS medical homes as a priority target area. The purpose of this technical assistance is "to help Ryan White grantees and service providers to both understand the requirements and successfully apply for and become certified medical homes for persons with HIV/AIDS, and ultimately be recognized as such by new health care reform and reimbursement policies. This technical assistance should also aid grantees as they work with groups of persons with HIV disease in identifying and demonstrating models that are successful in retaining persons in care."<sup>58</sup> Although the medical home concept has evolved since its inception, the central theme of coordinated, integrated, patient-centered care remains at its core. As medical homes are implemented by Ryan White-funded provider organizations, their application to improve the care of homeless or unstably housed, multiply-diagnosed people living with HIV/AIDS remains untested.

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<sup>55</sup> See National Committee for Quality Assurance. Patient Centered Medical Home. Available from: <http://www.ncqa.org/tabid/631/Default.aspx>

<sup>56</sup> Saag M. Ryan White: An Unintentional Home Builder. *The AIDS Reader*, 2009 May; 19(5): 166-168.

<sup>57</sup> See NCQA, <http://www.ncqa.org/tabid/631/Default.aspx>

<sup>58</sup> See HRSA-11-068 National HIV Training and Technical Assistance Cooperative Agreements, pages 8-9 available from:

<https://grants.hrsa.gov/webExternal/FundingOppDetails.asp?FundingCycleId=2719D73B-503C-41EE-88EF-60BD87B55A8A&ViewMode=EU&GoBack=&PrintMode=&OnlineAvailabilityFlag=&pageNumber=&version=&NC=&Popup=>

## **II. Award Information**

### **1. Type of Award**

Funding will be provided in the form of a grant.

### **2. Summary of Funding**

This program will provide funding during federal fiscal years 2012 - 2016. Approximately \$2,400,000 is expected to be available annually to fund up to eight (8) grantees. Applicants may apply for a ceiling amount of up to \$300,000 per year. The project period is five (5) years. Funding beyond the first year is dependent on the availability of appropriated funds for the SPNS Program in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal Government.

## **III. Eligibility Information**

### **1. Eligible Applicants**

Eligible demonstration site applicants include public and non-profit entities eligible for funding under the Ryan White HIV Program Parts A, B, C, and D. These include, but are not limited to state and local governments; academic institutions; local health departments; community health centers receiving support under Section 330 of the PHS Act; federally qualified health centers as described in Title XIX, Section 1905 of the Social Security Act; faith-based and community-based organizations; and Indian Tribes or tribal organizations with or without federal recognition.

Per Sec. 2691(c), HRSA may not make a grant unless the applicant demonstrates the proposed program is consistent with the statewide coordinated statement of need (SCSN), and agrees to participate in the ongoing revision process of such statement of need.

### **2. Cost Sharing/Matching**

Cost Sharing/Matching is not required for this program.

### **3. Other**

Applications that exceed the ceiling amount of \$300,000 will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization are allowable. For example, an organization/institution with various PI's are eligible to submit an application each for this funding opportunity.

## IV. Application and Submission Information

### 1. Address to Request Application Package

#### **Application Materials and Required Electronic Submission Information**

HRSA *requires* applicants for this funding opportunity announcement to apply electronically through Grants.gov. This robust registration and application process protects applicants against fraud and ensures that only authorized representatives from an organization can submit an application. Applicants are responsible for maintaining these registrations, which should be completed well in advance of submitting your application. All applicants *must* submit in this manner unless they obtain a written exemption from this requirement in advance by the Director of HRSA's Division of Grants Policy. Applicants must request an exemption in writing from [DGPWaivers@hrsa.gov](mailto:DGPWaivers@hrsa.gov), and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. Your email must include the HRSA announcement number for which you are seeking relief, the organization's DUNS number, the name, address, and telephone number of the organization and the name and telephone number of the Project Director as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to your submission along with a copy of the "Rejected with Errors" notification you received from Grants.gov. **HRSA and its Digital Services Operation (DSO) will only accept paper applications from applicants that received prior written approval.** However, the application must still be submitted by the deadline. Suggestion: submit application to Grants.gov at least two days before the deadline to allow for any unforeseen circumstances.

Note: Central Contractor Registration (CCR) information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). As of August 9, 2011, Grants.gov began rejecting submissions from applicants with expired CCR registrations.

Although active CCR registration at time of submission is not a new requirement, this systematic enforcement will likely catch some applicants off guard. According to the CCR Website it can take 24 hours or more for updates to take effect, so ***check for active registration well before your grant deadline.***

An applicant can view their CCR Registration Status by visiting <http://www.bpn.gov/CCRSearch/Search.aspx> and searching by their organization's DUNS. The [CCR Website](#) provides user guides, renewal screen shots, FAQs and other resources you may find helpful.

Applicants that fail to allow ample time to complete registration with CCR and/or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

All applicants are responsible for reading the instructions included in HRSA's *Electronic Submission User Guide*, available online at <http://www.hrsa.gov/grants/apply/userguide.pdf>. This Guide includes detailed application and submission instructions for both Grants.gov and HRSA's Electronic Handbooks. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.

Applicants are also responsible for reading the Grants.gov Applicant User Guide, available online at <http://www.grants.gov/assets/ApplicantUserGuide.pdf>. This Guide includes detailed information about using the Grants.gov system and contains helpful hints for successful submission.

Applicants must submit proposals according to the instructions in the Guide and in this funding opportunity announcement in conjunction with Application Form SF-424. The forms contain additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained from the following site by:

- 1) Downloading from <http://www.grants.gov>, or
- 2) Contacting the HRSA Digital Services Operation (DSO) at:  
[HRSADSO@hrsa.gov](mailto:HRSADSO@hrsa.gov)

Each funding opportunity contains a unique set of forms and only the specific forms package posted with an opportunity will be accepted for that opportunity. Specific instructions for preparing portions of the application that must accompany Application Form SF-424 appear in the “Application Format Requirements” section below.

## **2. Content and Form of Application Submission**

### **Application Format Requirements**

The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. The total file size may not exceed 10 MB. The 80-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit. **We strongly urge you to print your application to ensure it does not exceed the 80-page limit. Do not reduce the size of the fonts or margins to save space. See the formatting instructions in Section 5 of the Electronic Submission User Guide referenced above.**

**Applications must be complete, within the 80-page limit, within the 10 MB limit, and submitted prior to the deadline to be considered under this announcement.**

### **Application Format**

Applications for funding must consist of the following documents in the following order:

## SF-424 Non-Construction – Table of Contents

- 🔔 It is mandatory to follow the instructions provided in this section to ensure that your application can be printed efficiently and consistently for review.
- 🔔 Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.
- 🔔 For electronic submissions, applicants only have to number the electronic attachment pages sequentially, resetting the numbering for each attachment, i.e., start at page 1 for each attachment. Do not attempt to number standard OMB approved form pages.
- 🔔 For electronic submissions, no Table of Contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Application for Federal Assistance (SF-424)	Form	Pages 1, 2 & 3 of the SF-424 face page.	Not counted in the page limit
Project Summary/Abstract	Attachment	Can be uploaded on page 2 of SF-424 - Box 15	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
Additional Congressional District	Attachment	Can be uploaded on page 3 of SF-424 - Box 16	As applicable to HRSA; not counted in the page limit.
Project Narrative Attachment Form	Form	Supports the upload of Project Narrative document	Not counted in the page limit.
Project Narrative	Attachment	Can be uploaded in Project Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions. Provide table of contents specific to this document only as the first page.
SF-424A Budget Information - Non-Construction Programs	Form	Pages 1-2 to support structured budget for the request of Non-construction related funds.	Not counted in the page limit.
Budget Narrative Attachment Form	Form	Supports the upload of Project Narrative document.	Not counted in the page limit.
Budget Narrative	Attachment	Can be uploaded in Budget Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
SF-424B Assurances - Non-Construction Programs	Form	Supports assurances for non-construction programs.	Not counted in the page limit.
Project/Performance Site Location(s)	Form	Supports primary and 29 additional sites in structured form.	Not counted in the page limit.
Additional Performance Site Location(s)	Attachment	Can be uploaded in the SF-424 Performance Site Location(s) form. Single document with	Not counted in the page limit.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
		all additional site location(s)	
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
Other Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list.	Not counted in the page limit.
Attachment 1-15	Attachment	Can be uploaded in Other Attachments form 1-15.	Refer to the attachment table provided below for <b>specific</b> sequence. Counted in the page limit.

- 🔔 To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- 🔔 Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- 🔔 Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
- 🔔 Merge similar documents into a single document. Where several documents are expected in the attachment, ensure that you place a table of contents cover page specific to the attachment. The Table of Contents page will not be counted in the page limit.
- 🔔 Limit the file attachment name to under 50 characters. Do not use any special characters (e.g., %, /, #) or spacing in the file name or word separation. (The exception is the underscore ( \_ ) character.) Your attachment will be rejected by Grants.gov if you use special characters or attachment names greater than 50 characters

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Copy of SF-424a Section B for Fifth Year Budget
Attachment 2	Line Item Budgets for Years 1 through 5 Spreadsheet Table
Attachment 3	Staffing Plan
Attachment 4	Position Descriptions
Attachment 5	Biographical Sketches of Key Personnel
Attachment 6	Statement of Consistency with Statewide Coordinated Statement of Need
Attachment 7	Logic Model
Attachment 8	Work Plan
Attachment 9	Project Organizational Chart
Attachment 10	Signed Letters of Agreement, and Descriptions of Proposed and Existing Contracts
Attachment 11	Healthy People 2020 Statement
Attachments 12-15	Other Relevant Documents

## **Application Format**

### **i. Application Face Page**

Complete Application Form SF-424 provided with the application package. Prepare according to instructions provided in the form itself. Important note: enter the name of the **Project Director** in 8. f. “Name and contact information of person to be contacted on matters involving this application.” If, for any reason, the Project Director will be out of the office, please ensure their email Out of Office Assistant is set so HRSA will be aware if any issues arise with the application and a timely response is required. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.928.

### **DUNS Number**

All applicant organizations (and subrecipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-character identification number provided by the commercial company, Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found at <http://fedgov.dnb.com/webform> or call 1-866-705-5711. Please include the DUNS number in item 8c on the application face page. Applications **will not** be reviewed without a DUNS number. Note: A missing or incorrect DUNS number is the number one reason for applications being “Rejected for Errors” by Grants.gov. HRSA will not extend the deadline for applications with a missing or incorrect DUNS number. Applicants should take care in entering the DUNS number in the application.

Additionally, the applicant organization (and any subrecipient of HRSA award funds) is required to register annually with the Central Contractor Registration (CCR) in order to do electronic business with the Federal Government. CCR registration must be maintained with current, accurate information at all times during which an entity has an active award or an application or plan under consideration by HRSA. It is extremely important to verify that your CCR registration is active and your Marketing Partner ID Number (MPIN) is current. Information about registering with the CCR can be found at <http://www.ccr.gov>.

### **ii. Table of Contents**

The application should be presented in the order of the Table of Contents provided earlier. Again, for electronic applications no table of contents is necessary as it will be generated by the system. (Note: the Table of Contents will not be counted in the page limit.)

### **iii. Budget**

Complete Application Form SF-424A Budget Information – Non-Construction Programs provided with the application package. Please complete Sections A, B, E, and F, and then provide a line item budget for each year of the project period. In Section A use rows 1 - 4 to provide the budget amounts for the first four years of the project. Please enter the amounts in the “New or Revised Budget” column- not the “Estimated Unobligated Funds” column. In Section B Object Class Categories of the SF-424A, provide the object class category breakdown for the annual amounts specified in Section A. In Section B, use column (1) to provide category amounts for Year 1 and use columns (2) through (4) for subsequent budget years (up to four years). For year 5, please submit a copy of Sections A and B of the SF-424A as Attachment 1.

Applicants also must submit line item budgets **for each year of the proposed project period** as a spreadsheet table, using the Section B Budget Categories of the SF-424A and breaking down sub-categorical costs. Under Personnel, please list each position by title and name, with annual salary, FTE, and salary charged to the grant and provided in-kind. Equipment, supplies (office and medical) and contractual should each have individual items listed separately. The categorical amounts requested on the SF424A and listed on the line-item budget spreadsheet tables must match. The budget must relate to the activities proposed in the Project Narrative and the Work Plan. These line item budgets for Years 1 through 5 should be included in a single spreadsheet table as **Attachment 2**.

**Salary Limitation:**

The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is \$179,700. This amount reflects an individual’s base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

As an example of the application of this limitation: If an individual’s base salary is \$350,000 per year plus fringe benefits of 25% (\$87,500) and that individual is devoting 50% of their time to this award, their base salary should be adjusted to \$179,700 plus fringe of 25% (\$44,925) and a total of \$112,312.50 may be included in the project budget and charged to the award in salary/fringe benefits for that individual. See the breakdown below:

Individual’s <i>actual</i> base full time salary: \$350,000 50% of time will be devoted to project	
Direct salary	\$175,000
Fringe (25% of salary)	\$43,750
Total	\$218,750
<b>Amount that may be claimed on the application budget due to the legislative salary limitation:</b> Individual’s base full time salary <i>adjusted</i> to Executive Level II: \$179,700 50% of time will be devoted to the project	
Direct salary	<b>\$89,850</b>
Fringe (25% of salary)	<b>\$22,462.50</b>
Total amount	<b>\$112,312.50</b>

**iv. Budget Justification**

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant **must** submit one-year budgets for each of the subsequent budget periods within the requested project period (five years) at the time of application. Line item information must be provided to explain the costs entered in the SF-424A. Be very careful about showing how each item in the “other” category is justified. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period. The budget justification **MUST** be concise. Do **NOT** use the justification to expand the project narrative.

**Budget for Multi-Year Award**

This announcement is inviting applications for project periods up to five (5) years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be for up to five (5) years. Submission and HRSA approval of your Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the five-year project period is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government.

Include the following in the Budget Justification Narrative:

*Personnel Costs:* Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percentage of full-time equivalency, and annual salary. In-kind personnel contributions, including percentage of full-time equivalency, should also be listed. Reminder: Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II or \$179,700. An individual's base salary, per se, is NOT constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to HRSA grants and cooperative agreements. Please provide an individual’s actual base salary if it exceeds the cap. See the sample below.

Sample:

Name	Position Title	% of FTE	Annual Salary	Amount Requested
J. Smith	Chief Executive Officer	50	\$179,700*	\$89,850
R. Doe	Nurse Practitioner	100	\$75,950	\$75,950
D. Jones	Data/AP Specialist	25	\$33,000	\$8,250

\*Actual annual salary = \$350,000

*Fringe Benefits:* List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project. If an individual’s base salary exceeds the legislative salary cap, please adjust fringe accordingly.

*Travel:* List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing

the travel should be outlined. Long distance travel must be included for up to three staff members to attend the two SPNS grantee meetings held each project year in Washington, DC and should be broken down by airfare/train fare, ground transportation, lodging and meals and incidental expenses (use federal per diem rates).

*Equipment:* List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of \$5,000 or more and a useful life of one or more years). Please note that most computer devices and digital accessories generally do not meet the Federal equipment definition (\$5,000 or more per unit), and therefore those costs should be listed in the Supplies category.

*Supplies:* List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include computers and peripherals that do not meet the definition of equipment, paper, pencils, and the like. Medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. Remember, they must be listed separately.

*Contractual:* Applicants are responsible for ensuring that their organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential subrecipients that entities receiving subawards must be registered in CCR and provide the recipient with their DUNS number.

*Other:* Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

Applicants may include the cost of access accommodations as part of their project's budget, including sign interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications such as use of cultural brokers, translation or interpretation services at meetings, clinical encounters, and conferences, etc.

*Indirect Costs:* Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: <http://rates.psc.gov/> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

**v. Staffing Plan and Personnel Requirements**

Applicants must present a staffing plan as **Attachment 3** and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. The proposed staffing plan must include, at a minimum, a 0.25 full-time equivalent (FTE) data manager to coordinate the multi-site evaluation activities as led by the Evaluation and Technical Assistance Center. If applicant opts to conduct a local evaluation, it is recommended that an evaluator also be included to lead its design and implementation. Position descriptions that include the required qualifications, roles, and responsibilities of proposed project staff must be included in **Attachment 4**. Biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included in **Attachment 5**. Where applicable, biographical sketches should include training, language fluency and experience working with the cultural and linguistically diverse populations that are served by their programs.

**vi. Assurances**

Complete Application Form SF-424B Assurances – Non-Construction Programs provided with the application package.

**vii. Certifications**

Use the Certifications and Disclosure of Lobbying Activities Application Form provided with the application package.

**viii. Project Abstract**

Provide a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including its goals; the needs to be addressed; a summary of proposed plan of project operation; the target populations to be served; and a summary of the proposed intervention. The project abstract must be single-spaced and limited to one page in length. Please place the following at the top of the abstract:

- Project Title
- Applicant Organization Name
- Address
- Project Director Name
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable

**ix. Project Narrative**

This section provides a comprehensive framework and description of all aspects of the proposed program. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Use the following section headers for the Narrative:

▪ *INTRODUCTION*

Provide a clear and succinct description of the proposed project and its intervention model. Briefly describe the proposed strategies to be implemented in the intervention to improve timely entry, engagement and retention in quality HIV primary care and supportive services for homeless and unstably housed people living with HIV and co-occurring mental illness and substance use disorders.

▪ *NEEDS ASSESSMENT*

Provide a literature review that demonstrates an in-depth understanding of the issues related to identifying, engaging and retaining homeless or unstably housed people with co-occurring HIV infection, substance abuse and mental health issue in HIV primary care. Discuss the issues specific to your service area that interfere with identifying, engaging and retaining homeless persons with co-occurring HIV disease, mental illness and/or substance use in quality HIV primary care and supportive services.

Describe your local homeless population, including its demographic characteristics and social networks. Describe its incidence and/or prevalence rates of HIV infection, and discuss substance abuse and mental health issues amongst the homeless and unstably housed within your jurisdiction, using the most recent, available data. Data sources may include but are not limited to HIV testing data; surveillance and epidemiology reports and profiles of state and local public health departments; needs assessment surveys; risk behavioral surveys and other studies specific to the target population.

Identify the geographic area to be served by the demonstration project. Describe your organization's working experience with the local homeless population, and your ability to engage it. Describe the existing medical, mental health, substance abuse treatment and ancillary services and programs currently available to meet the needs of multiply diagnosed HIV positive homeless and unstably housed individuals. Describe any relevant gaps or barriers in the service area that the project plans to address.

Authorizing legislation indicates that the Secretary may not make a grant unless the applicant demonstrates the proposed program is consistent with the Statewide Coordinated Statement of Need (SCSN), and that the applicant agrees to participate in the ongoing revision process of the SCSN. Provide a statement indicating how the proposed project is consistent with your state's SCSN, and include as **Attachment 6**.

▪ *METHODOLOGY*

Provide a description of the theoretical basis for your proposed intervention, including its innovative methods and strategies, and the rationale for their use. Describe how the proposed intervention addresses key factors identified in the literature and the many patient-level barriers to access to and retention in care encountered by HIV positive homeless and unstably housed people. These barriers include but not limited to the lack of stable housing and health care; the lack of diagnosis and treatment of mental illness; physical and sexual violence; economic vulnerability; substance abuse; and competing sustenance needs.

Describe all components of the intervention and the specific activities that will facilitate the coordination and/or integration of care services for HIV positive homeless and unstably housed individuals with co-occurring mental illness and/or substance abuse issues. Provide a description of the enhancement of an existing model, or the creation of a new model, that will improve the coordination and/or integration of care services for the target population. Discuss the potential for replication of your proposed intervention, and how other Ryan White-funded providers might establish similar innovative models into practice. As appropriate, include development of effective tools and strategies for ongoing staff training, outreach, maintaining effective collaborations or integrated service agreements, and clear communication across collaborating providers.

Provide a logic model that illustrates the inputs, activities, outputs, and the short-term, intermediate and long term outcomes of the proposed project. Illustrate the logical flow at client, provider and structural levels, and include inputs and resources utilized to implement the components of the intervention, and anticipated outcomes as outputs. Include the proposed project's Logic Model as **Attachment 7**.<sup>59</sup> Discuss how the interventions, if proven successful, might be sustained within your service community beyond the five year project period the SPNS initiative.

- **WORK PLAN**

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of the proposed project. The work plan is to be used as a tool to manage the demonstration programs progress, identifying necessary changes, and quantifying accomplishments. The work plan should directly relate to the methods described in the Methodology section and the program requirements of this funding opportunity announcement.

The work plan should include (1) goals for the entire proposed 5-year project period; (2) objectives that are specific, time-framed, and measurable; (3) action steps with anticipated start and completion; and (4) staff responsible for each action step and dates. Include all aspects of planning, implementation, and evaluation, along with the role of key staff involved in each activity. Overall goals should be clearly written for each year of the project. Objectives and key action steps should be written in time-framed and measurable terms providing numbers for targeted outcomes where applicable, not just percentages.

First year objectives should describe key action steps or activities that will be undertaken to implement the demonstration model, including, but not limited to hiring appropriate staff, coordinating with the ETAC on the development of multi-site data components, establishing quality control mechanisms, as well as addressing IRB and HIPAA requirements. Clearly indicate the anticipated start date of the intervention, and provide numbers for targeted outcomes where applicable, not just percentages. Include the project's work plan in **Attachment 8**.

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<sup>59</sup> Additional information on developing logic models can be found at:  
<http://www.cdc.gov/eval/resources/index.htm> and  
[http://www.cdc.gov/nccdphp/dnpao/hwi/programdesign/logic\\_model.htm](http://www.cdc.gov/nccdphp/dnpao/hwi/programdesign/logic_model.htm)

- *RESOLUTION OF CHALLENGES*

Discuss the challenges that are likely to be encountered in planning and implementing the activities described in the work plan, and describe approaches to be used to resolve these challenges. Describe a means of systematically assessing client needs in order to anticipate the particular times when a client is especially at risk for not engaging in or falling out of care. Include a means to address the impact of relapse or severe mental illness.

- *EVALUATION CAPACITY*

State explicitly your willingness to participate in a five-year comprehensive multi-site evaluation and to fully cooperate with the Evaluation and Technical Assistance Center (ETAC) throughout the initiative. This cooperation includes but is not limited to data collection and reporting of outcome, process and cost data for the multi-site evaluation and additional focused evaluation studies; and publication and dissemination efforts of the initiative's findings and lessons learned at the national, State and local levels. State your agreement to submit proof of IRB approvals and renewals for all client-level data collection instruments, informed consents and evaluation materials to SPNS and to the ETAC on an annual basis

Describe the prior experience of proposed key project personnel (including any consultants and subcontractors) in participating in a multi-site evaluation of national scope. Describe the experience of proposed key project personnel (including any consultants and subcontractors) in writing and publishing study findings in peer reviewed journals and in disseminating findings to local communities, national conferences and to policy makers.

If a local evaluation is included by the applicant, describe the organization's capacity to conduct it. Describe the local evaluation plan with proposed outcome measures that will demonstrate whether the intervention's goals and objectives are met. Describe how the proposed key project personnel (including any consultants and subcontractors) have the necessary knowledge, experience, training and skills in designing and implementing public health program evaluations, specifically evaluations of innovative HIV access and retention projects. Include any specific experience in the evaluation of programs serving HIV positive homeless or unstably housed individuals with co-occurring mental illness or substance abuse issues. If applicable, detail any published materials, presentations and previous work of a similar nature.

Identify the Institutional Review Board (IRB) which will review the multi-site evaluation plan and, if applicable, the local evaluation plan. Describe any training in human subjects research protection by proposed key project staff. Describe your written plan to safeguard patients' privacy and confidentiality, and your documented procedures for electronically and physically protecting the privacy of patient information and data, in accordance with HIPAA regulations and human subjects research protections.

- *ORGANIZATIONAL INFORMATION*

Describe your organization's mission and experience in implementing and managing HIV programs serving marginalized and hard-to-reach populations, homeless and unstably housed individuals as well as HIV positive populations with co-occurring mental health and/or substance use disorders, if applicable. Describe your organization's experience and expertise in mental health, substance abuse and HIV/AIDS primary care service provision, coordination and evaluation. Provide information on your organization's current structure

and scope of current activities. Describe how these all contribute to the ability of your organization to conduct the proposed project and meet the expectations of the program requirements.

Describe your organization's capacity to conduct the required multi-site and local evaluation activities described earlier in this announcement. Describe the capacity of your organization's management information system (MIS) to support a comprehensive evaluation in the collection, reporting and secure storage of client level data.

Include a project organizational chart as **Attachment 9**. The organizational chart should be a one-page figure that depicts the organizational structure of only the project, not the entire organization, and it should include subcontractors and other significant collaborators. If consultants and/or subcontractors will be used to carry out aspects of the proposed project, describe their roles and responsibilities. Current and proposed collaborating organizations and individuals must demonstrate their commitment to fulfill the goals and objectives of the project through signed and dated letters or memoranda of agreement or understanding. If applicable, include any such letters or memoranda, and descriptions of any existing or proposed contracts relating to the proposed project, as **Attachment 10**.

Describe areas in which you anticipate the need for technical assistance in the design, implementation and evaluation of your project. Also describe any anticipated staff training needs related to the proposed project, and how these needs will be met. If awarded, this information will assist the Evaluation and Technical Assistance Center and SPNS staff to better address your needs and help you to identify technical assistance and training resources.

Describe your cultural and linguistic competency capabilities. *Cultural competence* means having a set of congruent behaviors, attitudes, and policies that come together in a system or organization or among professionals that enables effective work in cross-cultural situations.<sup>60</sup> It includes an understanding of integrated patterns of human behavior, including language, beliefs, norms, and values, as well as socioeconomic and political factors that may have significant impact on psychological well-being and incorporating those variables into assessment and treatment. Include the project's cultural and linguistic competence factors.

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<sup>60</sup> See *National Standards for Culturally and Linguistically Appropriate Services* at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

## **ADDITIONAL NARRATIVE GUIDANCE**

*Instructions:* In order to ensure that the Review Criteria in this Funding Opportunity Announcement Template are fully addressed, this table provides a bridge between the narrative language and where each section falls within the review criteria.

<b><u>Narrative Section</u></b>	<b><u>Generic Review Criteria</u></b>
Introduction	(1) Need
Needs Assessment	(1) Need
Methodology	(2) Response (3) Evaluative Measures & (4) Impact
Work Plan	(2) Response & (4) Impact
Resolution of Challenges	(2) Response
Evaluation Capacity	(5) Resources/Capabilities
Organizational Information	(5) Resources/Capabilities
(Budget and Budget Justification)	(6) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.

### **x. Attachments**

Please provide the following items to complete the content of the application. Please note that these are supplementary in nature, and are not intended to be a continuation of the project narrative. Unless otherwise noted, attachments count toward the application page limit. **Each attachment must be clearly labeled.**

#### **Attachment 1:** *Copy of SF-424A Section B for Fifth Year Budget*

For the proposed year 5 budget, complete and submit a copy of Section B of the SF-424A.

#### **Attachment 2:** *Line Item Budgets Spreadsheet for Years 1 through 5*

Submit line item budgets for each year of the proposed project period as a single spreadsheet table, using the Section B Budget Categories of the SF-424A and breaking down sub-categorical costs.

#### **Attachment 3:** *Staffing Plan*

#### **Attachment 4:** *Position Descriptions*

Keep each to one page in length as much as possible. Include the role, responsibilities, and required qualifications for each position. It is permissible to have more than one new job description per page.

#### **Attachment 5:** *Biographical Sketches of Key Personnel*

Include biographical sketches for persons occupying the key positions not to exceed two pages in length. Include the individual's key qualifications and experience. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch.

#### **Attachment 6:** *Statement of Consistency with Statewide Coordinated Statement of Need*

Authorizing legislation indicates that the Secretary may not make a grant unless the applicant demonstrates the proposed program is consistent with the statewide coordinated statement of need (SCSN), and agrees to participate in the ongoing revision process of such statement of need. Please describe how the program is consistent with your state's or territory's SCSN.

**Attachment 7: *Logic Model***

Provide a logic model that illustrates the inputs, activities, outputs, and the short-term, intermediate and long term outcomes of the proposed project. Illustrate the logical flow at client, provider and structural levels, and include inputs and resources utilized to implement the components of the intervention, and anticipated outcomes as outputs.

**Attachment 8: *Work Plan***

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. Include all aspects of planning, implementation, and evaluation, along with the role of everyone involved in each activity. The work plan should include clearly written (1) goals; (2) objectives that are specific, time-framed, and measurable; (3) action steps; and (4) staff responsible for each action step and by what date.

**Attachment 9: *Project Organizational Chart***, The organization chart should be a one-page figure that depicts the organizational structure of only the project, not the entire organization, and it should include subcontractors and other significant collaborators.

**Attachment 10: *Signed Letters of Agreement, and Descriptions of Proposed and Existing Contracts***

Provide any documents that describe working relationships between the applicant organization and other agencies and programs cited in the proposal. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the subcontractors. Letters of support should be specific in indicating a commitment to the proposed project and detail in-kind services, staff, space, equipment, etc. Letters and Memoranda of Agreement must be signed and dated.

**Attachment 11: *Healthy People 2020 Summary***

Applicants must summarize the relationship of their projects and identify which of their programs objectives and/or sub-objectives relate to the goals of the Healthy People 2020 initiative. Refer to Section VI. 2 for further information.

**Attachments 12-15: *Other Relevant Documents***

Include here any other documents that are relevant to the application and or referenced in the application.

### **3. Submission Dates and Times**

#### **Application Due Date**

The due date for applications under this funding opportunity announcement is **May 7, 2012 at 8:00 P.M. ET**. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by your organization's Authorized Organization Representative (AOR) through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

**Receipt acknowledgement:** Upon receipt of an application, Grants.gov will send a series of email messages advising you of the progress of your application through the system. The first will confirm receipt in the system; the second will indicate whether the application has been successfully validated or has been rejected due to errors; the third will be sent when the

application has been successfully downloaded at HRSA; and the fourth will notify the applicant of the Agency Tracking Number assigned to the application.

The Chief Grants Management Officer (CGMO) or designee may authorize an extension of published deadlines when justified by circumstances such as natural disasters (e.g., floods or hurricanes) or other disruptions of services, such as a prolonged blackout. The CGMO or designee will determine the affected geographical area(s).

**Late applications:**

Applications which do not meet the criteria above are considered late applications and will not be considered in the current competition.

**4. Intergovernmental Review**

The Special Projects of National Significance Program is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. Executive Order 12372 allows states the option of setting up a system for reviewing applications from within their states for assistance under certain federal programs. Application packages made available under this funding opportunity will contain a listing of states which have chosen to set up such a review system, and will provide a State Single Point of Contact (SPOC) for the review. Information on states affected by this program and State Points of Contact may also be obtained from the Grants Management Specialist listed in the Agency Contact(s) section, as well as from the following Web site: [http://www.whitehouse.gov/omb/grants\\_spoc](http://www.whitehouse.gov/omb/grants_spoc).

All applicants other than federally recognized Native American Tribal Groups should contact their SPOC as early as possible to alert them to the prospective applications and receive any necessary instructions on the state process used under this Executive Order.

Letters from the SPOC in response to Executive Order 12372 are due sixty days after the application due date.

**5. Funding Restrictions**

Applicants responding to this announcement may request funding for a project period of up to five (5) years, at no more than \$300,000 per year. Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

Funds under this announcement may not be used for the following purposes:

- 1) To directly provide health care or testing services that are billable to third party payers (e.g., private health insurance, prepaid health plans, Medicaid, Medicare, other Ryan White Program funding including ADAP);
- 2) With the exception of testing services allowable under criteria established in this funding opportunity announcement, to directly provide health care services or duplicate existing services;
- 3) Purchase, construction of new facilities or capital improvements to existing facilities;
- 4) Purchase or improvement to land;

- 5) Purchase vehicles;
- 6) Fundraising expenses;
- 7) Lobbying activities and expenses;
- 8) Reimbursement of pre-award costs;
- 9) International travel; and/or
- 10) Cash payments to intended service recipients, as opposed to various non-cash incentives to encourage participation in evaluation activities.

**Salary Limitation:** The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is \$179,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

Per Division F, Title V, Section 503 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011 (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

Per Division F, Title V, Section 523 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

## 6. Other Submission Requirements

As stated in Section IV.1, except in very rare cases HRSA will no longer accept applications in paper form. Applicants submitting for this funding opportunity are **required** to submit **electronically** through Grants.gov. To submit an application electronically, please use the APPLY FOR GRANTS section at <http://www.grants.gov>. When using Grants.gov you will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

It is essential that your organization **immediately register** in Grants.gov and become familiar with the Grants.gov site application process. If you do not complete the registration process you will be unable to submit an application. The registration process can take up to one month.

To be able to successfully register in Grants.gov, it is necessary that you complete all of the following required actions:

- Obtain an organizational Data Universal Numbering System (DUNS) number
- Register the organization with Central Contractor Registration (CCR)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's CCR "Marketing Partner ID Number (M-PIN)" password
- Register and approve an Authorized Organization Representative (AOR)
- Obtain a username and password from the Grants.gov Credential Provider

Instructions on how to register, tutorials and FAQs are available on the Grants.gov web site at <http://www.grants.gov>. Assistance is also available 24 hours a day, 7 days a week (excluding federal holidays) from the Grants.gov help desk at [support@grants.gov](mailto:support@grants.gov) or by phone at 1-800-518-4726. Applicants should ensure that all passwords and registration are current well in advance of the deadline.

**It is incumbent on applicants to ensure that the AOR is available to submit the application to HRSA by the published due date. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the deadline.** Therefore, you are urged to submit your application in advance of the deadline. If your application is rejected by Grants.gov due to errors, you must correct the application and resubmit it to Grants.gov before the deadline date and time. Deadline extensions will not be provided to applicants who do not correct errors and resubmit before the posted deadline.

**If, for any reason, an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's last validated electronic submission prior to the application due date as the final and only acceptable submission of any competing application submitted to Grants.gov.**

**Tracking your application:** It is incumbent on the applicant to track their application by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking your application can be found at <https://apply07.grants.gov/apply/checkApplStatus.faces>. Be sure your application is validated by Grants.gov prior to the application deadline.

## V. Application Review Information

### 1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Review Criteria are used to review and rank applications. The *Special Projects of National Significance Program* has six (6) review criteria:

#### **Criterion 1: Need (10 Points)**

The extent to which the application demonstrates an understanding of and the factors associated with contributing to the problem.

This corresponds to the Introduction and Needs Assessment sections of the Narrative.

#### **i. Introduction**

- Strength and clarity of the applicant's succinct description of the purpose of the proposed project and intervention model.
- Strength and clarity of the brief description of the proposed strategies to improve timely entry, engagement and retention in quality HIV primary care and supportive services for homeless and unstably housed people living with HIV and co-occurring mental illness and substance use disorders.

#### **ii. Needs Assessment**

- Strength, clarity and extent to which the applicant's summary of the literature demonstrates an in-depth understanding of issues related to the treatment of HIV positive homeless and unstably housed with co-occurring mental health and substance use disorders.
- Strength and clarity of the applicant's discussion of the issues specific to its service area that interfere with identifying, engaging and retaining homeless persons with co-occurring HIV disease, mental illness and/or substance use in quality HIV primary care.
- Strength and clarity of the description of the applicant's local homeless population, including its demographic characteristics and its social networks.
- Strength and clarity of the description of the most recent available incidence and/or prevalence rates of HIV infection among homeless populations within the applicant's jurisdiction.
- Evidence the applicant has identified a specific geographical area to be served by its proposed project.
- Strength and extent of the applicant's organization's working experience with the target homeless population, and its ability to engage it.

- Strength of the applicant’s description of the existing medical, mental health, substance abuse treatment and ancillary services and programs currently available to meet the needs of multiply diagnosed HIV positive homeless and unstably housed individuals, and specific gaps or barriers the project plans to address.
- Strength and clarity of the project’s statement indicating how it is consistent with the statewide coordinated statement of need (in **Attachment 6**).

**Criterion 2: Response (35 Points)**

The extent to which the proposed project responds to the Purpose of the initiative as described earlier in this funding opportunity announcement. The strength, clarity, and quality of the proposed goals and objectives and their relationship to the identified project. The extent to which the activities (scientific or other) described in the application are capable of attaining the project objectives and are responsive to the program expectations.

This corresponds to the Methodology, Work Plan and Resolution of Challenges sections of the Narrative.

**i. Methodology**

- Strength and clarity of the description of the theoretical basis for the proposed intervention, including its innovative methods and strategies, and the rationale for their use.
- Strength and extent to which the proposed intervention addresses key factors identified in the literature and patient-level barriers to access to and retention in care encountered by HIV positive homeless and unstably housed people.
- Strength and clarity of the description of all necessary components of the intervention and the specific activities that will facilitate the coordination of care for HIV positive homeless individuals with co-occurring mental illness and substance use issues.
- Strength of the description of the enhancement of an existing model, or the creation of a new model, that will improve the coordination and/or integration of care services for the target population.
- Strength of the applicant’s discussion of the potential for replication of the proposed intervention.
- Strength and clarity of the applicant’s logic model that illustrates the inputs, activities, outputs, and the short-term, intermediate and long term outcomes of the proposed project (in **Attachment 7**).
- Strength and feasibility of the applicant’s proposed means of sustaining the intervention (if proven successful) within its service community beyond the five year project period the SPNS initiative.

**ii. Work Plan**

- Strength, clarity and feasibility of the applicant’s Work Plan and its goals for the 5-year project period (**Attachment 8**).
- Extent to which the goals of the applicant’s Work Plan address the program expectations and requirements the applicant described in the Methodology section of the Narrative.
- Evidence the applicant’s objectives for Year 1 are specific to each goal, time-framed, and measurable.

- Evidence the applicant's Work Plan includes each planning, implementation and evaluation activity; the staff responsible to accomplish each step; and anticipated dates of completion.
- Evidence the applicant clearly identifies the project's anticipated start date of the intervention, and provides numbers for targeted outcomes where applicable, not just percentages.

**iii. Resolution of Challenges**

- Extent to which the applicant identifies possible challenges that are likely to be encountered during the planning and implementation of the project.
- Extent to which the applicant identifies realistic and appropriate responses to be used to resolve those challenges.

**Criterion 3: Evaluative Measures (20 points)**

The strength and effectiveness of the methods proposed to monitor and evaluate the project results. Evaluative measures must be able to assess the extent to which the program objectives have been met and the extent to which these can be attributed to the project.

This corresponds to the evaluation methodology described in the Methodology section of the Narrative.

- Evidence of the explicit commitment to work in close collaboration with the Evaluation and Technical Assistance Center and fully participate in the multi-state evaluation activities.
- If applicable, strength of the applicant's capacity to conduct a local evaluation.
- If applicable, strength of the applicant's local evaluation plan.
- Evidence the applicant identifies the Institutional Review Board (IRB) which will review the multi-site evaluation plan and, if applicable, the local evaluation plan.
- Evidence the applicant agrees to submit proof of IRB approvals and renewals for all client-level data collection instruments, informed consents and evaluation materials to SPNS and to the ETAC on an annual basis.

**Criterion 4: Impact (10 Points)**

The feasibility and effectiveness of plans for dissemination of project results and whether the project results may be national in scope, The extent to which the project activities are replicable, and the sustainability of the program beyond the Federal funding.

This corresponds to the Methodology and Work Plan sections of the Narrative.

- Evidence the applicant clearly expresses its commitment to collaborate with the Evaluation and Technical Assistance Center in the publication and dissemination efforts of the initiative's findings and lessons learned at the national, State and local levels.
- Strength of evidence the applicant addresses the means of sustaining the intervention within its service community beyond the five year project period of the SPNS initiative.

### **Criterion 5: Resources/Capabilities (15 Points)**

The extent to which project personnel (including consultants and sub-contractors) are qualified by training and/or experience to implement and carry out the project. The capabilities of the applicant organization, including quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project.

This corresponds to the Evaluation Capacity and Organizational Information sections of the Narrative.

- Extent to which the applicant's mission and experience has been focused in implementing and managing HIV programs serving marginalized and hard-to-reach populations, including if applicable, homeless and unstably housed individuals and HIV positive populations with co-occurring mental health and/or substance use disorders.
- Extent of applicant organization's experience and expertise in mental health, substance abuse and HIV/AIDS primary care service provision, coordination and evaluation.
- Extent to which the applicant's mission, experience, current organizational structure and scope of current activities contribute to its ability to conduct the proposed project and meet the program requirements and expectations.
- Extent to which proposed key project personnel (including any consultants and subcontractors) have experience in participating in a multi-site evaluation of national scope.
- Evidence of any training in human subjects research protection by proposed key project staff of the applicant.
- Extent to which proposed key project personnel (including any consultants and subcontractors) have experience in writing and publishing study findings in peer reviewed journals and in disseminating findings to local communities, national conferences and to policy makers.
- Strength of the applicant's capacity to participate in the required multi-site evaluation activities.
- Strength of the capacity of the applicant's management information system (MIS) to support a comprehensive local evaluation in the collection, reporting and securely storage of client level data.
- If applicable, capacity of the applicant organization to conduct a local evaluation.
- Extent to which the proposed key project personnel (including any consultants and subcontractors) possess the necessary knowledge, experience, training and skills in designing and implementing public health program evaluations, specifically evaluations of innovative HIV access and retention projects.
- Evidence of a project organizational chart, depicting only the project, not the entire organization, including subcontractors and other significant collaborators (**Attachment 9**).
- If applicable, the strength of signed and dated letters or memoranda of agreement or understanding from current and proposed collaborating organizations and individuals to fulfill the goals and objectives of the project (**Attachment 10**).
- If applicable, clarity of the description of anticipated needs for technical assistance in the design, implementation and evaluation of the applicant's project, as well as any anticipated staff training needs.
- Strength of the applicant's cultural and linguistic competency capabilities.

### **Criterion 6: Support Requested (10 Points)**

The reasonableness of the proposed budget for each year of the project period in relation to the objectives, the complexity of the research activities, and the anticipated results. The extent to which costs, as outlined in the budget and required resources sections, are reasonable given the scope of work. The extent to which key personnel have adequate time devoted to the project to achieve project objectives.

This corresponds to the Budget, Budget Justification, and Staffing Plan sections.

#### **i. Budget and Budget Justification**

- Strength of the applicant's line item budgets for each year of the project period and their appropriateness to the proposed work plan.
- Strength and clarity of the application's budget justification narrative's support for each line item.
- Evidence the line item budgets specify allocations for staffing in percentages of full-time equivalents (FTEs) that are adequate for the proposed activities for each year of the project.
- If applicable, strength of rationale provided in the budget justification narrative for significant changes in subsequent years' budgets.
- If applicable, the extent to which contracts for proposed subcontractors and consultants are clearly described in terms of contract purposes; how costs are derived; and that payment mechanisms and deliverables are reasonable and appropriate.
- Evidence the budgets allocate sufficient support to meet the long distance travel expenses associated with the two SPNS grantee meetings in Washington, DC; and any travel relating to proposed staff training.

#### **ii. Staffing Plan**

- Extent to which the application's staffing plan is consistent with the project description and project activities (in **Attachment 3**).
- Extent to which the staffing plan is appropriate to carrying out all aspects of the proposed project.
- Evidence the applicant's staffing plan includes, at a minimum, a 25 percent full-time equivalent (0.25 FTE) data manager to coordinate the multi-site evaluation with the ETAC.
- Evidence the applicant's staffing plan includes key personnel with the skills, knowledge, education and training required to successfully implement all of the project activities throughout the project as described in the work plan.
- Extent to which the time allocated for key staff is consistent with their expected workload and goals and objectives of the project.
- Strength and appropriateness of the job descriptions for key staff (in **Attachment 4**).
- Strength and appropriateness of the biographical sketches (in **Attachment 5**).

## **2. Review and Selection Process**

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applications competing for Federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or

disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of the committee, e.g., geographic distribution. Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review criteria noted above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

Applications that pass the initial HRSA eligibility screening will be reviewed and rated by a panel based on the program elements and review criteria presented in relevant sections of this funding opportunity announcement. The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

### **3. Anticipated Announcement and Award Dates**

It is anticipated that awards will be announced prior to the start date of September 1, 2012.

## **VI. Award Administration Information**

### **1. Award Notices**

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's strengths and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to Conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-Federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative, and reflects the only authorizing document. It will be sent prior to the start date of September 1, 2012.

### **2. Administrative and National Policy Requirements**

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 [Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations](#) or 45 CFR Part 92 [Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments](#), as appropriate.

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes, as applicable, any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at <http://www.hrsa.gov/grants/>. The general

terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

### **Human Subjects Protection**

Federal regulations (45 CFR 46) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained. If research involving human subjects is anticipated, you must meet the requirements of the DHHS regulations to protect human subjects from research risks as specified in the Code of Federal Regulations, Title 45 – Public Welfare, Part 46 – Protection of Human Subjects (45 CFR 46), available online at [www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html](http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html).

### **Trafficking in Persons**

Awards issued under this funding opportunity announcement are subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to <http://www.hrsa.gov/grants/trafficking.html>. If you are unable to access this link, please contact the Grants Management Specialist identified in this funding opportunity to obtain a copy of the Term.

### **Smoke-Free Workplace**

The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. Further, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

### **Cultural and Linguistic Competence**

HRSA programs serve culturally and linguistically diverse communities and multiple cultures. Although race and ethnicity are often thought to be dominant elements of culture, HRSA funded programs embrace a broader definition to include language, gender, socio-economic status, sexual orientation and gender identity, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA-supported entities respect and respond to the cultural diversity of communities, clients and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) published by HHS and available online at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>. Additional cultural competency and health literacy tools, resources and definitions are available online at <http://www.hrsa.gov/culturalcompetence> and <http://www.hrsa.gov/healthliteracy>.

### **Healthy People 2020**

Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of

preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. The program consists of over 40 topic areas, containing measurable objectives. HRSA has actively participated in the work groups of all the topic areas and is committed to the achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found online at <http://www.healthypeople.gov/>.

### **National HIV/AIDS Strategy (NHAS)**

The National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for people living with HIV to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against people living with HIV.

To the extent possible, program activities should strive to support the three primary goals of the NHAS. As encouraged by the NHAS, programs should seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. Programs providing direct services should comply with federally-approved guidelines for HIV Prevention and Treatment (see <http://www.aidsinfo.nih.gov/Guidelines/Default.aspx> as a reliable source for current guidelines). More information can also be found at <http://www.whitehouse.gov/administration/eop/onap/nhas>.

### **Health IT**

Health information technology (Health IT) provides the basis for improving the overall quality, safety and efficiency of the health delivery system. HRSA endorses the widespread and consistent use of health IT, which is the most promising tool for making health care services more accessible, efficient and cost effective for all Americans.

### **Related Health IT Resources:**

- [Health Information Technology \(HHS\)](#)
- [What is Health Care Quality and Who Decides? \(AHRQ\)](#)

## **3. Reporting**

The successful applicant under this funding opportunity announcement must comply with the following reporting and review activities:

### **a. Audit Requirements**

Comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at [http://www.whitehouse.gov/omb/circulars\\_default](http://www.whitehouse.gov/omb/circulars_default).

**b. Payment Management Requirements**

Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant or cooperative agreement. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to <http://www.dpm.psc.gov> for additional information.

**c. Status Reports**

1) **Federal Financial Report.** The Federal Financial Report (SF-425) is required within 90 days of the end of each budget period. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the Notice of Award.

2) **Progress Report(s).** The awardee must submit a progress report to HRSA on a semi-annual basis. Timely submission and HRSA approval of your Federal Financial Report (FFR) and your Progress Report for the prior budget period triggers the budget period renewal and release of subsequent year funds. Further information on specific content will be provided post-award.

3) **Final Report(s)** A final report is due within 90 days after the project period ends. Further information on specific content will be provided post-award. The final report must be submitted on-line by awardees in the Electronic Handbooks system at <https://grants.hrsa.gov/webexternal/home.asp>.

**d. Transparency Act Reporting Requirements**

New awards (“Type 1”) issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of \$25,000 or more in federal funds and executive total compensation for the recipient’s and subrecipient’s five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (FFATA details are available online at <http://www.hrsa.gov/grants/ffata.html>).

Competing continuation awardees, etc. may be subject to this requirement and will be so notified in the Notice of Award.

## VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Donna Giarth, Grants Management Specialist  
Attn.: *Building a Medical Home for Multiply Diagnosed HIV positive Homeless Populations - Demonstration Sites* (# HRSA-12-100)  
HRSA Division of Grants Management Operations, OFAM  
Parklawn Building, Room 11-03  
5600 Fishers Lane  
Rockville, MD 20857  
Telephone: (301) 443-9142  
Fax: (301) 443-6343  
Email: [DGiarth@hrsa.gov](mailto:DGiarth@hrsa.gov)

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Adan Cajina  
Demonstration and Evaluation Branch  
Attn: *Building a Medical Home for Multiply Diagnosed HIV positive Homeless Populations - Demonstration Sites* (# HRSA-12-100)  
HIV-AIDS Bureau, HRSA  
Parklawn Building, Room 7C-07  
5600 Fishers Lane  
Rockville, MD 20857  
Telephone: (301) 443-3180  
Fax: (301) 594-2511  
Email: [ACajina@hrsa.gov](mailto:ACajina@hrsa.gov)

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding federal holidays at:

Grants.gov Contact Center  
Telephone: 1-800-518-4726  
E-mail: [support@grants.gov](mailto:support@grants.gov)  
iPortal: <http://grants.gov/iportal>

## IX. Tips for Writing a Strong Application

A concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at:

<http://www.hhs.gov/asrt/og/grantinformation/apptips.html>.