

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

HIV/AIDS Bureau  
Division of Metropolitan HIV/AIDS Programs

***HIV Care Program Part A  
HIV Emergency Relief Grant Program***

**Announcement Type:** New  
**Announcement Number:** HRSA-13-155

**Catalog of Federal Domestic Assistance (CFDA) No. 93.914**

**FUNDING OPPORTUNITY ANNOUNCEMENT**

Fiscal Year 2013

**Application Due Date: October 22, 2012**

*Ensure your Grants.gov registration and passwords are current immediately!  
Deadline extensions are not granted for lack of registration.  
Registration may take up to one month to complete.*

**Release Date: July 17, 2012  
Issuance Date: July 17, 2012**

**Revised on 8/17 to include Columbus, OH as a Transitional Grant Area (TGA) and to  
revise the deadline for all applications to October 22, 2012.**

**Revised on 10/6 to clarify that Columbus, OH is exempted from the first requirement  
listed in Appendix A (please see footnote 2 in Appendix A).**

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Authority: Public Health Service Act, Sections 2601-2610 (42 USC 300ff-11 – 300ff-20), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87)

## EXECUTIVE SUMMARY

The Ryan White HIV/AIDS Program Part A funding opportunity announcement (FOA) is provided to assist applicants in preparing their fiscal year (FY) 2013 single-grant application for funds under Part A of Title XXVI of the Public Health Service (PHS) Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87), (hereafter referred to as the Ryan White HIV/AIDS Program), which includes Minority AIDS Initiative (MAI) funds. Applicants are reminded that MAI funds should be fully integrated into Part A planning, priority setting and allocation processes. The legislation can be obtained at: [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).

Part A funding is based on living cases of HIV and AIDS reported to and confirmed by the Centers for Disease Control and Prevention (CDC). Therefore, applicants are required to report on the number of persons living with HIV and AIDS in their jurisdictions

As of 2012, Columbus, Ohio was designated as a Transitional Grant Area (TGA) and is eligible to receive funding in FY 2013 as part of this announcement. This FOA modifies HRSA-13-155, previously released on July 17, 2012, to include Columbus, OH. Text boxes provide instructions related to the appropriate jurisdictions. If there is no text box, then that section applies to all 53 eligible EMAs/TGAs.

This announcement contains instructions for completing a comprehensive application response and communicates information on current and new program initiatives. It also provides background information on reporting requirements and other forms of documentation that will be required from grantees, once awards have been made.

### Important Notes:

- The Ryan White HIV/AIDS Program legislation requires a waiver to request carryover of unobligated Formula funds before the end of the grant year. A carryover waiver application, together with the estimated unobligated balance (UOB), must be submitted to the Health Resources and Services Administration (HRSA)/HIV/AIDS Bureau (HAB) stating the purpose for which such funds will be expended during the carryover year.
- Part A grantees must submit a waiver/carryover request **NO LATER THAN DECEMBER 31 (with an automatic extension to the first workday following December 31, should it be a weekend or holiday). Failure to submit a timely carryover request and estimated UOB to HRSA will result in a grantee being ineligible to receive Ryan White HIV/AIDS Program Part A Formula carryover funds.** If a grantee does not submit a carryover request by December 31 because there is no anticipated UOB, and then later identifies and reports Part A Formula UOB on the final Federal Financial Report (FFR), the grantee is **not** eligible to submit a final Ryan White HIV/AIDS Program Part A carryover request, and no such request will be honored. If a waiver for carryover is approved, and, if at the end of the grant year, funds remain unobligated, the grantee can expend the approved UOB in accordance with the approved carryover waiver application.

- The exact amount of unobligated funds must be reported on an FFR due annually **on JULY 30** after the end of the grant year. **NO EXTENSIONS WILL BE GRANTED FOR LATE SUBMISSION OF THE FINAL FFR.** In addition, the grantee must submit a final carryover request with their final FFR or within 30 days of submitting the final FFR, containing the actual amount of UOB.
- The timely submission of the final FFR is of critical importance to the successful administration of the Ryan White HIV/AIDS Program. Final FFRs are used by HRSA/HAB to calculate statutory penalties; those penalties result in changes to the amounts of Supplemental funds available for award in a subsequent FY. Therefore, no final FFRs will be accepted after the due date of July 30, and grantees are put on notice that HRSA/HAB will utilize the grant balances available in the Payment Management System as of July 30 for the calculation of penalties.

HRSA/HAB recognizes that Part A Eligible Metropolitan Areas (EMA) and Transitional Grant Areas (TGA) must use grant funds to support and further develop and/or expand systems of care to meet the needs of People Living with HIV/AIDS (PLWH/A) within the EMA/TGA and strengthen strategies to reach minority populations. HAB has required EMAs/TGAs to collect data to support identification of need, for planning purposes, and to validate the use of Ryan White HIV/AIDS Program funding. A comprehensive application should reflect how those data were used to develop and expand the system of care in their jurisdictions. Grantees should review/reference relevant needs assessments conducted by other federal programs such as CDC, Substance Abuse and Mental Health Services Administration, HRSA's Bureau of Primary Health Care, and Housing Urban Development.

Ongoing CDC initiatives, as well as HAB efforts with grantees to estimate and address Unmet Need of those aware of their HIV status and the newer requirement to identify and bring into care persons in their jurisdictions that are unaware of their positive HIV status, should result in many more PLWH entering into the EMA/TGA care system. The EMA/TGA planning process must ensure that essential core medical services have been adequately funded to meet the needs of both those already in care and those being linked to care as a result of increased efforts to bring both the aware and previously unaware into care.

As of March 2012, the CDC estimates 1.2 million people are living with HIV and 1 in 5 people do not know their HIV status. The ultimate United States (U.S.) Public Health goal is to inform all HIV+ persons of their status and bring them into care in order to improve their health status, prolong their lives and slow the spread of the epidemic in the U.S. through enhanced prevention efforts. A list of CDC initiatives can be found at [http://www.cdc.gov/hiv/topics/prev\\_prog/index.htm](http://www.cdc.gov/hiv/topics/prev_prog/index.htm)

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 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. Therefore, the NHAS 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 HIV/AIDS Program activities should strive to support the three primary goals of the NHAS. The Early Identification of Individuals with HIV/AIDS and the Enhanced Comprehensive HIV Prevention Plan are two Federal initiatives which currently support the NHAS.

**The following information will assist in understanding and completing this year's grant application:**

- National Monitoring Standards: Grantees are required to have implemented the Part A and Part B National Monitoring Standards at both the grantee and provider/sub-recipient levels. HRSA has developed and distributed guidelines outlining the responsibilities of HRSA, the grantee, and provider staff. The National Monitoring Standards can be found at: <http://hab.hrsa.gov/manageyourgrant/granteebasics.html>.
- Grantees are required to submit Prospective Women, Infants, Children and Youth (WICY) Waiver Requests with their application as outlined in the Part A and Part B Ryan White HIV/AIDS Program Guidelines for Implementing the Minimum Expenditure Requirement to Provide Services to Women, Infants, Children and Youth previously distributed to grantees. This includes joint Part A and Part B Prospective WICY Waiver Requests. The Prospective WICY Waiver request, together with the required Prospective WICY Waiver Assurances contained in the Guidelines, should be uploaded as **Attachment 11**. The assurances must be signed by the Chief Elected Official (CEO) or the CEO's officially delegated authority.
- Part A funds are subject to Section 2604(c) of the PHS Act, which requires that not less than 75 percent of the funds be used to provide core medical services that are needed in the EMA/TGA for individuals with HIV/AIDS who are identified and eligible under the Ryan White HIV/AIDS Program. Core medical services and support services allowed under Part A are limited to services that are needed for individuals with HIV/AIDS to achieve their medical outcomes as defined by the Ryan White HIV/AIDS Program. The most recent service definitions can be found in the Ryan White Services Report Instructions Manual that is available online at: <http://www.hab.hrsa.gov/manageyourgrant/files/rsrinstructionmanual2010.pdf>.
- Applicants seeking a waiver to the core medical services requirement must submit a waiver request with this grant application in accordance with the information and criteria published by HRSA in the Federal Register Notice, Vol. 73, No. 113, dated Wednesday June 11, 2008, and may be found at <http://edocket.access.gpo.gov/2008/E8-13102.htm>. In addition, grantees are advised that a FY 2013 Part A waiver request must include funds awarded under the

MAI. A waiver request that does not include MAI will not be considered. A core medical services waiver request should be included as **Attachment 8**.

- *Usage of Ryan White funds for Early Intervention Services including HIV testing: SEC 2604(e)(2)(A) of the Ryan White Care Act states that “With respect to an entity that proposes to provide early intervention services under paragraph (1), such paragraph shall apply only if the entity demonstrates to the satisfaction of the chief elected official for the eligible area involved that--(A) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and the entity will expend funds pursuant to such paragraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.”.*

Ryan White funds can be used for the purpose of HIV testing under the service category of Early Intervention Services when the two following conditions are met:

- 1) The agency proposing the use of Ryan White funds for HIV testing must provide documentation illustrating that current federal, State, and local funds are inadequate to meet the HIV testing need in the proposed testing area, as well as documentation illustrating that funds used for this purpose will supplement and not supplant other federal, State, and local funds available for HIV testing in the proposed fiscal year.
  - 2) The proposing agency must submit a request via the “prior approval portal” within the Electronic Handbook (EHB) along with the documentation mentioned above for Project Officer review and approval. Ryan White funds may not be used for HIV testing without Project Officer approval via EHB.
- EMA/TGA Agreements and Compliance Assurances are included (**Appendix A**) with this FOA and require the signature of the CEO, or of his or her designee. This document should be included as **Attachment 2**.
  - The Ryan White Services Report captures information necessary to demonstrate program performance and accountability. All Ryan White HIV/AIDS Program core medical service and support service providers are required to submit client-level data for Calendar Year 2013. For additional information, please refer to the HIV/AIDS Program Client Level Data website at: <http://hab.hrsa.gov/manageyourgrant/reportingrequirements.html#RSR>.
  - The NHAS also calls for improved federal coordination of HIV/AIDS programs, as evidenced by **streamlining and standardizing data collection and reducing reporting requirements for grantees**. Over the past year, the Office of HIV/AIDS and Infectious Disease Policy in the Department of Health and Human Services (HHS) has worked with a group of Federal Agencies, National Partners and grantees to identify indicators, data systems, and elements used across HHS programs to monitor HIV prevention, treatment and care services. A set of common indicators is being catalogued within seven domains: 1) HIV testing; 2) Late HIV diagnosis; 3) Initial linkage to HIV medical care; 4) Retention/engagement in HIV medical care; 5) Anti-retro Viral (ARV) Therapy; 6) Viral Load suppression; and 7) Housing Status. These indicators are covered under the Ryan

White HIV/AIDS Program Services Report (RSR) that grantees and service providers report to HRSA on an annual basis, and thus HRSA/HAB will be positioned to calculate and report on these indicators.

- Clinical Quality Management: HAB has developed the HIV/AIDS Clinical Performance Measures for Adults and Adolescents and companion guide to assist grantees in the use and implementation of the core clinical performance measures, which can be found at: <http://hab.hrsa.gov/deliverhivaidscore/habperformmeasures.html>.
- Healthcare providers funded via HRSA grants need to be alert to the importance of cross-cultural and language appropriate communications and general health literacy issues. HRSA supports and promotes a unified health communication perspective that addresses cultural competency, limited English proficiency, and health literacy in an integrated approach in order to develop the skills and abilities needed by HRSA-funded providers and staff to deliver the best quality healthcare effectively to the diverse populations they serve. EMA/TGAs can find National Standards for cultural and linguistically appropriate services in healthcare online at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>. Cultural competence resources for healthcare providers are available at: <http://www.hrsa.gov/culturalcompetence>.

Additional information and technical assistance can be found at HRSA's Target Center: <http://www.careacttarget.org>.

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# **I. Funding Opportunity Description**

## **1. Purpose**

This announcement solicits applications for the HIV Care Program Part A HIV Emergency Relief Grant Program. Part A funds provide direct financial assistance to an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA) that has been severely affected by the HIV epidemic. Formula and Supplemental grants assist eligible program areas in developing or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV. A comprehensive continuum of care includes the 13 core medical services specified in law, and appropriate support services that assist People Living With HIV/AIDS (PLWH/A) in accessing treatment for HIV/AIDS infection that is consistent with the Department of Health and Human Service (HHS) Treatment Guidelines. (See <http://www.aidsinfo.nih.gov>). Comprehensive HIV/AIDS care beyond these core services may include supportive services that meet the criteria of enabling individuals and families living with HIV/AIDS to access and remain in primary medical care to improve their medical outcomes.

## **2. Background**

This program is authorized by Public Health Service Act, Sections 2601-2610 (42 USC 300ff-11 – 300ff-20), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 11-87). Part A grants to EMAs and TGAs include formula and supplemental components as well as Minority AIDS Initiative (MAI) funds, which supports services targeting minority populations. Formula grants are based on reported living HIV/AIDS cases as of December 31 in the most recent calendar year for which data are available. Supplemental grants are awarded competitively on the basis of demonstrated need and other criteria. MAI funding is awarded using a formula that is based on the distribution of living HIV/AIDS cases among racial and ethnic minorities. In each EMA, local Planning Councils set priorities and allocate Part A funds on the basis of the size, demographics, and needs of the population living with or affected by HIV. TGAs are required to use a community planning process; use of Planning Councils is optional.

# **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 year (FY) 2013. Approximately \$751,877,000 is expected to be available annually to fund 53 grantees. The period of support and budget period is one year (March 1, 2013-February 28, 2014). In FY 2013, Formula awards will be based ONLY on name-based data. Name-based reporting is defined as the number of living name-based cases of HIV/AIDS reported to the Centers for Disease Control and Prevention (CDC) as of December 31 of the most recent calendar year for which data is available.

Supplemental funding for Part A is available on a competitive grant application basis to EMAs/TGAs whose applications address the following legislative criteria:

- a) contains a report concerning the dissemination of the Part A Formula funds and the plan for utilization of such funds;
- b) demonstrates the need in such area, on an objective and quantified basis for supplemental financial assistance to combat the HIV epidemic;
- c) demonstrates the existing commitment of local resources of the area, both financial and in-kind to combating the HIV epidemic;
- d) demonstrates the ability of the area to utilize such supplemental financial resources in a manner that is immediately responsive and cost effective;
- e) demonstrates that resources will be allocated in accordance with the local demographic incidence of AIDS including appropriate allocations for services for women, infants, children, youth (WICY), and families with HIV/AIDS;
- f) demonstrates the inclusiveness of affected communities and individuals living with HIV/AIDS;
- g) demonstrates the manner in which the proposed services are consistent with the local needs assessment and the Statewide Coordinated Statement of Need;
- h) demonstrates the ability of the applicant to expend funds efficiently by not having had, for the most recent Part A Formula grant year for which data is available, more than five percent of grant funds unobligated at the end of the year, even if a request for carryover was granted; and
- i) demonstrates success in identifying individuals with HIV and AIDS who are unaware of their HIV/AIDS status, and provides a description of the Strategy, Plan, and Data associated with the early identification of these individuals.

### **III. Eligibility Information**

#### **1. Eligible Applicants**

Part A Grantees that were classified as an EMA or as a TGA in fiscal year (FY) 2007 and continue to meet the statutory requirements are eligible to apply for these funds. For an EMA, this is more than 2,000 cases of AIDS reported and confirmed during the most recent 5 calendar years, and for a TGA, this is at least 1,000, but fewer than 2,000 cases of AIDS reported and confirmed during the most recent period of 5 calendar years for which such data are available". Additionally, they must not have fallen below, for three consecutive years, the required incidence levels already specified AND required prevalence levels (cumulative total of living cases of AIDS reported to and confirmed by the Director of the CDC as of December 31 of the most recent calendar year for which such data are available). For an EMA, this is 3,000 living cases of AIDS, and for a TGA, this is 1,400 living cases of AIDS.

## 2. Cost Sharing/Matching

Cost Sharing/Matching is not required for this program.

## 3. Other

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 not allowable.

### **Maintenance of Effort (MOE)**

The Ryan White HIV/AIDS Program legislation requires Part A Grantees to maintain, as a Condition of Award, EMA/TGA political subdivision expenditures for HIV-related core medical services and support services at a level equal to the 1-year period preceding the FY for which the grantee is applying to receive a Part A grant. After enactment of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Section 2604 (b) (1) of the enacting legislation states: “In general – The chief elected official of an eligible area shall use amounts from a grant under Section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services.” Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation and the HIV/AIDS Bureau service definitions distributed to all grantees. Part A Grantees must document that they have met the Maintenance of Effort (MOE) requirement.

To demonstrate that grantees understand this revision to the Part A MOE requirement, applicants must submit the following information:

- a) A table that identifies the MOE budget elements and the amount of expenditures related to core medical services and support services for FY 2010 and FY 2011, and;
- b) A description of the process used to determine the amount of expenditures reported in the table.

This requirement is included as part of the Budget and MOE submission.

## 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. The 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 an 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 [DGPPwaivers@hrsa.gov](mailto:DGPPwaivers@hrsa.gov), and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. If requesting a waiver, include the

following in the e-mail request: the HRSA announcement number for which the organization is 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 the submission along with a copy of the "Rejected with Errors" notification as 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.

**IMPORTANT NOTICE: CCR to be moved to SAM on July 30, 2012**

CCR will transition to SAM at the end of July. CCR must stop accepting new data in order to successfully migrate the existing data into SAM. CCR's last business day is Tuesday, July 24, 2012. It will no longer accept new registrations or updates to current registrations after that time. The CCR Search capability will remain active through the transition to allow users to search for an entity's current registration status. SAM will be online for use Monday morning, July 30, 2012.

CCR will stop accepting data at 11:59 pm on Tuesday, July 24, 2012. **No new registrations can be submitted after that time. No updates to existing registrations can be submitted after that time.** Any registrations in process will be on hold until SAM goes live the morning of July 30, 2012. If users are in the middle of a registration, the data that has been submitted will be migrated to SAM.

If a record was scheduled to expire between July 16, 2012 and October 15, 2012, CCR is extending the expiration date by 90 days. The registrant will receive an e-mail notification from CCR when it extends the expiration date. The registrant will then receive standard e-mail reminders to update their record based on this new expiration date. Those future e-mail notifications will come from SAM.

SAM will reduce the burden on those seeking to do business with the government. Vendors will be able to log into one system to manage their entity information in one record, with one expiration date, through one streamlined business process. Federal agencies will be able to look in one place for entity pre-award information. Everyone will have fewer passwords to remember and see the benefits of data reuse as information is entered into SAM once and reused throughout the system.

**Active CCR registration is a pre-requisite to the successful submission of grant applications!**

Grants.gov strongly suggests visiting CCR prior to this change and checking the account status. Some things to consider are:

- When does the account expire?
- Does the origination need to complete the annual renewal of registration?
- Who is the eBiz POC? Is this person still with the organization?
- Does anything need to be updated?

To learn more about the switch from CCR to SAM, more information [is](https://www.bpn.gov/ccr/NewsDetail.aspx?id=2012&type=N) available at <https://www.bpn.gov/ccr/NewsDetail.aspx?id=2012&type=N>. To learn more about SAM, please visit <https://www.sam.gov>.

Note: CCR or SAM 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. 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; or SAM Quick Guide for Grantees ([https://www.sam.gov/sam/transcript/SAM\\_Quick\\_Guide\\_Grants\\_Registrations-v1.6.pdf](https://www.sam.gov/sam/transcript/SAM_Quick_Guide_Grants_Registrations-v1.6.pdf)), an entity's registration will become active after 3-5 days. Therefore, ***check for active registration well before the 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 number. The [CCR Website](#) provides user guides, renewal screen shots, FAQs and other resources.

Applicants that fail to allow ample time to complete registration with CCR (prior to July 25, 2012) / SAM (starting July 30, 2012) 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 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. 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 100 pages when printed by HRSA. The total file size may not exceed 10 MB. The 100-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. **HRSA strongly urges applicants to print their application to ensure it does not exceed the 100-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 100-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 the application can be printed efficiently and consistently for review.
-  Failure to follow the instructions may make the 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; 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	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.
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.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Organizational Chart, Staffing Plan, Position Descriptions, Bio-sketches
Attachment 2	Letters of Agreement, Memorandum of Understanding (MOU), Intergovernmental Agreements (IGAs), FY 2013 Agreements and Compliance Assurances
Attachment 3	HIV/AIDS Epidemiology Table
Attachment 4	Co-morbidities, Cost and Complexity Table
Attachment 5	Report on the Availability of Other Public Funding
Attachment 6	Unmet Need Framework
Attachment 7	FY 2013 Implementation Plan
Attachment 8	Planned Services Table, Core Medical Services Waiver Request (if applicable)
Attachment 9	EIIHA Matrix
Attachment 10	EIIHA HIV Testing and Awareness Data
Attachment 11	FY 2013 WICY Waiver Request (Prospective), including Prospective WICY Waiver Assurances
Attachments 12-15	Other attachments, as necessary

## **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 the 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 93.914.

### **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) (soon to be SAM) in order to conduct electronic business with the Federal Government. CCR (or SAM) 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 the applicant organization CCR (or SAM) registration is active and the Marketing Partner ID Number (MPIN) is current. Information about registering with the CCR can be found at <http://www.ccr.gov>. Please see Section IV of this funding opportunity announcement for **IMPORTANT NOTICE: CCR to be moved to SAM on July 30, 2012.**

### **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, and F, and then provide a line item budget for each year of the project period using Section B Budget Categories of the SF-424A.

Under Section B, Budget Categories, use the following column headings: "Administrative," "Clinical Quality Management," "MAI," and "HIV Services." Personnel and fringe benefits

for program staff assigned to these budget categories should be placed on the appropriate line. On the Contractual Services line-item list the amounts allocated for personnel or services contracted to outside providers for all HIV services. Show the amount allocated to any activities that are not conducted “in-house” on the Contractual line.

Grantee Administration and Planning Council (PC) Support are all now considered within the Grantee Administration budget and together are capped at 10 percent. Grantees must determine the amounts necessary to cover all administrative and program support activities. The grantee must also ensure adequate funding for PC mandated functions within the administrative line item. “Planning Council support should cover *reasonable and necessary costs* associated with carrying out legislatively mandated functions.”

**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>\$ 89,850.00</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 at the time of application. Line item information must be provided to explain the costs entered in the SF-424A budget form. 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.

**Caps on expenses:** Part A Grantee Administration Costs (including PC Support) may **not** exceed 10 percent of the grant award. Administrative expenditures for first-line entities or subcontractors may **not** exceed 10 percent of the aggregate amount allocated for services. Grantees are allowed to allocate up to 5 percent of the total grant award or \$3,000,000 (whichever is less) for Clinical Quality Management (CQM) activities.

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. 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. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops.

*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).

*Supplies:* List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include 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 (or SAM starting July 30, 2012 - See Section IV of this document for more SAM details.) 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. The indirect cost rate agreement will not count toward the page limit. **Reminder: Indirect costs are considered an administrative cost, which is capped at 10 percent of the grant award.**

*Program Income:* HHS Grants Regulations require grantees and/or sub-grantees to collect and report program income. The program income shall be returned to the respective Ryan White HIV/AIDS Program and used to provide eligible services to eligible clients. "Program income is gross income—earned by a recipient, sub-recipient, or a contractor under a grant—directly generated by the grant-supported activity or earned as a result of the award. Program income includes, but is not limited to, income from fees for services performed (e.g., direct payment, or reimbursements received from Medicaid, Medicare and third-party insurance); and income a recipient or sub-recipient earns as the result of a benefit made possible by receipt of a grant or grant funds, (e.g., income as a result of drug sales when a recipient is eligible to buy the drugs because it has received a Federal grant)."

#### **v. Staffing Plan and Personnel Requirements**

Applicants must present a staffing plan 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. Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff must be included in **Attachment 1**, along with their biographical sketches. When 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. Also complete and submit the required Part A Grant Program FY 2013 Agreements and Compliance Assurances (see Appendix A), which should be submitted as part of **Attachment 2**.

**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 the needs to be addressed, the proposed services, and the population group(s) to be served.

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

The project abstract must be single-spaced and limited to one page in length. The information above should be followed by brief paragraphs that provide, in this order:

- General demographics of EMA/TGA;
- Demographics of HIV/AIDS populations in the EMA/TGA;
- Geography of the EMA/TGA with regard to communities affected by HIV/AIDS and the location of HIV/AIDS services in relation to those communities, including minority populations served with Minority AIDS Initiative (MAI) funds;
- Description of the continuum of care offered in the EMA/TGA, including relevant information about the primary medical care services, how HIV primary care services are delivered, and how clients are supported in accessing and remaining in care; and
- Number of years the EMA/TGA has received Part A and MAI funding.

## **ix. Project Narrative**

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

**Note:** *There are different legislative requirements for the TGA grantees that received Part A funding for the first time in FY 2007. The narrative section responses are different for Baton Rouge, LA and Charlotte, NC that elected to utilize a community planning process. The other three TGA grantees that elected to seat a Planning Council will respond to the application as a Part A Grantee with a Planning Council.*

### **1) Demonstrated Need**

*The purpose of this section is to demonstrate the severity of the HIV/AIDS epidemic in the EMA/TGA, using quantifiable data on HIV epidemiology, co-morbidities, cost of care for Ryan White HIV/AIDS Program services, the service needs of emerging populations, Unmet Need for services, and unique service delivery challenges. This section should explain why Supplemental funding for health services is needed to provide necessary services for PLWH/A in the EMA/TGA.*

*Supplemental awards are to be directed principally to those eligible areas with the greatest demonstrated need based on documented factors that are comparable across the EMA/TGAs. In order to target funding to these areas, demonstrated need is given greater weight in the scoring process. The FY 2013 plan, budget, and allocations table should be consistent with the discussion of demonstrated need.*

#### **Factors to be considered in assessing demonstrated need for the FY 2013 application include:**

- The Unmet Need for HIV-related services determined by the PC or other community input process;
- An increasing need for HIV/AIDS related services, including relative rates of increase in the number of living cases of HIV/AIDS;
- The relative rates of increase in the number of living cases of HIV/AIDS within new or emerging subpopulations;
- The current prevalence of HIV/AIDS;
- Relative factors related to the cost of care and complexity of delivering healthcare to individuals with HIV/AIDS in the eligible area;
- The impact of co-morbid factors, including co-occurring conditions, identified relevant by The Secretary, including high rates of sexually transmitted infections (STI), Hepatitis, Tuberculosis (TB), substance use, severe mental illness, and other co-morbid factors;
- The prevalence of individuals who were released from Federal, state or local prisons during the preceding 3 years, and diagnosed with HIV/AIDS on the date of their release;
- The prevalence of homelessness;
- Relevant factors that limit access to health care including geographic variation, adequacy of health insurance coverage, and language barriers; transportation; and

- Impact of a decline in the amount received in Formula funding on services available to all individuals with HIV/AIDS identified and eligible under Part A.

**Note:** When describing *Demonstrated Need*, applicants should **document the use of multiple data sets**, such as HIV/AIDS epidemiologic data, co-morbidity data, poverty and insurance status data, current utilization data and assessments of emerging populations with special needs.

### **1) A. HIV/AIDS Epidemiology**

*When made available for funding, Supplemental funds will be targeted to those eligible areas where epidemiologic data demonstrates that HIV disease prevalence rates are increasing, where there is documented Unmet Need, and where there is a demonstrated disproportionate impact on vulnerable populations. Grantees are strongly encouraged to use the HRSA/CDC Integrated Guidelines as a tool for developing and reporting their epidemiological profile data. The document can be found at*

<http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/epi-guideline/index.htm>

- (1) Use a table to describe the EMA/TGA living cases of HIV disease through December 31, 2011; AIDS Prevalence and HIV (non AIDS) Prevalence data by demographic group and exposure category. Place the table in **Attachment 3** of the application and **clearly label the data sources**.
- (2) Provide a narrative description of the current HIV/AIDS prevalence in the EMA/TGA, including all of the following elements:
  - a) HIV/AIDS cases by demographic characteristics and exposure category in the EMA/TGA including: 1) people living with HIV, 2) the number of people living with AIDS, and 3) the number of new AIDS cases reported within the past 3 years (2009, 2010, and 2011);
  - b) Disproportionate impact of HIV/AIDS on certain populations in comparison to the impact on the general population, including disproportionately impacted minority communities, homeless and formerly-incarcerated individuals living with HIV/AIDS;
  - c) Populations of PLWH/A in the EMA/TGA that are underrepresented in the Ryan White HIV/AIDS Program funded system of HIV/AIDS primary medical care; and
  - d) Estimated level of service gaps among PLWH/A in the EMA/TGA.

### **1) B. Impact of Co-morbidities on the Cost and Complexity of Providing Care**

*Ryan White HIV/AIDS Program funds are intended to supplement funding for local healthcare systems overburdened by the increasing cost of providing healthcare services. In addition to HIV/AIDS, public healthcare systems must address a variety of co-morbidities that may increase the cost of delivering care to persons living with HIV/AIDS. Caring for large numbers of PLWH/A clients with multiple diagnoses also adds to the cost and complexity of care.*

- (1) Describe how both service costs and the complexity of providing care to PLWH/A in the EMA/TGA are affected by co-morbidities and co-factors such as poverty and lack of insurance by comparing their rates in the general EMA/TGA population with their rates

among PLWH/A in the EMA/TGA. Applicants must provide quantitative evidence (in table format in **Attachment 4**) and document data sources. **These descriptions must include:**

- a) STI rates;
- b) Prevalence of homelessness;
- c) The number and percent of persons without insurance coverage (including those without Medicaid and Medicare);
- d) The number and percent of persons living at or below 300 percent of the 2012 Federal Poverty Level (FPL); and.
- e) Identify trends in services and fiscal resources as a result of municipal and state budget cuts in HIV related and funded clinical and non-clinical services.

(2) Provide a narrative explanation of the information included in the above mentioned table.

(3) Describe, in terms of the cost of care and complexity of care, the impact on the service delivery system in the EMA/TGA of individuals who were formerly Federal, state or local prisoners, were released from custody of the penal system during the preceding 3 years (2009, 2010 and 2011) and had HIV/AIDS as of the date of their release.

#### **1) C. Impact of Part A Funding: Funding Mechanisms**

*The purpose of this section is to describe the impact of Part A funding and how service and funding mechanisms are coordinated in the EMA/TGA.*

(1) Report on the Availability of Other Public Funding

*The Ryan White HIV/AIDS Program requires services to be provided in a coordinated, cost-effective manner that ensures that Ryan White HIV/AIDS Program Part A funds is the payor of last resort for HIV/AIDS services.*

The applicant's "Report on the Availability of Other Public Funding" within the EMA/TGA from Federal, state and local sources should reflect the HIV/AIDS-related service funds available in 2012 and anticipated funds for the FY 2013 budget period. This information should be reported in a table format and submitted as **Attachment 5**. The table should include the actual dollar amounts and the percentage of the total available funds from each source for each of the categories below:

- (a) Ambulatory/Outpatient Medical Care;
- (b) State AIDS Drug Assistance Programs (ADAP);
- (c) Home and Community Based Support Services;
- (d) Other Outpatient/ Community Based Primary Medical Care Services;
- (e) Oral Healthcare;
- (f) Substance Abuse/Mental Health;
- (g) Minority AIDS Initiative; and
- (h) HIV Counseling and Testing Services

\*\*\* Section 1.C.2 should be **completed by all applicants except the Columbus TGA** \*\*\*

## (2) Coordination of Services and Funding Streams

*Part A EMA/TGA planning efforts should expand the availability of services, reduce duplication of services, and bring people into care who know their status but are not presently in the HIV/AIDS care system. Planning should also be coordinated with all other public funding for HIV/AIDS to: (1) ensure that Ryan White HIV/AIDS Program funds are the payor of last resort, (2) maximize the number and accessibility of services available, and (3) reduce any duplication.*

(a) Discuss ways in which services funded by other Federal and local sources (including other Ryan White HIV/AIDS Programs) are taken into consideration in planning for the continuum of HIV/AIDS care and during the priority setting and allocation processes. Sources may include but are not limited to:

- i) Medicaid;
- ii) Medicare, including Medicare Part D;
- iii) Children's Health Insurance Program (CHIP);
- iv) Veterans Affairs;
- v) Housing Opportunities for Persons With HIV/AIDS Programs (HOPWA);
- vi) CDC Prevention;
- vii) Services for Women and Children (e.g., Special Supplemental Food Program for Women, Infants, and Children (WIC) Program ,and Substance Abuse Treatment Programs for Pregnant Women);
- viii) Other state and local Social Service Programs (e.g., General Assistance, Vocational Rehabilitation);
- ix) Local, state, and Federal Public Health programs;
- x) Local and Federal funds for Substance Abuse/Mental Health Treatment Services and;
- xi) Other Ryan White HIV/AIDS Program Funding (Parts B, C, D and F).

**\*\*\* Section (1.C.3) should be completed by the Columbus TGA only \*\*\***

(3) *Discuss how services provided by other Ryan White HIV/AIDS Program within the TGA (including ADAP funds) will be taken into consideration during the planning and allocation processes and how programs receiving these funds will be coordinated to maximize the number and accessibility of services available:*

*Discuss ways in which services funded by other Federal and local sources will be taken into consideration in planning for the continuum of HIV care and during the allocation process. Sources may include but not limited to:*

- i) Medicaid;
- ii) Medicare, including Medicare Part D;
- iii) Children's Health Insurance Program (CHIP);
- iv) Veterans Affairs;
- v) Housing Opportunities for Persons With HIV/AIDS Programs (HOPWA);
- vi) CDC Prevention;

- vii) Services for Women and Children (e.g., Special Supplemental Food Program for Women, Infants, and Children (WIC) Program, and Substance Abuse Treatment Programs for Pregnant Women);
- viii) Other state and local Social Service Programs (e.g. General Assistance, Vocational Rehabilitation);
- ix) Local, state, and Federal Public Health programs;
- x) Local and Federal funds for Substance Abuse/Mental Health Treatment Services and;
- xi) Other Ryan White HIV/AIDS Program Funding (Parts B, C, D and F).

**1) D. Assessment of Emerging Populations with Special Needs**

*The Ryan White HIV/AIDS Program requires PCs and community input processes to determine the needs of emerging populations from the most recent local Needs Assessment, incorporate them into the Implementation Plan and Comprehensive Plan, and identify service gaps so that Part A (and MAI) funds can be directed to PLWH/A who may have limited access or are disenfranchised from existing HIV/AIDS care services. Costs associated with providing services to these populations will be considered a factor in determining Supplemental funding.*

- (1) Select no more than six (6) emerging populations and provide a narrative describing:
- (a) Unique challenges that each population presents to the service delivery system;
  - (b) Service gaps; and,
  - (c) Estimated costs associated with delivering services to each of these populations.

**Note:** *The narrative discussion of the assessment of emerging populations should be consistent with the FY 2013 Plan, Allocations Table, and the EMA/TGA most recent Comprehensive Plan.*

**1) E. Unique Service Delivery Challenges**

Provide a clear narrative description of the need for HIV/AIDS emergency grant funds in the EMA/TGA based on factors not already discussed in the preceding demonstrated need narratives. The narrative should describe any unique service delivery challenges specific to the EMA/TGA Ryan White HIV/AIDS Program funded services, in terms of service costs and complexity of providing care as a result of these challenges.

\*\*\* Section 1(F) should be **completed by all applicants except the Columbus TGA** \*\*\*

**1) F. Impact of Decline in Ryan White HIV/AIDS Program Formula Funding**

If the EMA/TGA experienced a decline in Ryan White HIV/AIDS Program Part A Formula Funding, provide a narrative that addresses:

- (1) The impact of the decline in Formula Funding including the number of services reduced or eliminated, what services were reduced or eliminated and/or any cost-containment measures implemented, (e.g. waiting lists, sliding-scale client co-pays, or other measures).
- (2) The response of the PC or community planning body regarding the reduction in Formula

Funding, and any transitional planning for clients receiving services that were either eliminated or reduced.

\*\*\* Section 1(G) should be **completed by all applicants except the Columbus TGA** \*\*\*

### **1) G. Unmet Need**

*Unmet Need for Health Services, also referred to as Unmet Need, is the need for HIV related Health Services by individuals with HIV who are aware of their HIV status, but are not receiving regular primary health care.*

- (1) Provide an updated estimate of Unmet Need in your jurisdiction, using the HRSA/HAB Unmet Need Framework and Calendar Year (CY) 2011 data. Include a copy of the framework in **Attachment 6** of this application.
- (2) Describe the process for updating the Unmet Need Estimate.
- (3) Provide a table showing the percent of Unmet Need for PLWA and PLWH for CY 2009, 2010, and 2011. Based on this table, describe the trends in your Unmet Need percentages. Describe to what you attribute these changes (e.g. increased outreach, increased linkages to care, increased number of low income PLWH/A).
- (4) Describe how these Unmet Need trends are reflected in planning and decision making. Provide a narrative description of the following:
  - (a) Determination of the demographics and location of people who know their HIV/AIDS status and are not in care. Use geographic mapping such as zip code or geo-mapping data if available.
  - (b) Describe the trends associated with the past 3 years regarding Unmet Need.
  - (c) Describe the method used to assess service needs, gaps, and barriers to care for people not in care; note the date of the latest assessment.
  - (d) Describe efforts to assist the people who know their status and are not in care in accessing primary care; specifically how the results of the Unmet Need Framework are reflected in the planning and decision making process about priorities, resource allocations, and the system of care. Examples include: (1) outreach activities, (2) collaboration with other Ryan White and non-Ryan White HIV/AIDS Program funded providers.

\*\*\* Section 1(H) should be **completed by the Columbus TGA only** \*\*\*

### **1) H. Unmet Need (Columbus, OH)**

*Unmet Need for Health Services, also referred to as Unmet Need, is the need for HIV related Health Services by individuals with HIV who are aware of their HIV status, but are not receiving regular primary health care.*

- (1) Provide an estimate of unmet need for your jurisdiction, based on the TGA's HIV disease cases and the number of clients receiving primary medical care in the TGA. This estimate can be calculated by using the HRSA/HAB Unmet Need Framework.
- (2) **Unmet Need Framework:** A copy must be included showing the: (a) values, (b) all data sources, and (c) calculations. You may wish to use the automated Excel worksheets of

the Framework to help calculate your estimates of unmet need, which you can download from the HAB Web site: <http://hab.hrsa.gov/tools/unmetneed>. Include a copy of the framework in **Attachment 6** of this application.

- (3) **Population estimates:** Estimates of the total number of: (a) people living with HIV/non-AIDS who know their status (people living with HIV/non-AIDS/aware), and (b) people living with AIDS who know their status in your jurisdiction as of a specified recent time period.
- (4) **Estimates of people in care:** Estimates of the number and percent of: (a) people living with HIV/non-AIDS/aware, and (b) people living with AIDS in your jurisdiction who received HIV primary medical care during a specified 12-month time period, using the Framework definition.
- (5) **Estimates of unmet need:** Estimates of the number and percent of: (a) people living with HIV/non-AIDS/aware, and (b) people living with AIDS in your jurisdiction who did *not* receive HIV primary medical care during the same 12-month time period – which are your estimates of unmet need.
- (6) **Data sources:** List and explain the data sources used.
- (7) **Estimation methods:** The methods used to develop the unmet need estimates, reasons for choosing this method, any limitations, and any cross-title collaboration that occurred.
- (8) **Assessment of unmet need:** Describe any activities the TGA is planning that involves the assessment of unmet need.

\*\*\* Section 2 (A, B & C) should be **completed by all applicants except the Columbus TGA** \*\*\*

## **2) Early Identification of Individuals with HIV/AIDS (EIIHA)**

*The purpose of this section is to describe the FY 2013 Strategy, Plan, and Data associated with ensuring that individuals who are unaware of their HIV status are identified, informed of their status, referred to supportive services, and linked to medical care if HIV positive. The goals of this initiative are to: 1) increase the number of individuals who are aware of their HIV status 2) increase the number of HIV positive individuals who are in medical care 3) increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative.*

**EIIHA Definition:** *Early Identification of Individuals with HIV/AIDS (EIIHA) is the identifying, counseling, testing, informing, and referring of **diagnosed and undiagnosed** individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to medical care.*

### **2) A. Strategy (Blueprint for implementation)**

#### **(1) Describe the Strategy to Identify Individuals who are Unaware of their HIV Status.**

- (a) Describe the specific goals this strategy is intended to achieve.
  - i) Describe how each goal is consistent with The National HIV/AIDS Strategy (NHAS) goals.
  - ii) Describe how each goal is consistent with making individuals who are unaware of their HIV status aware of their status.

- (b) Describe how this strategy will coordinate with other programs/facilities and community efforts (*e.g., correctional facilities, CBO, hospitals, etc.*).
  - (c) Describe how EIIHA activities and strategies will be incorporated into the program's Request for Proposals (RFP's).
  - (d) Describe how EIIHA activities and strategies will be incorporated into the program's contracts/agreements with providers performing EIIHA related activities.
  - (e) Describe how ADAP and other medication resources will be considered in order to accommodate the needs of new positives.
  - (f) Describe how this strategy addresses disparities in access and services among affected subpopulations and historically underserved communities.
  - (g) Describe the programmatic, systemic, and logistical challenges associated with making individuals aware of their HIV status.
  - (h) Describe the role of Ryan White HIV/AIDS Part A Programs in facilitating routine HIV testing within the EMA/TGA.
  - (i) Describe how the applicant will coordinate with other Ryan White Parts for the purpose of making HIV unaware individuals aware of their HIV status.
  - (j) If your state receives Special Programs of National Significance (SPNS) funding regarding System Linkage and Access to Care, please describe how your state's EIIHA strategy will be coordinated with these system linkage activities.
- (2) **Develop a Matrix listing the Parent and Target Groups, which illustrates how the overall unaware population will be broken down into specific targetable groups.** (For an example, please refer to "EIIHA Matrix 1.2" listed in Appendix B). Submit the EIIHA Matrix as **Attachment 9**. The EIIHA Matrix should include all Target Groups that the applicant's EIIHA Strategy, Plan, and Data intend to address.
- (a) At a minimum, the following **Parent Groups** MUST be addressed **in the EIIHA Matrix**:
- i) All Unaware Individuals in the EMA/TGA
  - ii) Individuals Tested in the Past 12 Months
  - iii) Individuals Not Tested in the Past 12 Months

**Important Note:** The following groups are considered Parent Groups and may **NOT** be listed as Target Groups. These groups must be broken down into smaller, more specific populations.

- Men Who Have Sex With Men
- Substance Abusers/IVDU
- African Americans
- Hispanics
- Caucasians
- Women
- Men
- Youth
- Heterosexuals
- Immigrants

**Important Note:** DO NOT include numerical values in the EIIHA Matrix.

**2) B. Plan** (Activities, Methods, and/or Means utilized to implement the strategy)

**Note:** All Ryan White HIV/AIDS Program funded EIIHA activities may be reported under but are not limited to Early Intervention Services (EIS), Outreach Services and Case Management Services categories. If the EIIHA activities are funded by a source other than Ryan White HIV/AIDS Program, then list the funding sources.

**IMPORTANT:** Ryan White HIV/AIDS Program funds may **NOT** be used to supplant funds which support activities to identify, counsel, test, inform, refer, and link to medical care HIV positive individuals unaware of their status.

**(1) Describe the barriers that obstruct awareness of HIV status**

- (a) For each **TARGET GROUP** listed in the EIIHA Matrix, describe the respective **Priority Needs** which obstruct awareness of HIV status (including any local legislation or policies).
- (b) For *each* **TARGET GROUP** listed in the EIIHA Matrix, describe the **Cultural Challenges** which obstruct awareness of HIV status.

**(2) Describe the activities to address barriers that obstruct awareness of HIV status.**

- (a) For **EACH TARGET GROUP** listed in the EIIHA Matrix, describe the respective **activities to address Priority Needs** that obstruct awareness of HIV status.
- (b) For **EACH TARGET GROUP** listed in the EIIHA Matrix, describe the respective **activities to address Cultural Challenges** that obstruct awareness of HIV status, and include the timeline(s) and responsible parties for each activity.

**(3) Describe the actions taken to promote routine HIV screening in the EMA/TGA.**

- (a) Describe your coordination with other organizations to promote routine HIV screening.
- (b) Describe the role of EIS in promoting routine HIV screening.
- (c) Describe the role of Outreach in promoting routine HIV screening.

**(4) Identifying, Informing, Referring, and Linking**

**Important Note:** The following information provided should address all individuals unaware of their HIV status, and does **NOT** need to be Target Group specific.

**(a) Identifying** individuals unaware of their HIV status

- i) Describe the activities essential for identifying HIV positive individuals who are unaware of their status (*activities do NOT need to be Target Group specific*).
  - a. Describe which essential activities your program is currently implementing.

- b. Describe which essential activities are proposed but NOT currently implemented.
  - i. Describe the timeline associated with each essential activity to be implemented.
  - ii. Describe the parties responsible for ensuring each of these essential activities is implemented according to the timeline described.
- ii) Describe how the applicant will coordinate with other Ryan White HIV/AIDS Program Parts with regard to *identifying* individuals unaware of their HIV status.
  - a. Describe progress from the previous fiscal year.
- iii) Describe how the applicant will coordinate with prevention and disease control/intervention programs (*without supplanting funds*) with regard to *identifying* individuals unaware of their HIV status.
  - a. Describe progress from the previous fiscal year.

**(b) Informing** individuals of their HIV status

- i) Describe the activities essential to informing unaware individuals of their HIV status (*activities do NOT need to be Target Group specific.*)
  - a. Describe which essential activities your program is currently implementing.
  - b. Describe which essential activities are proposed but are **NOT** currently implemented.
    - i. Describe the timeline associated with each essential activity to be implemented.
    - ii. Describe the parties responsible for ensuring that each essential activity is implemented according to the timeline described.
- ii) Describe how the applicant will coordinate with other Ryan White HIV/AIDS Program Parts with regard to *informing* individuals unaware of their HIV status.
  - a. Describe progress from the previous fiscal year.
- iii) Describe how the applicant will coordinate with prevention and disease control/intervention programs (without supplanting funds) with regard to *informing* individuals unaware of their HIV status.
  - a. Describe progress from the previous fiscal year.

**(c) Referring** to Medical Care and Supportive Services

- i) Describe the activities essential to referring individuals recently informed of their HIV positive status to medical care (*activities do NOT need to be Target Group specific.*)
  - a. Describe which essential activities your program is currently implementing.
  - b. Describe which essential activities are proposed but are **NOT** currently implemented.

- i. Describe the timeline associated with essential activities to be implemented.
  - ii. Describe the parties responsible for ensuring that all essential activities are implemented according to the timeline.
- ii) Describe how the applicant will coordinate with other Ryan White HIV/AIDS Program Parts with regard to **referring** newly aware individuals to appropriate supportive services.
  - a. Describe progress from the previous fiscal year.
- iii) Describe how the applicant will coordinate with prevention and disease control/intervention programs (without supplanting funds) with regard to **referring** newly aware individuals to appropriate supportive services.
  - a. Describe progress from the previous fiscal year.
- iv) *“Describe how this applicant will coordinate with prevention and disease control/intervention programs-without supplanting funds-with regard to **referring** newly aware individuals to appropriate Supportive Services and/or care. Newly aware individuals may include HIV negative individuals, as well as HIV positive individuals who are not eligible for Ryan White services. In these two instances, there is an expectation that they will be referred to the appropriate Non-Ryan White services to ensure that HIV negative individuals remain negative and HIV positive individuals are referred to care in accordance with SEC 2662 (a)-(c) of the Ryan White Care Act.”*

**(d) Linking to Medical Care**

- i) Describe the activities essential to ensuring access to medical care regardless of where any newly identified HIV positive individual enters the continuum of care.
  - a. Describe which essential activities you are currently implementing.
  - b. Describe which essential activities are proposed but are **NOT** currently implemented.
    - i. Describe the timeline associated with when each essential activity will be implemented.
    - ii. Describe the parties responsible for ensuring each of these essential activities are implemented according to the timeline.
- ii) Describe how the applicant will coordinate with the Ryan White HIV/AIDS Program Parts with regard to **linking** individuals unaware of their HIV positive status to medical care.
  - a. Describe progress from the previous fiscal year.
- iii) Describe how the applicant will coordinate with prevention and disease control/intervention programs (without supplanting funds) with regard to **linking** individuals unaware of their HIV positive status to medical care.
  - a. Describe progress from the previous fiscal year.
- iv) For any newly identified HIV positive individual referred into a Ryan White HIV/AIDS funded program describe the activities undertaken post-referral to

verify that medical care services were accessed.

- a. Describe which essential activities your program is currently implementing.
  - b. Describe which essential activities are proposed but are **NOT** currently implemented.
    - i. Describe the timeline associated with when each essential activity will be implemented.
    - ii. Describe the parties responsible for ensuring that each essential activity will be implemented according to the timeline described.
  - c. Describe progress from the previous fiscal year.
- v) Describe the activities undertaken to form and maintain relationships with private HIV care providers for the purpose of verifying that individuals referred into private care have accessed medical care post-referral.
- a. Describe which essential activities you are currently implementing.
  - b. Describe which essential activities are proposed but are **NOT** currently implemented.
    - i. Describe the timeline associated with when each essential activity will be implemented.
    - ii. Describe the parties responsible for ensuring that each essential activity will be implemented according to the timeline.
  - c. Describe progress from the previous fiscal year.
- vi) Describe the efforts to address legal barriers to routine HIV screening, including local and state laws and regulations.

## 2) C. Data

**Application of CDC National Estimates (National Proportion Undiagnosed) to Jurisdictional Data:** *To obtain a local estimate of undiagnosed persons living with HIV at the end of 2010, areas should apply the National percentage using the formula below. The number of persons living with diagnosed HIV infection at the end of 2010 should be obtained from data reported to the local health department as of **June 2012**. This allows for 18 months for cases and deaths to be reported.*

- (1) Report the estimated number of living HIV positive individuals who were unaware of their status in the CY ending December 31, 2010.

**(a) Estimated Back Calculation (EBC) Methodology:**

**(ALL applicants must use the following formula to calculate the local size of the HIV positive unaware population, which is based on CDC's National estimate).**

i) **Formula:**

*National Proportion Undiagnosed HIV (21 percent) = p*

*Number of individuals diagnosed with HIV and living as of **December 31, 2010** = N*

$$\text{Local Undiagnosed} = \frac{p}{(1-p)} \times N$$

ii) **Example:**

*National Proportion Undiagnosed = 21 percent*

$$\frac{.21}{(.79)} \times 1,000 \text{ (diagnosed living)} = 266 \text{ (undiagnosed)}$$

**Note:** The number of **diagnosed living cases** of HIV is used exclusively to calculate the estimated number of undiagnosed HIV positive individuals, and will **NOT be used to calculate the final award.**

- (2) Describe how the applicant will coordinate with the Ryan White HIV/AIDS Part B counterpart with regard to data collection and sharing.
- (3) Describe how the applicant will coordinate with disease control and prevention/intervention with regard to data collection and sharing.
- (4) Report the **total number** of HIV tests conducted using **Federal, state, and local funds as of December 31, 2011**. Please include the **HIV Testing and Awareness Data** listed below as **Attachment 10**.
- (a) Report the following:
- i) **Total number of HIV tests conducted** (as reported above).
  - ii) **Total number informed** of their HIV status (HIV positive and HIV negative).
  - iii) **Total number NOT informed** of their HIV status (HIV positive and HIV negative).
  - iv) **Total number of HIV positive tests**.
  - v) **Total number of HIV positive informed** of their HIV status.
  - vi) **Total number of HIV positive referred** to medical care.
  - vii) **Total number of HIV positive linked** to medical care.
  - viii) **Total number of HIV positive NOT informed** of their HIV status.
  - ix) **Total number of HIV negative tests**.
  - x) **Total number of HIV negative informed** of their HIV status.
  - xi) **Total number of HIV negative referred** to services.
  - xii) **Total number of HIV negative NOT informed** of their HIV status.

**Note:** At this time, the estimated number of living HIV positive individuals who were unaware of their status at the end of **2010** should **NOT** be compared to, or correlated with, any data regarding the number of HIV tests conducted using local, state and Federal funds at the end of **2011**.

***EIHA Scoring: Important Notes***

- Scoring will be based on the comprehensiveness, strength, and feasibility of the Strategy, Plan, and Data provided by the applicant.
- Scoring will **NOT** be affected by the amount of Ryan White HIV/AIDS Program funds committed to EIHA efforts as long as the Strategy, Plan, and Data can be effectively carried out via collaborative efforts.
- Scoring will **NOT** be affected by the estimated number of individuals unaware of their HIV positive status.
- Scoring will **NOT** be affected by the number of unaware HIV positive individuals identified, informed, referred, and linked to medical care.
- Scoring will **NOT** be affected by the number of activities that are currently implemented verses the number of activities that are **NOT** able to be implemented currently.

**\*\*\* Section 2.D should be completed by the Columbus TGA only \*\*\***

**2)D Early Identification of Individuals with HIV/AIDS (EIHA)**

The purpose of this section is to describe the TGA's plan to ensure that individuals who are unaware of their HIV status are identified and made aware of their HIV status.

***EIHA Definition:*** Early Identification of Individuals with HIV/AIDS (EIHA) is the identifying, counseling, testing, informing, and referring of **diagnosed and undiagnosed** individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to medical care.

**(1) Plan**

Describe how the TGA will identify HIV positive individuals who are aware of their HIV status. This plan should also describe how those individuals identified will be made aware of their HIV status.

**2) E. Enhanced Comprehensive HIV Prevention Planning (ECHPP) and Implementation for Metropolitan Statistical Areas (MSA's) Most Affected by HIV/AIDS**

The purpose of this CDC initiative is to facilitate the development and implementation of ECHPP for MSAs most affected by the HIV epidemic in order to reduce HIV risk and incidence in those areas. The enhanced plans are intended to identify the optimal combination of coordinated HIV prevention, care, and treatment services that can maximize the impact of these services on reducing new HIV infections within that jurisdiction. More information about ECHPP is available online at: <http://cdc.gov/hiv/strategy/echpp/index.htm>.

**Important Note:** Only the following EMA’s must respond to this section titled “Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS.” This section is required but will not be included in the scoring criteria. Please limit ECHPP responses to one page.

New York City, NY	Philadelphia, PA
Los Angeles, CA	Houston, TX
Washington, DC	San Francisco, CA
Chicago, IL	Baltimore, MD
Atlanta, GA	Dallas, TX
Miami, FL	San Juan, PR

- (1) Identify the NHAS goals that are supported by the collaborative efforts of the Part A Program and the ECHPP initiative. (NHAS goals are described in the Executive Summary on page i.)
- (2) Describe the planned activities of the Part A Program in collaborating with the EMA’s ECHPP initiative. Please include a timeline for each activity, any data sharing and/or joint planning in these 12 jurisdictions, as well as responsible parties.

**3) Access to HIV/AIDS Care and the Plan for FY 2013**

*The purpose of this section is to provide a narrative summary describing the EMA/TGA continuum of care during FY 2013, including: access to care for those who know their status but are not presently in the system of HIV/AIDS primary medical care, and access to primary medical HIV/AIDS care for emerging populations. It should also describe how Part A funded services are integrated and coordinated with other available programs and services at the local level to enhance the continuum of HIV care. Additionally, this section presents the applicant’s FY 2013 HIV/AIDS service plan, addressing disparities among populations with specific needs including emerging populations identified in the Demonstrated Need Section. The plan must also address the needs of those persons in care, those who know their HIV status but are not in HIV/AIDS primary medical care, as well as the population groups identified in EIIHA, persons who are unaware of their HIV status.*

*The Ryan White HIV/AIDS Program requires the EMA/TGA to develop a comprehensive continuum of HIV/AIDS care accessible to eligible PLWH/A in the EMA/TGA. The system of care should address the service needs of newly affected and underserved populations — including disproportionately impacted communities of color and emerging populations. The EMA/TGA system of HIV/AIDS care should be consistent with HRSA’s goals of increasing access to services and decreasing HIV/AIDS health disparities among affected subpopulations and historically underserved communities.*

**3) A. Continuum of Care for FY 2013**

Describe the EMA/TGA’s continuum of care for FY 2013 including how integration and coordination of other available services or programs with Part A funded services contributes to the continuum of care. The description should include: mechanisms within the EMA/TGA that enable newly infected, underserved, hard-to-reach individuals, emerging populations

and/or disproportionately impacted communities of color to access and remain in primary medical care.

\*\*\* Sections 3(B & C) should be **completed by all applicants except Columbus TGA** \*\*\*

### **3) B. Table: FY 2013 Implementation Plan**

*The Ryan White HIV/AIDS Program requires that grantees funded under Part A use not less than 75 percent of grant funds, after Program Administration and Quality Management reductions, for essential core medical services. Core medical services are defined as follows: 1) Outpatient and ambulatory health services; 2) AIDS Drug Assistance Program (ADAP) treatments in accordance with Section 2616 of the PHS Act; 3) AIDS pharmaceutical assistance; 4) Oral healthcare; 5) Early intervention services (EIS); 6) Health insurance premium and cost sharing assistance for low-income individuals in accordance with Section 2615 of the PHS Act; 7) Home healthcare; 8) Medical nutrition therapy; 9) Hospice services; 10) Home and community-based health services as defined under Section 2614(c) of the PHS Act; 11) Mental health services; 12) Substance abuse outpatient care; and 13) Medical case management, including treatment adherence services.*

*In addition, support services in Section 2604 of the PHS Act are described as services, subject to approval of The Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes. Support services as defined by the Ryan White HIV/AIDS Program may include: 1) Case management (non-medical); 2) Child care services; 3) Emergency financial assistance; 4) Food bank/home-delivered meals; 5) Health education/risk reduction; 6) Housing services; 7) Legal services; 8) Linguistics services; 9) Medical transportation services; 10) Outreach services; 11) Psychosocial support services; 12) Referral for healthcare/supportive services; 13) Rehabilitation services; 14) Respite care; and 15) Treatment adherence counseling.*

List the EMA/TGA's four core medical service categories and two support service categories which comprise the largest amounts of Part A funding allocated for FY 2013 on the Implementation Plan. For each of the core medical and support services listed, develop one or more service goals with time limited and measurable program objectives. For MAI funds, list two service categories that comprise the largest amounts of MAI funding allocated for FY 2013 and use the same Implementation Plan format as for the Part A funding.

- (1) For each objective, define the service unit, the number of persons to be served, the total number of service units to be delivered, timeframe, and the estimated cost of meeting the objective.
- (2) These service goals and objectives will comprise the major elements of the FY 2013 Implementation Plan. Each service goal should clearly reference the appropriate strategy(ies) identified in the 2013-2015 Comprehensive Plan.
- (3) The Implementation Plan should be placed in **Attachment 7** of the application.

### **3) C. Narrative**

Based upon the FY 2013 Implementation Plan, provide a narrative that describes the following:

- (1) How the EMA/TGA links its latest needs assessment (including results of the EMA's/TGA's Unmet Need Framework), service priorities, the FY 2013

- Implementation Plan, and the 2013-2015 Comprehensive Plan, including how the goals and objectives relate to the strategies identified in the Comprehensive Plan;
- (2) Identify any prioritized core medical services that will not be funded with FY 2013 Ryan White HIV/AIDS Program funds and how these services will be delivered in the EMA/TGA;
  - (3) How the activities described in The Plans will provide increased access to the HIV continuum of care for minority communities;
  - (4) How the activities described in The Plans will address the needs of emerging populations, as discussed in the Demonstrated Needs section;
  - (5) How the activities described in The Plans will encourage PLWH/A to remain engaged in HIV/AIDS primary medical care and adherent to HIV treatments;
  - (6) How the activities described in The Plans will promote parity of HIV services throughout the EMA. Parity of services should be addressed in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness;
  - (7) How planned activities assure that services delivered by subcontractors are culturally and linguistically appropriate to the populations served within the EMA/TGA;
  - (8) How the services and their goals and objectives relate to the goals of the Healthy People 2020 initiative. Refer to: <http://www.healthypeople.gov/2020/default.aspx>;
  - (9) How the EMA/TGA will ensure that resource allocations to provide services for WICY are in proportion to the percentage of EMA/TGA AIDS cases represented by each priority population;
  - (10) How the EMA/TGA Planning Council (PC) or community planning process is using MAI funding to reduce disparities in access to care, to further enhance the quality of care and health outcomes in communities of color disproportionately impacted by the HIV epidemic, and how those activities are integral to the overall Part A FY 2013 plan;
  - (11) How the results of the Unmet Need analysis was utilized by the PC or community planning body and impacted in their allocation decisions;
  - (12) How the PC or community planning body considered/addressed the need of HIV medications by the target population during their Part A funding allocation process; and
  - (13) How the PC or community planning body considered/addressed the population groups indentified in EIIHA during their Part A funding allocation process.

\*\*\* Section 3 (D&E) should be completed by the Columbus TGA only \*\*\*

### **3) D. Table: FY 2013 Implementation Plan**

*The Ryan White HIV/AIDS Program requires that grantees funded under Part A use not less than 75 percent of grant funds, after Program Administration and Quality Management reductions, for essential core medical services. Core medical services are defined as follows: 1) Outpatient and ambulatory health services; 2) AIDS Drug Assistance Program (ADAP) treatments in accordance with Section 2616 of the PHS Act; 3) AIDS pharmaceutical assistance; 4) Oral healthcare; 5) Early intervention services (EIS); 6) Health insurance*

*premium and cost sharing assistance for low-income individuals in accordance with Section 2615 of the PHS Act; 7) Home healthcare; 8) Medical nutrition therapy; 9) Hospice services; 10) Home and community-based health services as defined under Section 2614(c) of the PHS Act; 11) Mental health services; 12) Substance abuse outpatient care; and 13) Medical case management, including treatment adherence services.*

*In addition, support services in Section 2604 of the PHS Act are described as services, subject to approval of The Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes. Support services as defined by the Ryan White HIV/AIDS Program may include: 1) Case management (non-medical); 2) Child care services; 3) Emergency financial assistance; 4) Food bank/home-delivered meals; 5) Health education/risk reduction; 6) Housing services; 7) Legal services; 8) Linguistics services; 9) Medical transportation services; 10) Outreach services; 11) Psychosocial support services; 12) Referral for healthcare/supportive services; 13) Rehabilitation services; 14) Respite care; and 15) Treatment adherence counseling.*

List the EMA/TGA's four core medical service categories and two support service categories which comprise the largest amounts of Part A funding allocated for FY 2013 on the Implementation Plan. For each of the core medical and support services listed, develop one or more service goals with time limited and measurable program objectives. For MAI funds, list two service categories that comprise the largest amounts of MAI funding allocated for FY 2013 and use the same Implementation Plan format as for the Part A funding.

- (1) For each objective, define the service unit, the number of persons to be served, the total number of service units to be delivered, timeframe, and the estimated cost of meeting the objective.
- (2) The Implementation Plan should be placed in **Attachment 7** of the application.

### **3) E. Narrative:**

Based upon the FY 2013 Implementation Plan, provide a narrative that describes the following:

- (1) How the latest needs assessment, including results of the HRSA/HAB Unmet Need Framework, the State comprehensive plan, and service priorities link to the FY 2013 implementation plan;
- (2) If one or more of the core medical services (outpatient and ambulatory health services; AIDS Drug Assistance Program treatments; AIDS pharmaceutical assistance; oral health care; early intervention services; health insurance premium; home health care; medical nutrition therapy; hospice services; home and community-based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence.) were **NOT** selected, briefly explain why not?
- (3) How the plan will provide increased access to the HIV continuum of care for communities where HIV (not AIDS) prevalence is increasing among minority communities disproportionately impacted by HIV disease, and persons who know their HIV status but are not in HIV/AIDS primary medical care;
- (4) How the plan will address the needs of special populations;
- (5) How the plan will encourage PLWH to remain engaged in HIV/AIDS primary medical care and adhere to HIV treatments;

- (6) How the plan will promote parity of HIV services throughout the TGA. Parity of services should be addressed in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness;
- (7) How the services and their goals and objectives relate to the goals of the Healthy People 2010 Initiative, particularly those indicated in Chapter 13 of the Healthy People 2010 document. Copies of the Healthy People 2010 may be obtained from the Superintendent of Documents or downloaded at the Healthy People 2010 website: <http://www.health.gov/healthypeople/document/>.
- (8) How the TGA will ensure that resource allocations for services to women, infants, children, and youth (WICY) are in proportion to the percentage of the TGA's AIDS cases represented by each population; and
- (9) Should the TGA receive Minority AIDS Initiative (MAI) funding, describe how the funding will further enhance the quality of care and health outcomes in communities of color disproportionately impacted by the HIV epidemic, and how those activities are integral to the overall 2013 plan.

#### **4) Grantee Administration**

*The purpose of this section is to demonstrate the extent to which the Chief Elected Official (CEO) or designee in the EMA/TGA has met the legislative requirements to disburse funds quickly, closely monitor their use, and ensure that the Ryan White HIV/AIDS Program is the payor of last resort. The Ryan White HIV/AIDS Program stresses the importance of timely obligation of Ryan White HIV/AIDS Program funds. Timely obligation of Ryan White HIV/AIDS Program funds ensures that services can be provided as rapidly as possible and decreases the possibility that unobligated funds will remain at the end of the program year. Please refer to Section 2603(c) (1), (2) and (3) of the PHS Act regarding the Part A Formula and Supplemental unobligated balance (UOB) requirement. The UOB requirement does not apply to MAI funds.*

##### **Note: UOB Penalties**

*If unobligated balances of formula award exceed five percent, two penalties are imposed:*

- 1. Future year award is reduced by amount of UOB less the amount of approved carryover; and*
- 2. The grantee is not eligible for a future year supplemental award*

*NOTE that like all other grantees with UOB, the amount of UOB not covered by a waiver for carryover is subject to offset.*

*If the grantee reports unobligated formula funds of five percent or less, no penalties are imposed, although a future year award will be subject to offset.*

##### **Supplemental Funds**

*Under the Ryan White HIV/AIDS Program legislation, the Secretary has flexibility regarding supplemental funds. Grantees may not submit a carryover request for supplemental funds, which would permit those funds to be added to the subsequent grant year. Instead, UOB supplemental funds are subject to offset. UOB supplemental funds do not make a grantee ineligible for a future year supplemental award.*

**\*\*\* Section 4A should be completed by all applicants except the Columbus TGA \*\*\***

#### **4) A. Program Organization**

- (1) Provide a description of how Part A funds are administered within the EMA/TGA with reference to the staff positions described in the budget narrative and the organizational chart provided in **Attachment 1**. The narrative should describe: the local agency responsible for the grant and identify the entity responsible for administering the Part A Program, including the department, unit, staffing levels (FTEs, including any vacancies), fiscal agents, PC/planning body staff, and in-kind support staff. Describe the approaches to fill vacant staff positions that are essential for delivery, oversight, and monitoring of the Part A and MAI services/activities.
- (2) Provide a descriptive narrative of the process and mechanisms, including data collection to ensure that providers funded through multiple Ryan White HIV/AIDS Program Parts (i.e. Parts A, B, C, D, and F) will be able to distinguish which clients are served by each individual funding stream to avoid duplication of services.

**\*\*\* Section 4B should be completed by the Columbus TGA only \*\*\***

#### **4) B. Program Organization**

- (1) Provide a description of how Part A funds will be administered within the EMA/TGA with reference to the staff positions described in the budget narrative and the organizational chart provided in **Attachment 1**. The narrative should describe: the local agency responsible for the grant and identify the entity responsible for administering the Part A Program, including the department, unit, staffing levels (FTEs, including any vacancies), fiscal agents, PC/planning body staff, and in-kind support staff. Describe the approaches to fill vacant staff positions that are essential for delivery, oversight, and monitoring of the Part A and MAI services/activities.
- (2) Provide a descriptive narrative of the process and mechanisms, including data collection to ensure that providers funded through multiple Ryan White HIV/AIDS Program Parts (i.e. Parts A, B, C, D, and F) will be able to distinguish which clients are served by each individual funding stream to avoid duplication of services.

**\*\*\* Sections 4C should be completed by all applicants except the Columbus TGA \*\*\***

#### **4) C. Grantee Accountability**

*HRSA/HAB holds grantees accountable for the expenditure of funds awarded under Part A and expects grantees to monitor fiscal and programmatic compliance with all contracts and other agreements for HIV/AIDS services in the EMA/TGA. Grantees are also required to have on file a copy of each contractor's procurement document (contracts), and fiscal, program and site visit reports.*

- (1) Provide a narrative that describes the following:
  - (a) An update on the grantee's implementation of the National Monitoring Standards;
  - (b) The process used to separately track Formula, Supplemental, MAI, and carry over funds, including information on the data systems utilized;
  - (c) The process used to ensure timely monitoring and redistribution of unexpended funds;

- (d) The process used in fiscal and program monitoring, including frequency of reports;
- (e) The frequency of fiscal and programmatic monitoring site visits during a program year;
- (f) The process and timeline for corrective actions when a fiscal or programmatic-related concern is identified;
- (g) The total number of contractors funded in FY 2012; and the number and percentage of contractors that have received a fiscal and/or programmatic monitoring site visit to date and the total number planned for the FY 2013 grant year;
- (h) Any improper charges or other findings in FY 2012 to date and a summary of the corrective actions planned or taken to address these findings;
- (i) The number of contractors that have received technical assistance (TA) for FY 2012 to date (types of TA, scope, and timeline);
- (j) The number and percentage of contractors compliant with the audit requirement in OMB Circular A-133;
- (k) If there were findings in any subcontractors' A-133 audit reports, describe what the grantee has done to ensure that subcontractors have taken appropriate corrective action. Corrective actions may include but are not limited to HRSA/HAB sponsored TA and training requests from the grantee of record;
- (l) The process of receiving vouchers or invoices from contractors/subcontractors; and
- (m) The process of payment made to contractors/subcontractors, from receipt of voucher/invoice to reimbursement.

(2) Fiscal Staff Accountability

- (a) Provide a narrative that describes the following information:
  - i) The role and responsibilities of program and fiscal staff responsible for ensuring adequate reporting, reconciliation, and tracking of program expenditures;
  - ii) The process and coordination of program and fiscal staff in ensuring adequate reporting, reconciliation, and tracking of program expenditures. For example, the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, Formula and Supplemental UOB, and program income; and
  - iii) The applicant should include an organizational chart for fiscal staff in **Attachment 1**, only if the fiscal staff is not listed within the program staff personnel.

**\*\*\* Section 4D should be completed by the Columbus TGA only \*\*\***

**4) D. Grantee Accountability**

- (1) Provide a narrative that describes the following:
  - a) The process that will be used to separately track Formula, Supplement, MAI, and carry over funds, including information on data system to be utilized;
  - b) The process that will be used to ensure timely monitoring and redistribution of unexpended funds;
  - c) The process that will be used in fiscal and program monitoring, including frequency of reports;

- d) How often fiscal and programmatic monitoring site visits will be conducted;
- e) Estimate the number of contractors that will receive a fiscal and/or programmatic monitoring site visit during the FY 2013 grant year;
- f) The process for corrective actions if a fiscal or programmatic-related concern is identified;
- g) The planned frequency of fiscal and programmatic monitoring site visit during a program year; and
- h) The plan to respond to any improper charges or other audit findings
- i) The planned process of receiving vouchers or invoices from contractors/subcontractors; and
- j) The planned process of payment made to contractors/subcontractors, from receipt of voucher/invoice to reimbursement.

(2) Fiscal Staff Accountability

- a) Provide a narrative that describes the following information:
  - i. The role and responsibilities of program and fiscal staff responsible for ensuring adequate reporting, reconciliation, and tracking of program expenditures;
  - ii. The process and coordination of program and fiscal staff in ensuring adequate reporting, reconciliation, and tracking of program expenditures. For example, the program and fiscal staff’s meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, Formula and Supplemental UOB, and program income; and
  - iii. The applicant should include an organizational chart for fiscal staff in **Attachment 1**, only if the fiscal staff is not listed within the program staff personnel.

\*\*\*Sections 4E should be completed by ***all applicants except the Columbus TGA*** \*\*\*

**4) E. Third Party Reimbursement**

*The Ryan White HIV/AIDS Program is the payer of last resort, and grantees must make every effort to ensure that alternate sources of payments are pursued and that program income is used consistent with grant requirements. HRSA expects grantees to screen for proof of status and financial eligibility for use of funds in each program year. Grantees are required to use effective strategies to coordinate between Part A and third party payers that are ultimately responsible for covering the cost of services provided to eligible or covered persons. Third party sources include Medicaid, State Children’s Health Insurance Programs (SCHIP), Medicare, including Medicare Part D, and private insurance. Subcontractors providing Medicaid eligible services must be Medicaid certified.*

- (1) Provide a narrative that describes the following:
  - (a) The process used by grantees to ensure that sub-recipients are monitoring third party reimbursement; also describe the contract language or other mechanism to ensure that this takes place;
  - (b) How subcontractors document that clients have been screened for and enrolled in eligible programs (i.e., Medicare, Medicaid, private health insurance or other programs) to coordinate benefits and to ensure that Ryan White HIV/AIDS Program funds are the payor of last resort; and
  - (c) How the grantee monitors the appropriate tracking and use of any program income at both the grantee and sub-grantee level.

**\*\*\*Section 4F should be completed by the Columbus TGA only\*\*\***

#### **4) F Third Party Reimbursement**

(1) Provide a narrative that describes the following:

- (a) The process to be used by the grantee to ensure that sub-recipients will monitor third party reimbursement; also describe the contract language or other mechanism to ensure that this will take place;
- (b) How subcontractors will document that clients have been screened for and enrolled in eligible programs (i.e., Medicare, Medicaid, private health insurance or other programs) to coordinate benefits and to ensure that Ryan White HIV/AIDS Program funds are the payor of last resort; and
- (c) How the grantee will monitor the appropriate tracking and use of any program income at both the grantee and sub-grantee level.

**\*\*\* Section (4G.1) should be completed by all applicants except the Baton Rouge, LA, Columbus, OH and the Charlotte, NC TGAs \*\*\***

#### **4) G. Administrative Assessment**

*The Ryan White HIV/AIDS Program mandates that the EMA/TGA PCs must assess the efficiency of the administrative mechanism to rapidly allocate funds to the areas of greatest need within the EMA/TGA.*

(1) Provide a narrative that describes the results of the PC's assessment of the administrative mechanism in terms of:

- (a) Assessment of grantee activities to ensure timely allocation/contracting of funds and payments to contractors; and
- (b) If any deficiencies were identified by the PC, what were the deficiencies, what was the grantee's response to those deficiencies, and what is the current status of the grantee's corrective actions?

**\*\*\*Section [4G.2&3] should be completed by the Baton Rouge, LA TGA and the Charlotte, NC TGA ONLY\*\*\***

(2) Provide a narrative that describes the process used to assess that the distribution of program funds is done in an efficient and effective manner. Grantees may conduct a self assessment or contract for the assessment of the administrative mechanism.

(3) Provide a narrative that describes the results of the grantee's self assessment or contracted assessment of the administrative mechanism in terms of:

- (a) Grantee activities to ensure timely allocation/contracting of funds and payments to contractors; and
- (b) If any deficiencies were noted, what were the deficiencies? What was the grantee's response and what is the current status of the grantee's corrective actions

## 5) Planning and Resource Allocation

*The purpose of this section is to document the existence of a functioning planning process in the EMA/TGA consistent with Ryan White HIV/AIDS Program and HRSA/HAB program requirements.*

*Grantees that received Part A funding prior to FY 2007 are required to have an HIV Health Services Planning Council (PC) that plans for the use of Part A funds to support HIV services throughout the EMA/TGA. The composition of the Council must reflect the demographics of the HIV/AIDS epidemic in the EMA/TGA. PC members must be trained regarding their legislatively mandated responsibilities and other competencies necessary for full participation in collaborative decision-making.*

**\*\*\* Sections [5A and 5B] should be completed by all applicants except the Baton Rouge, LA TGA, the Charlotte, NC TGA, and the Columbus, OH TGA \*\*\*\*\***

### 5) A. Letter of Assurance from Planning Council Chair(s)

Provide a letter of assurance signed by the PC Chair(s). The letter must address the following:

- (a) The FY 2012 Formula, Supplemental, and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the PC;
- (b) That all FY 2012 Conditions of Award relative to the PC have been addressed;
- (c) The FY 2013 priorities were determined by the PC, and the approved process for establishing those priorities were used by the PC;
- (d) The PC annual membership training took place, including the date(s); and
- (e) The PC is representative and reflective of the epidemic in the EMA/TGA. If there are any vacancies on the Council, provide a plan and timeline for addressing each vacancy. Note variations between the demographics of the non-aligned consumers and the HIV disease prevalence of the EMA/TGA.

### 5) B. Describe how the priority setting and allocation process was conducted, including:

- (a) How the needs of those persons not in care were considered;
- (b) How the needs of those persons unaware of their HIV status were considered;
- (c) How the needs of historically underserved populations were considered;
- (d) How PLWH/A were involved in the priority setting and allocation process and how their priorities are considered in the process;
- (e) How data were used in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the EMA/TGA;
- (f) How changes and trends in HIV/AIDS epidemiology data were used in the priority setting and allocation process;
- (g) How cost data were used by the PC in making funding allocation decisions;
- (h) How Unmet Need data were used by the PC in making priority and allocation decisions;
- (i) How the PC considered and addressed in their prioritization and allocation process any funding increases or decreases in the Part A award;

- (j) How MAI funding was considered during the planning process to enhance access to services for disproportionately impacted minority populations; and
- (k) How the data related to EIIHA was used in the priority and allocations decision making process.
- (l) How data from other federally funded HIV/AIDS programs were used in developing priorities (**Attachment 5**).

\*\*\* Section 5C should be completed by **Baton Rouge, LA & Charlotte, NC TGAs ONLY** \*\*\*

**Note:** A TGA that received Part A funding for the first time in FY 2007 is not required to establish a PC. However, each TGA is required to provide documentation that details the process used to obtain community input for formulating the overall plan for priority setting and allocating funds.

### 5) C. Description of the Community Input Process

- 1) Describe the over-all structure and process used by your TGA to obtain community and consumer input for the priority setting and allocations process.
- 2) Describe specific prioritization and allocation process include the following:
  - (a) How the needs of those persons not in care were considered;
  - (b) How the needs of those persons unaware of their HIV status were considered;
  - (c) How the needs of historically underserved populations were considered;
  - (d) How PLWH/A were involved in the planning and allocation processes and how their priorities were considered in the process;
  - (e) How data were used in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the TGA;
  - (f) How changes and trends in HIV/AIDS epidemiology data were used in the planning and allocation process;
  - (g) How cost data were used in making funding allocation decisions;
  - (h) How Unmet Need data were used in making priority and allocation decisions;
  - (i) How the community input process considered and addressed any funding increases or decreases in the Part A award;
  - (j) How MAI funding was considered during the planning process to enhance services to minority populations; and
  - (k) How the data related to EIIHA was used in the priority and allocation decision making process.
  - (l) How data from other federally funded HIV/AIDS programs were used in developing priorities (**Attachment 5**).

## 5) D. Planning and Resource Allocation for newly designated TGA

- (I) Describe how the planning and allocation processes will be conducted. The narrative should include a description of:
- (a) How PLWH will be involved in the planning and allocation processes and how their priorities will be considered in the process;
  - (b) How the needs of those persons not in care will be considered;
  - (c) How the needs of those persons unaware of their HIV status will be considered;
  - (d) How the needs of historically underserved populations will be considered;
  - (e) How data will be used in the planning and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the TGA;
  - (f) How changes and trends in HIV/AIDS epidemiology data will be used in the planning and allocation process;
  - (g) How cost data will be used in making funding allocation decisions;
  - (h) How Unmet Need data will be used in making priority and allocation decisions;
  - (i) How MAI funding will be considered during the planning process to enhance services to minority populations; and
  - (j) How data from other federally funded HIV/AIDS programs were used in developing priorities (**Attachment 5**).

\*\*\*Section (5E) should be completed by **ALL applicants** \*\*\*

## 5) E. Funding for Core Medical Services

*Part A funds are subject to Section 2604(c) of the PHS Act, which requires that grantees expend 75 percent of Part A funds on core medical services that are needed in the EMA/TGA for individuals with HIV/AIDS identified and eligible under the Ryan White HIV/AIDS Program.*

All applicants are required to submit a table that lists planned services for FY 2013 that address the 75 percent core medical services allocation requirement, regardless of whether the applicant has received or intends to apply for a Core Medical Services Waiver. In addition, applicants must provide a table that is reflective of the results of the priority setting and resource allocation process, **if** those results are different from the table reflecting compliance with the 75 percent core medical services allocation requirement. (The Planned Services Table and the Core Medical Services Waiver request, if applicable, should be included as **Attachment 8**.)

## 6) Budget and Maintenance of Effort (MOE)

\*\*\* Section (6A) should be completed by **ALL applicants** \*\*\*

### 6) A. Budget

Follow instructions provided under Section IV, Application Format, iv-Budget

\*\*\* Section (6B) should be **completed by all applicants except the Columbus, OH TGA** \*\*\*

**6) B. Maintenance of Effort**

*The Ryan White HIV/AIDS Program legislation requires Part A Grantees to maintain, as a Condition of Award, EMA/TGA political subdivision expenditures for HIV-related core medical services and support services at a level equal to the 1-year period preceding the FY for which the grantee is applying to receive a Part A grant. After enactment of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Section 2604 (b) (1) of the enacting legislation states: “In general – The chief elected official of an eligible area shall use amounts from a grant under Section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services.” Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation and the HAB service definitions distributed to all grantees. Part A Grantees must document that they have met the MOE requirement.*

To demonstrate that grantees understand this revision to the Part A MOE requirement, applicants must submit in this section the following information:

- (1) A table that identifies the MOE budget elements and the amount of expenditures related to HIV/AIDS core medical and support services for FY 2010 and FY 2011; and
- (2) A description of the process used to determine the amount of expenditures in the table.

\*\*\* Section (6C) should be **completed by the Columbus TGA only** \*\*\*

**6) C. Maintenance of Effort**

*The Ryan White HIV/AIDS Program legislation requires Part A Grantees to maintain, as a Condition of Award, EMA/TGA political subdivision expenditures for HIV-related core medical services and support services at a level equal to the 1-year period preceding the FY for which the grantee is applying to receive a Part A grant. After enactment of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Section 2604(b)(1) of the enacting legislation states: “In general – The chief elected official of an eligible area shall use amounts from a grant under Section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services.” Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation and the HAB service definitions distributed to all grantees. Part A Grantees must document that they have met the MOE requirement.*

To demonstrate that applicants understand this revision to the Part A MOE requirement, applicants must submit in this section the following information:

- (1) Document the current level of local government expenditures related to HIV core medical services and support services in the TGA.
- (2) Provide a brief narrative assuring that the TGA will maintain the expenditures related to HIV core medical and support services by the local government at the level equal to the level documented in (1) above.

## 7) Clinical Quality Management

*Clinical Quality Management (CQM) data plays a critical role in documenting that services delivered to clients are improving their health status. Information gathered through the CQM program, as well as client-level health outcomes data, should be used as part of the EMA/TGA planning process and ongoing assessment of progress toward achieving program goals and objectives. It should also be used by the grantee to examine and refine services based on outcomes and the cost of delivering quality care.*

The Ryan White HIV/AIDS Program legislation requires that Part A Grantees “provide for the establishment of a CQM program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent PHS guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services”. The legislation allow grantees to use the lesser of 5 percent of the amount of the grant or \$3,000,000 for the activities associated with a CQM program, and states that CQM is not counted towards the administrative expense cap (Sec. 2604 (h)(5)).

**Note:** *The HAB currently has six sets of performance measures, including Clinical Performance Measures for Adults & Adolescents, Systems Level, Pediatric, Medical Case Management, Oral Health, and ADAP for use in monitoring the quality of care provided. Grantees can select appropriate performance measures from the sets to compose a portfolio of performance measures. The performance measures can be modified by the grantee to meet specific needs of the EMA/TGA. Grantees should select performance measures that are most important to their programs and the populations they serve, as they relate to their overall goals for improving clinical health outcomes. The HAB performance measures, as well as frequently asked questions, can be found online at: <http://hab.hrsa.gov/deliverhivaidscares/habperformmeasures.html>*

*Links to the HHS HIV/AIDS guidelines (formerly called the Public Health Service guidelines), the Ryan White HIV/AIDS Program legislation, and the resources and TA available to grantees with respect to improving the quality of care and establishing CQM programs may be found online at: <http://hab.hrsa.gov/manageyourgrant/granteebasics.html>.*

*The HAB Part A Program Monitoring Standards (including the standards for Quality Management) can be found online at: <http://hab.hrsa.gov/manageyourgrant/files/programmonitoringparta.pdf>*

**\*\*\* Sections 7(A)& 7(B) should be completed by all applicants except the Columbus TGA \*\*\***

### 7) A. Description of CQM Program

(I) Provide a narrative that describes the EMA/TGA’s overall **CQM Program**, which describes the following:

(a) CQM plan and infrastructure:

i) Overall vision/mission, purpose and goals of the CQM Program;

- ii) Roles of staff members or quality management committees/team responsible for overseeing and managing the CQM activities, including allocated resources;
  - iii) Number of staff FTE's assigned to CQM;
  - iv) Entities under contract or to be contracted with for CQM Program activities, reporting, data collection and/or training; and
  - v) CQM resources and training provided to grantee staff, quality management committees/team, and sub-grantees.
- (b) CQM Program processes and activities:
- i) Internal processes that assess the administrative agency's CQM Program;
  - ii) Process to implement, monitor, and evaluate the CQM Program, including specific activities that have been implemented to assess the quality of services provided by providers/subcontractors;
  - iii) Process to determine priorities for quality improvement projects and the development and monitoring of quality improvement projects;
  - iv) Specific performance measures that are being monitored by service category for outpatient/ambulatory health services and medical case management. Include a description of how MAI outcome data is being used to meet the CQM Program objectives to improve access to clinical care; and
  - v) Specific quality improvement projects that are currently being implemented within the EMA/TGA. Describe how CQM data have been used to improve and/or change service delivery in the EMA/TGA, including strategic long-range service delivery planning.

#### **7) B. Data for Quality and Program Reporting**

- (1) Name and describe the Management Information System(s) (MIS) within the EMA used for data collection and reporting operations;
- (2) Describe what CQM data has been collected to date, and provide a summary of results, including any trending data on outcomes and impact of quality improvement projects;
- (3) Describe how the CQM data was reviewed and validated by the grantee, and how the CQM data and analysis was shared with the PC; and
- (4) Describe the grantee's current client level data collection capabilities (RSR), including the percentage of providers that are able to report client level data. For CYs 2011 and 2012, describe the process used to collect and report to HRSA client level data (RSR) from all core medical and support service providers.

<p>*** Section (7C) should be <b>completed by the Columbus TGA only</b> ***</p>
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#### **7) C. Description of CQM Program for newly designated TGA**

- (1) Provide a narrative that describes the TGA's overall clinical quality management plan. Describe the following:

- (a) The process to be used to assess the current clinical quality management activities in the TGA;
- (b) Overall purpose and goals of the clinical quality management program;
- (c) Roles of the clinical quality management team responsible for overseeing and managing the quality management activities, including allocated resources;
- (d) Specific indicators that will be monitored by service category for outpatient and ambulatory health services and medical case management, including how these indicators will be measured;
- (e) Data collection strategy including how data will be collected; and
- (f) Describe how the data will be used to improve or change service delivery in the TGA.

**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 and on a separate page.**

- Attachment 1 Organizational Chart, Staffing Plan, Position Descriptions, Biographical Sketches
- Attachment 2 Letters of Agreement, Memorandum of Understanding, Intergovernmental Agreements, FY 2013 Agreements and Compliance Assurances, Certifications
- Attachment 3 HIV/AIDS Epidemiology Table
- Attachment 4 Co-morbidities, Cost and Complexity Table
- Attachment 5 Report on the Availability of Other Public Funding
- Attachment 6 Unmet Need Framework
- Attachment 7 FY 2013 Implementation Plan
- Attachment 8 Planned Services Table, Core Medical Services Waiver Request (if applicable)
- Attachment 9 EIIHA Matrix
- Attachment 10 EIIHA – HIV Testing and Awareness Data
- Attachment 11 Prospective FY 2013 WICY Waiver Request (including required Prospective WICY Waiver Assurances)

**3. Submission Dates and Times**

**Application Due Date:**

The due date for applications under this FOA is October 22, 2012 at 8:00 P.M. ET. Applications completed online are considered formally submitted when the application has been successfully

transmitted electronically by the organization's Authorized Organization Representative (AOR) through Grants.gov and 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 to document the progress of an application through the system.

1. The first will confirm receipt in the system;
2. The second will indicate whether the application has been successfully validated or has been rejected due to errors;
3. The third will be sent when the application has been successfully downloaded at HRSA; and
4. 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 Part A HIV Emergency Relief Grant 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 FOA 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\\_spoec](http://www.whitehouse.gov/omb/grants_spoec).

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 60 days after the application due date.

**5. Funding Restrictions**

Applicants responding to this announcement may request funding for a project period of up to one (1) year.

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

- Construction is not allowable. Minor alterations and renovations to an existing facility,

to make it more suitable for the purpose of the grant program are allowable with prior HRSA approval;

- Entertainment costs are not allowable. This includes the cost of amusements, social activities and related incidental costs;
- Fundraising expenses are not allowable;
- Lobbying expenses are not allowable;
- International travel is not allowable.
- Syringe language – On December 23, 2011 the Congress enacted the Consolidated Appropriations Act, 2012 (Public Law 112-74). The law reinstates the ban on Federal funding for syringe exchange programs. Consequently, funding for Syringe Services Programs (SSPs), inclusive of syringe exchange, access and disposal is no longer a permissible activity. Ryan White HIV/AIDS Program grantees are prohibited from using Ryan White HIV/AIDS Program funds to support SSPS.
- Pre-Exposure Prophylaxis (PrEP) – Ryan White HIV/AIDS Program funds cannot pay for PrEP as the person using PrEP is not HIV infected and therefore not eligible for Ryan White HIV/AIDS Program funded medication.
- Payment for any item or service to the extent that payment has been made (or reasonably can be expected to be made), with respect to that item or service, under any state compensation program, insurance policy, Federal or state benefits program, or any entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services).

Other non-allowable costs can be found in the appropriate OMB Circular, available at <http://www.whitehouse.gov/omb/circulars/>.

**Caps on expenses:** Part A Grantee Administrative Costs (including PC Support and indirect costs) may not exceed 10 percent of the grant award. Administrative expenditures for first-line entities or subcontractors may not exceed 10 percent of the aggregate amount allocated for services. Grantees are allowed to allocate up to 5 percent of the total grant award or \$3,000,000 (whichever is less) for CQM 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 applicants 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 organizations **immediately register** in Grants.gov and become familiar with the Grants.gov site application process. Applicants that do not complete the registration process 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 to complete all of the following required actions:

- Obtain an organizational Data Universal Numbering System (DUNS) number
- Register the organization with Central Contractor Registration (CCR) (or System for Award Management (SAM) starting July 30, 2012. See Section IV of this document for more SAM details.)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's CCR (or SAM – starting July 30, 2012) "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, an organization is urged to submit an application in advance of the deadline. If an application is rejected by Grants.gov due to errors, it must be corrected and resubmitted 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 Grants.gov application due date as the final and only acceptable application.**

**Tracking an application: It is incumbent on the applicant to track the application status by using the Grants.gov tracking number (GRANTXXXX) provided in the confirmation email from Grants.gov. More information about tracking an application can be found at <https://apply07.grants.gov/apply/checkAppStatus.faces> Be sure the 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 grant 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. A review criterion is outlined below with specific detail and scoring points.

Review Criteria is used to review and rank applications, and to determine Supplemental funding. The **HIV Emergency Relief Grant Program** has seven (7) review criteria:

***Note:** There are different legislative requirements for the TGA grantees that received Part A funding for the first time in FY 2007. The narrative section responses are different for Baton Rouge, LA and Charlotte, NC that elected to utilize a community planning process. The other three TGA grantees that elected to seat a PC will respond to the application as a Part A Grantee with a PC.*

**The following review criteria apply to all TGAs except Columbus, OH. [Review Criteria for Columbus, OH can be found below.](#)**

**Criterion 1: NEED (34 points)** - The extent to which the application demonstrates a comprehensive understanding of the problem and associated contributing factors to the problem.

## **Demonstrated Need**

- a. The HIV/AIDS Epidemiology Table (**Attachment 3**) is clear, complete and consistent with the information in the narrative. The sources for all data are clearly indicated.
- b. The strength of the narrative description of current HIV disease prevalence in the EMA, which includes all of the following elements:
  - 1) HIV/AIDS cases by demographic characteristics and exposure category in the EMA including (1) the estimated number of people living with HIV, (2) the number of people living with AIDS and (3) the number of new AIDS cases reported within the past 3 years (2009, 2010 and 2011);
  - 2) Disproportionate impact of HIV/AIDS on certain populations in comparison to the impact on the general population, including disproportionately impacted minority communities;
  - 3) Populations of PLWH/A in the EMA/TGA that are underrepresented in the Ryan White HIV/AIDS Program funded system of HIV/AIDS primary medical care; and
  - 4) Estimated level of service gaps among PLWH/A in the EMA/TGA.
- c. The strength of the quantitative evidence provided in a table format on the impact of co-morbidities and co-factors on the cost and complexity of providing care to PLWH/A (**Attachment 4**). The data sources on co-morbidities should be identified and compared:
  - 1) Numbers for the general population and the population of PLWH/A in the EMA/TGA;
  - 2) Sexually Transmitted Infection (STI) rates;
  - 3) Estimated number of homeless persons;
  - 4) The number and percent of persons without insurance coverage (including those without Medicaid and Medicare); and
  - 5) The number and percent of person living at or below 300 percent of the 2011 Federal Poverty Level (FPL).
- d. The strength of the narrative description of the impact of co-morbidities and co-factors on the cost and complexity of care in the EMA/TGA and trends in services and fiscal resources due to local and state budget cuts, consistent with the table above.
- e. The narrative clearly describes the impact on the EMA's/TGA's service delivery system by individuals who were released from Federal, state or local prisons during the preceding 3 years (2009, 2010 and 2011), and had HIV/AIDS on the date of their release.
- f. The clarity and completeness of the table "Report on the Availability of Other Public Funding" (**Attachment 5**) in describing the availability of other public funding in the EMA. It should include both the dollar amount(s) and the percentage of the total available funds in 2012 and the anticipated funds in 2013 for the following:
  - 1) Ambulatory/Outpatient Medical Care;
  - 2) State ADAP;
  - 3) Home and Community Based Support Services;
  - 4) Other Outpatient/Community Based Primary Medical Care Services;
  - 5) Oral Healthcare;
  - 6) Substance Abuse/Mental Health;
  - 7) MAI; and
  - 8) HIV Counseling and Testing Services

- g. Clear evidence of ways in which services funded by Federal and local sources (including other Ryan White HIV/AIDS Program) are taken into consideration in planning for the continuum of HIV care during the priority setting and allocation processes.
- h. The applicant fully documents the needs of no more than six (6) emerging populations, including:
  - 1) Unique challenges that each population presents to the services delivery system;
  - 2) Service gaps for each population; and
  - 3) Estimated costs associated with delivering services to each population.
- i. The applicant provides a clear and compelling narrative description of the need for HIV/AIDS emergency grant funds in the EMA/TGA based on factors not already discussed. The narrative describes the unique service delivery challenges in terms of service cost and complexity.
- j. If the applicant experienced a decline in Part A Formula funding, the clarity and completeness of the description of the impact of the decline in funding (state, local, and municipal), including what services were reduced or eliminated and/or any cost-containment measures implemented and the response of the PC or community planning body regarding the reduction in Formula funding, and any transitional planning for clients receiving services that were either eliminated or reduced.
- k. The clarity and completeness of the applicant's Unmet Need Framework estimates using (**Attachment 6**), which should include data sources and calculations. The applicant provided a table showing the percent of Unmet Need for PLWA and PLWH for 2009, 2010 and 2011.
- l. The strength of the narrative description of Unmet Need trends, including the demographics and location of people who know their HIV/AIDS status and are not in care. The applicant used geographic mapping such as zip code data where applicable.
- m. The strength of the narrative description of the method used to assess service needs, gaps and barriers to care for people not in care. The applicant notes the date of the latest assessments being used in the Unmet Need Framework.
- n. The applicant clearly describes how the results of the Unmet Need Framework are reflected in planning and decision making about priorities, resource allocations, and the system of care. This could include outreach activities and collaborations with Ryan White and non-Ryan White HIV/AIDS Program funded providers. The strength of the description of efforts to assist the people who know their status and are not in care in accessing primary care.

**Criterion 2: EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA)  
(33 points)**

**Unaware of HIV Status Requirement**

**This Criterion includes the distribution of the total 33 points allotted for this Section.**

### **Strategy: 8 Points**

- a. The feasibility of the EIIHA **strategy to identify** individuals who are unaware of their HIV status that includes the following:
  - 1) Specific goals this strategy is intended to achieve.
    - a) Describes how goals are consistent with the NHAS goals.
    - b) Describes how each goal is consistent with making individuals who are unaware of their HIV status aware of their status.
  - 2) A clear description of how this strategy coordinates with other programs/facilities and community efforts.
  - 3) A clear description of how EIIHA activities and strategies will be incorporated into the program's RFP's.
  - 4) A clear description of how ADAP resources will be considered in order to accommodate the needs of new positives.
  - 5) A clear description of how this strategy addresses disparities in access and services among affected subpopulations and historically underserved communities.
  - 6) A clear description of the programmatic, systemic, and logistical challenges associated with making individuals aware of their HIV status.
  - 7) A clear description of the role of Ryan White HIV/AIDS Programs in promoting routine HIV testing within the EMA/TGA.
  - 8) A clear description of how the applicant will coordinate with Ryan White HIV/AIDS Part C Program(s) for the purpose of making HIV unaware individuals aware of their HIV status.
  - 9) The EIIHA Matrix contains, at a minimum, the following Parent Groups:
    - a) All Unaware Individuals in the EMA/TGA
    - b) Individuals Tested in the Past 12 Months
    - c) Individuals Not Tested in the Past 12 Months

### **Plan: 20 Points (Total)**

#### **Barriers, Activities, and Facilitation of HIV Testing (10 Points)**

- a. The clarity and completeness of the description of the barriers that obstruct awareness of HIV status
  - 1) For each TARGET group listed in the EIIHA Matrix, describes the respective **Priority Needs** that obstruct awareness of HIV status (including local legislation or policies).
  - 2) For each TARGET group listed in the EIIHA Matrix, describes the **Cultural Challenges** that obstruct awareness of HIV status.
- b. The strength of the proposed activities to address barriers that obstruct awareness of HIV status
  - 1) For each TARGET group listed in the EIIHA Matrix, describes the respective planned activities to address **Priority Needs** that obstruct awareness of HIV status, as well as associated timeline and responsible party for each action.

- 2) For each TARGET group listed in the EIIHA Matrix, describes the respective planned activities to address **Cultural Challenges** that obstruct awareness of HIV status, as well as associated timeline and responsible party for each action.
- c. The strength of the proposed activities to promote HIV testing in the EMA/TGA.
- 1) Describes the program's coordination with other organizations to facilitate HIV testing.
  - 2) Describes the role of EIS in facilitating HIV testing.

**Identifying, Informing, Referring, and Linking (10 Points)**

***Important Note:*** *The following information provided should address all individuals unaware of their HIV status, and does **NOT** need to be Target Group specific.*

- a. Identifying individuals unaware of their HIV status
- 1) Describes the activities essential for identifying HIV positive individuals who are unaware of their status.
    - a) Describes which essential activities are to be implemented immediately.
    - b) Describes which essential activities are proposed but CANNOT be implemented immediately.
      - i. Describes the timeline associated with each essential activity to be implemented.
      - ii. Describes the parties responsible for ensuring each of these essential activities will be implemented according to the timeline.
      - iii. Describes how the applicant will coordinate with the Ryan White HIV/AIDS Part B Program with regard to **identifying** individuals unaware of their HIV status.
        - a. Describes progress from the previous FY.
      - iv. Describes how the applicant will coordinate with prevention and disease control/intervention programs (*without supplanting fund*) with regard to **identifying** individuals unaware of their HIV status.
        - a. Describes progress from the previous FY.
- b. Informing Individuals of Their HIV Status
- 1) Describes activities essential for informing unaware individuals of their HIV status.
    - a) Describes which essential activities are to be implemented immediately.
    - b) Describes which essential activities are proposed but CANNOT be implemented immediately.
      - i) Describes the timeline associated with each essential activity to be implemented.
      - ii) Describes the parties responsible for ensuring that each essential activity will be implemented according to the timeline.
      - iii) Describes how the applicant will coordinate with the Ryan White HIV/AIDS Programs with regard to informing individuals who are unaware of their HIV status.

- a. Describes progress from the previous fiscal year.
  - iv) Describes how the applicant will coordinate with prevention and disease control/intervention program (without supplanting funds) with regard to informing individuals who are unaware of their HIV status.
    - a. Describes progress from the previous fiscal year.
- c. Referring to Medical Care and Services
  - 1) Describes the activities essential to referring individuals recently informed of their HIV positive status to medical care.
    - a) Describes which essential activities are to be implemented immediately.
    - b) Describes which essential activities are proposed but **CANNOT** be implemented immediately.
      - i) Describes the timeline associated with each essential activity to be implemented.
      - ii) Describes the parties responsible for ensuring that each essential activity will be implemented according to the timeline.
      - iii) Describes how the applicant will coordinate with Ryan White HIV/AIDS Programs with regard to referring newly aware individuals to appropriate Support Services.
        - a. Describes progress from the previous fiscal year.
    - iv) Describes how the applicant will coordinate with prevention and disease control/intervention programs (without supplanting funds) with regard to referring newly aware individuals to appropriate Support Services.
      - a. Describes progress from the previous fiscal year.
- d. Linking to Medical Care
  - 1) Describes the activities essential to ensuring access to medical care regardless of where any newly identified HIV positive individual enters the continuum of care.
    - a) Describes which essential activities are to be implemented immediately.
    - b) Describes which essential activities are proposed but **CANNOT** be implemented immediately.
      - i) Describes the timeline associated with each essential activity to be implemented.
      - ii) Describes the parties responsible for ensuring that each essential activity will be implemented according to the timeline.
      - iii) Describes how the applicant will coordinate with Ryan White HIV/AIDS Programs with regard to linking individuals unaware of their HIV positive status to medical care.
        - a. Describes progress from the previous fiscal year.
    - iv) Describes how the applicant will coordinate with prevention and disease control/intervention programs – without supplanting funds – with regard to linking individuals unaware of their HIV positive status to medical care.
      - a. Describes progress from the previous fiscal year.

- v) For newly identified HIV positive individuals referred to a Ryan White HIV/AIDS funded Program, describes the activities undertaken post-referral to verify that medical care/services were accessed.
  - a. Describes which essential activities are to be implemented immediately.
  - b. Describes which essential activities are proposed but **CANNOT** be implemented immediately.
    - 1) Describes the timeline associated with each essential activity to be implemented.
    - 2) Describes the parties responsible for ensuring that each essential activity is implemented according to the timeline.
  - c. Describes progress from the previous fiscal year.
- vi) Describes the activities undertaken to form and maintain relationships with private HIV care providers for the purpose of verifying that individuals referred into private care have accessed medical care post-referral.
  - a. Describes which essential activities are to be implemented immediately.
    - 1) Describes which essential activities are proposed but **CANNOT** be implemented Describes the timeline associated with each essential activity to be implemented.
    - 2) Describes the parties responsible for ensuring that each essential activity is implemented according to the timeline.
  - b. Describes progress from the previous fiscal year.
- vii) Describes the efforts to address legal barriers to routine testing, including local and state laws and regulations.

**Data: (5 Points)**

- a. The clarity and completeness of the following **Data**:
  - 1) For CY 2010, the applicant reports the estimated number of HIV positive individuals who are unaware of their HIV status
  - 2) Describes how the applicant will coordinate with the Ryan White HIV/AIDS Programs with regard to data collection and sharing.
  - 3) Describes how the applicant will coordinate with disease control and prevention/intervention with regard to data collection and sharing.
  - 4) For CY 2011, the applicant reports the total number of HIV tests conducted using local, state and Federal funds in **Attachment 10** which includes:
    - a) Total number of HIV tests conducted.
    - b) Total number informed of their HIV status (HIV positive and HIV negative).
    - c) Total number NOT informed of their HIV status (HIV positive and HIV negative).
    - d) Total number of HIV positive tests.
    - e) Total number of HIV positive informed of their HIV status.
    - f) Total number of HIV positive referred to medical care.
    - g) Total number of HIV positive linked to medical care.

- h) Total number of HIV positive **NOT** informed of their HIV status.
- i) Total number of HIV negative tests.
- j) Total number of HIV negative informed of their HIV status.
- k) Total number of HIV negative referred to services.
- l) Total number of HIV negative **NOT** informed of their HIV status.

**Criterion 3: RESPONSE (8 points)** - The evaluation should be based on 1) the extent to which the proposed plan responds to the purpose described in the introduction of this section, 2) the strength of the proposed goals and objectives that reflect the identified need, and 3) the extent to which the activities described in the plan are capable of addressing the project objectives.

### **Access to HIV/AIDS Care and Plan for FY 2013**

- a. The clarity and completeness of the description of the comprehensive continuum of HIV/AIDS care services that are accessible to eligible PLWH/A within the EMA/TGA, including effective integration and coordination of other available services or programs with Part A funded services.
- b. The clarity and completeness of the description of the mechanisms within the EMA/TGA that enable newly infected, underserved, hard-to-reach individuals and/or disproportionately impacted communities of color to access and remain in primary medical care.
- c. The clarity and completeness of the FY 2013 Implementation Plan Table that includes at least one service goal with time-limited and measurable program objectives for four core medical services, two support services, and two MAI funded services; and the services included represent those to which the PC or community planning body has allocated the largest amounts of Part A and MAI funds for FY 2013. Each service goal clearly references the appropriate strategy (ies) identified in the 2013 Comprehensive Plan.
- d. The completeness of the table with each objective that includes all of the following elements:
  - 1) A service unit definition that clearly and consistently measures the objective (e.g. a one-hour face-to-face encounter, one round-trip bus ride, one primary care visit);
  - 2) The number of people who will be served;
  - 3) The total number of service units that will be provided;
  - 4) The time frame to meet each objective (with beginning and ending dates); and
  - 5) The estimated cost (funded by Part A and/or by MAI) for meeting each objective during the time periods.
- e. The comprehensiveness and strength of the narrative that is based on the FY 2013 Implementation Plan. The narrative should expand and clarify the information presented in the table and describes the following:
  - 1) How the EMA/TGA links its latest needs assessment (including results of the EMA's/TGA's Unmet Need Framework), service priorities, the FY 2013 Implementation Plan, and the 2013-2015 Comprehensive Plan, including how the goals and objectives relate to the strategies identified in the Comprehensive Plan.

- 2) If there are any prioritized core medical services to which no Ryan White HIV/AIDS Part A Program funding is allocated, explains why and how these services will be delivered in the EMA/TGA;
- 3) How the activities described in The Plans will provide increased access to the HIV continuum of care for minority communities;
- 4) How the activities described in The Plans will address the needs of emerging populations, as discussed in the Demonstrated Need section;
- 5) How the activities described in The Plans will encourage PLWH/A to remain engaged in HIV/AIDS primary medical care and adherent to HIV treatments;
- 6) How the activities described in The Plans will promote parity of HIV services throughout the EMA/TGA, in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness;
- 7) How the activities assure that the services delivered by subcontractors are culturally and linguistically appropriate to the population served within the EMA/TGA;
- 8) How the services and their goals and objectives relate to the goals of the Healthy People 2020 Initiative;
- 9) How the EMA/TGA will ensure that resource allocations for services to WICY are in proportion to the percentage of EMA/TGA AIDS cases represented by each population group;
- 10) How the EMA/TGA Planning Council (PC) or community planning process is using MAI funding to reduce disparities in access to care and how those activities are integral to the overall Part A FY 2013 plan;
- 11) How the results of the Unmet Need analysis were utilized by the PC or community planning body and impacted their allocation decisions;
- 12) How the PC or community planning body addressed the need of HIV medications by the target population during their Part A funding allocation process;
- 13) How the PC or community planning body addressed the needs of the population groups identified in EIIHA, persons who are unaware of their HIV status, during their Part A funding allocation process.

**Criterion 4: EVALUATIVE MEASURES (10 Points)** - The effectiveness of the method proposed to monitor and evaluate the project results. Evaluative measures must be able to assess: 1) to what extent the program objectives have been met, and 2) to what extent these can be attributed to the project.

#### **Grantee Administration and Accountability**

- a. The clarity and completeness of the description of the local agency responsible for the grant and identifies the entity responsible for administering the Part A Program. Included should be the department, unit, staffing levels (FTEs, including any vacancies), fiscal and/or management agents, planning and evaluation bodies, and in-kind support staff. Also, the clarity of the description of the process used by providers (sub-recipients) with multiple funding sources (Parts A, B, C, D, and F) to distinguish Part A and MAI funding allocated to individual clients.
- b. The strength and feasibility of the steps taken by the EMA/TGA in 2012 to implement the National Monitoring Standards.

- c. The process used to separately track Formula, Supplemental, MAI, and carry over funds, including information on the data systems utilized.
- d. The clarity and completeness of the description of the EMA/TGA processes and requirements for reporting and monitoring rates of utilization of funds by contractor/subcontractor (sub-recipient), including how the grantee takes action if contractors/subcontractors are non-compliant with programmatic and fiscal requirements. This should include a discussion of:
  - 1) The process used to ensure timely monitoring and redistribution of unexpended funds;
  - 2) The process used in fiscal and program monitoring, including frequency of reports;
  - 3) The frequency of fiscal and programmatic monitoring site visits during a program year;
  - 4) The process and timelines for corrective actions when a fiscal or programmatic-related concern is identified;
  - 5) The total number of contractors funded in FY 2012; and the number and percentage of contractors that have received a fiscal and/or programmatic monitoring site visit to date and the total number of planned site visits for the FY 2012 grant year;
  - 6) Any improper charges or other findings in FY 2012 to date and a summary of the corrective actions planned or taken to address these findings;
  - 7) The number of contractors that received technical assistance (TA) for FY 2012 to date (types, scope, and timeline of TA);
  - 8) The number and percentage of contractors compliant with the audit requirement in OMB Circular A-133; and
  - 9) If there were findings in any subcontractors' A-133 audit reports, what the grantee has done to ensure that subcontractors have taken appropriate corrective action.
- e. The clarity and completeness of the description of the process for reporting and reconciling program expenditures with fiscal staff. This should include a discussion of:
  - 1) The process of receiving vouchers or invoices from contractors/subcontractors.
  - 2) The process of payments made to contractors/subcontractors, from receipt of voucher/invoice to reimbursement.
  - 3) The role and responsibilities of program and/or fiscal staff in reporting and reconciling program expenditures; the applicant should include an organizational chart for fiscal staff, if fiscal staff is not within the program staff personnel.
  - 4) The process and coordination of program and/or fiscal staff in ensuring adequate reporting, reconciliation, and tracking of program expenditures.
- f. The clarity and completeness of the description of how the EMA/TGA assures that clients who are eligible for third-party payments (including Medicaid and Medicare) enroll in these programs and that Ryan White HIV/AIDS Program funds are used only as a payor of last resort. This should also include a discussion of:
  - 1. The process used by grantees to ensure that contractors (sub-recipients) are monitoring third party reimbursement. Also describe the contract language or other mechanism to ensure that this takes place.
  - 2. How subcontractors document that clients have been screened for and enrolled in eligible programs (i.e., Medicare, Medicaid, private health insurance or other programs) to coordinate benefits and to ensure that Ryan White HIV/AIDS Program funds are the payor of last resort; and how the grantee monitors the appropriate tracking and use of any program income.

**Review criteria for all applicants except Baton Rouge, LA TGA and Charlotte, NC TGA:**

The clarity and completeness of the description of the results of the PC's assessment of the administrative mechanism in terms of:

- 1) Activities to ensure timely allocation/contracting of grant funds and timely payments to contractors; and
- 2) If any deficiencies were identified by the PC, the applicant (grantee) described the deficiencies, the grantee's response to those deficiencies, and the current status of the grantee's corrective actions.

**Review criteria for the Baton Rouge, LA TGA and the Charlotte, NC TGA ONLY:**

- a. The clarity and completeness of the description of the process used to assess that the distribution of program funds is done in an efficient and effective manner.
- b. The clarity and completeness of the description of the *results* of the TGA assessment of the administrative mechanism in terms of:
  - 1) Activities to ensure timely allocation/contracting of grant funds and timely payments to contractors; and
  - 2) If any deficiencies were identified by the PC, the applicant (grantee) described the deficiencies, the grantee's response to the deficiencies, and the current status of the grantee's corrective actions.

**Criterion 5: PLANNING AND RESOURCE ALLOCATION (5 Points)**

**Review criteria for all applicants except Baton Rouge, LA TGA and Charlotte, NC TGA:**

- A. The Letter of Assurance signed by the PC Chair(s) addressed the following components:
  - (a) The FY 2012 Formula, Supplemental, and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the PC;
  - (b) That all FY 2012 Conditions of Award relative to the PC have been addressed;
  - (c) The FY 2012 priorities were determined by the PC, and the approved process for establishing those priorities was used by the PC;
  - (d) The PC's annual membership training took place; and
  - (e) The PC is representative and reflective of the epidemic in the EMA/TGA. If there are any vacancies on the Council, provided a plan and timeline for addressing each vacancy. If applicable, noted variations between the demographics of the non-aligned consumers and the HIV disease prevalence of the EMA/TGA.
- B. The applicant clearly and comprehensively described how the priority setting and allocation process was conducted, including a description of:
  - (a) How the needs of those persons not in care were considered;
  - (b) How the needs of those persons unaware of their HIV status were considered;
  - (c) How the needs of historically underserved populations were considered;
  - (d) How PLWH/A were involved in the priority setting and allocation process and how their priorities are considered in the process;

- (e) How data were used in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the EMA/TGA;
- (f) How changes and trends in HIV/AIDS epidemiology data were used in the priority setting and allocation process;
- (g) How cost data were used by the PC in making funding allocation decisions;
- (h) How Unmet Need data were used by the PC in making priority and allocation decisions;
- (i) How the PC considered and addressed in their prioritization and allocation process any funding increases or decreases in the Part A award;
- (j) How MAI funding was considered during the planning process to enhance access to services for disproportionately impacted minority populations; and
- (k) How the data related to EIIHA was used in the priority and allocations decision making process.
- (l) How data from other federally funded HIV/AIDS programs were used in developing priorities (**Attachment 5**).

\*\*\* Section 5C should be completed by **Baton Rouge, LA & Charlotte, NC TGAs ONLY** \*\*\*

**Note:** A TGA that received Part A funding for the first time in FY 2007 is not required to establish a Planning Council. However, each TGA is required to provide documentation that details the process used to obtain community input for formulating the overall plan for priority setting and allocating funds.

### **C. Description of the Community Input Process**

- 1) The over-all structure and process used to obtain community and consumer input are appropriate and effective for priority setting and allocations
- 2) Described specific prioritization and allocation process include the following:
  - (a) How the needs of those persons not in care were considered;
  - (b) How the needs of those persons unaware of their HIV status were considered;
  - (c) How the needs of historically underserved populations were considered;
  - (d) How PLWH/A were involved in the planning and allocation processes and how their priorities were considered in the process;
  - (e) How data was used in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the TGA;
  - (f) How changes and trends in HIV/AIDS epidemiology data were used in the planning and allocation process;
  - (g) How cost data was used in making funding allocation decisions;
  - (h) How Unmet Need data was used in making priority and allocation decisions;
  - (i) How the community input process considered and addressed any funding increases or decreases in the Part A award;

- (j) How MAI funding was considered during the planning process to enhance services to minority populations; and
- (k) How the data related to EIIHA was used in the priority and allocation decision making process.
- (l) How data from other federally funded HIV/AIDS programs were used in developing priorities **Attachment 5**

**D. Funding for Core Medical Services – Should be completed by ALL applicants**

Submission of a table that lists all the planned services for FY 2013 that address the 75 percent core medical services allocation requirement. The Planned Services Table and the Core Medical Services Waiver request (if applicable) should be included as **Attachment 8**.

**Criterion 6: SUPPORT REQUESTED (5 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.

**Budget and Maintenance of Effort (MOE) Documentation**

- a. The reasonableness and completeness of the SF 424A with the required categories.
- b. The clarity and strength of the budget justification with descriptions that explain the amounts requested for each line in the budget.
- c. The clarity and completeness of the documentation describing how the EMA/TGA met the MOE legislative requirement as supported by the MOE Table included with the application. The clarity and completeness of the list of core medical services and support services budget elements and a description of the tracking systems used to document the elements. The clarity and completeness of the list of the entities and/or departments of local government reporting eligible HIV-related expenditures and a description of the methodology used to track and report on the MOE.

**Note:** *The final budget and MOE will be approved by HRSA/HAB after the award amounts are determined.*

**Criterion 7: SPECIFIC PROGRAM CRITERIA (5 Points):**

**Clinical Quality Management (CQM)**

- a. The clarity and completeness of the description of the overall purpose and goal(s) of the CQM Program that meets the legislative requirements for CQM stated in the Part A FOA.
- b. The applicant makes it clear that a formal process for overseeing and managing the CQM Program has been established and identifies the roles of the staff or committees responsible for the CQM Program including the resources allocated for the program.
- c. The applicant demonstrates that the administrative agency has a system in place to monitor and conduct periodic assessments of its CQM Program and describes specific activities that have been implemented to assess the quality of services provided by

provider/subcontractors. These should include such activities as ensuring that clinical practices adhere to HHS/PHS guidelines and that other health services provided by providers/subcontractors adhere to the EMA/TGA established standards of care (if developed within the EMA/TGA).

- d. The applicant clearly identifies the specific indicators for primary medical care and medical case management that are being monitored by service category.
- e. The applicant discusses quality improvement projects that have been undertaken to improve service delivery and what improvements have been seen.
- f. The clarity and completeness of the description of the ongoing activities and/or specific concrete plans to use data to show how Part A funded services, including support services, are improving HIV-related clinical health outcomes of PLWH/A in the EMA/TGA.
- g. The clarity and completeness of the description of the data collection strategy including how data are collected, what data has been collected to date, and the results.
- h. The applicant demonstrates that an information loop exists between the administrative agency and PC or community planning process regarding CQM findings. The narrative clearly suggests that the PC or community planning process considered the quality efforts as a component of the priority setting and resource allocation process within the EMA/TGA.

Review Information <b>applies to the Columbus, OH TGA only</b> ***
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## Review Criteria for Columbus, Ohio only

**Criterion 1: NEED (34 points)** - The extent to which the application demonstrates a comprehensive understanding of the problem and associated contributing factors to the problem.

### Demonstrated Need

- a. The HIV/AIDS Epidemiology Table (**Attachment 3**) is clear, complete and consistent with the information in the narrative. The sources for all data are clearly indicated.
- b. The strength of the narrative description of current HIV disease prevalence in the TGA, which includes all of the following elements:
  - 1) HIV/AIDS cases by demographic characteristics and exposure category in the TGA including (1) the estimated number of people living with HIV, (2) the number of people living with AIDS and (3) the number of new AIDS cases reported within the past 3 years (2009, 2010 and 2011);
  - 2) Disproportionate impact of HIV/AIDS on certain populations in comparison to the impact on the general population, including disproportionately impacted minority communities;
  - 3) Populations of PLWH/A in the TGA that are underrepresented in the Ryan White HIV/AIDS Program funded system of HIV/AIDS primary medical care; and
  - 4) Estimated level of service gaps among PLWH/A in the TGA.

- c. The strength of the quantitative evidence provided in a table format on the impact of co-morbidities and co-factors on the cost and complexity of providing care to PLWH/A (**Attachment 4**). The data sources on co-morbidities should be identified and compared:
  - 1) Numbers for the general population and the population of PLWH/A in the TGA;
  - 2) Sexually Transmitted Infection (STI) rates;
  - 3) Estimated number of homeless persons;
  - 4) The number and percent of persons without insurance coverage (including those without Medicaid and Medicare); and
  - 5) The number and percent of person living at or below 300 percent of the 2011 Federal Poverty Level (FPL).
  
- d. The strength of the narrative description of the impact of co-morbidities and co-factors on the cost and complexity of care in the TGA and trends in services and fiscal resources due to local and state budget cuts, consistent with the table above.
  
- e. The narrative clearly describes the impact on the TGA's service delivery system by individuals who were released from Federal, state or local prisons during the preceding 3 years (2009, 2010 and 2011), and had HIV/AIDS on the date of their release.
  
- f. The clarity and completeness of the table "Report on the Availability of Other Public Funding" (**Attachment 5**) in describing the availability of other public funding in the EMA. It should include both the dollar amount(s) and the percentage of the total available funds in 2012 and the anticipated funds in 2013 for the following:
  - 1) Ambulatory/Outpatient Medical Care;
  - 2) State ADAP;
  - 3) Home and Community Based Support Services;
  - 4) Other Outpatient/Community Based Primary Medical Care Services;
  - 5) Oral Healthcare;
  - 6) Substance Abuse/Mental Health;
  - 7) MAI; and
  - 8) HIV Counseling and Testing Services
  
- g. Clear evidence of ways in which services funded by Federal and local sources (including other Ryan White HIV/AIDS Program) are taken into consideration in planning for the continuum of HIV care during the priority setting and allocation processes.
  
- h. The applicant fully documents the needs of no more than six (6) emerging populations, including:
  - 4) Unique challenges that each population presents to the services delivery system;
  - 5) Service gaps for each population; and
  - 6) Estimated costs associated with delivering services to each population.
  
- i. The applicant provides a clear and compelling narrative description of the need for HIV/AIDS emergency grant funds in the TGA based on factors not already discussed. The narrative describes the unique service delivery challenges in terms of service cost and complexity.
  
- j. The clarity and completeness of the applicant's Unmet Need Framework estimates using (**Attachment 6**), which should include data sources and calculations.

- k. The strength of the narrative description of Unmet Need trends, including the demographics and location of people who know their HIV/AIDS status and are not in care. The applicant used geographic mapping such as zip code data where applicable.
- l. The strength of the narrative description of the method used to assess service needs, gaps and barriers to care for people not in care.

**Criterion 2: EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA) (33 points)** – The evaluation should be based on 1) the extent to which the plan responds to the purpose described in the introduction of this section; 2) the strength of the proposed activities to identify HIV positive individuals who are unaware of their HIV status; and 3) the degree to which the planned activities will result in individuals becoming aware of their HIV status.

- a. The clarity and completeness of the plan to address identifying individuals living with HIV aware of their HIV status.
- b. The clarity and completeness of the plan to make those individuals identified aware of their HIV status.

**Criterion 3: RESPONSE (8 points)** - The evaluation should be based on 1) the extent to which the proposed plan responds to the purpose described in the introduction of this section, 2) the strength of the proposed goals and objectives that reflect the identified need, and 3) the extent to which the activities described in the plan are capable of addressing the project objectives.

#### **Access to HIV/AIDS Care and Plan for FY 2013**

- a. The clarity and completeness of the description of the comprehensive continuum of HIV/AIDS care services that are accessible to eligible PLWH/A within the TGA, including effective integration and coordination of other available services or programs with Part A funded services.
- b. The clarity and completeness of the description of the mechanisms within the TGA that enable newly infected, underserved, hard-to-reach individuals and/or disproportionately impacted communities of color to access and remain in primary medical care.
- c. The clarity and completeness of the FY 2013 Implementation Plan Table that includes at least one service goal with time-limited and measurable program objectives for four core medical services, two support services, and two MAI funded services; and the services included represent those to which the PC or community planning body has allocated the largest amounts of Part A and MAI funds for FY 2013. Each service goal clearly references the appropriate strategy (ies) identified in the 2013 Comprehensive Plan.
- d. The completeness of the table with each objective that includes all of the following elements:
  - 1) A service unit definition that clearly and consistently measures the objective (e.g. a one-hour face-to-face encounter, one round-trip bus ride, one primary care visit);
  - 2) The number of people who will be served;
  - 3) The total number of service units that will be provided;
  - 4) The time frame to meet each objective (with beginning and ending dates); and

- 5) The estimated cost (funded by Part A and/or by MAI) for meeting each objective during the time periods.
- e. The comprehensiveness and strength of the narrative that is based on the FY 2013 Implementation Plan. The narrative should expand and clarify the information presented in the table and describes the following:
- 1) How the TGA links its latest needs assessment (including results of the TGA's Unmet Need Framework), service priorities, the FY 2013 Implementation Plan, and the 2013-2015 Comprehensive Plan, including how the goals and objectives relate to the strategies identified in the Comprehensive Plan.
  - 2) If there are any prioritized core medical services to which no Ryan White HIV/AIDS Part A Program funding is allocated, explains why and how these services will be delivered in the TGA;
  - 3) How the activities described in The Plans will provide increased access to the HIV continuum of care for minority communities;
  - 4) How the activities described in The Plans will address the needs of emerging populations, as discussed in the Demonstrated Need section;
  - 5) How the activities described in The Plans will encourage PLWH/A to remain engaged in HIV/AIDS primary medical care and adherent to HIV treatments;
  - 6) How the activities described in The Plans will promote parity of HIV services throughout the TGA, in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness;
  - 7) How the activities assure that the services delivered by subcontractors are culturally and linguistically appropriate to the population served within the TGA;
  - 8) How the services and their goals and objectives relate to the goals of the Healthy People 2020 Initiative;
  - 9) How the TGA will ensure that resource allocations for services to WICY are in proportion to the percentage of EMA/TGA AIDS cases represented by each population group;
  - 10) How the TGA Planning Council (PC) or community planning process is using MAI funding to reduce disparities in access to care and how those activities are integral to the overall Part A FY 2013 plan;
  - 11) How the results of the Unmet Need analysis were utilized by the PC or community planning body and impacted their allocation decisions;
  - 12) How the PC or community planning body addressed the need of HIV medications by the target population during their Part A funding allocation process;
  - 13) How the PC or community planning body addressed the needs of the persons who are unaware of their HIV status, during their Part A funding allocation process.

**Criterion 4: EVALUATIVE MEASURES (10 Points)** - The effectiveness of the method proposed to monitor and evaluate the project results. Evaluative measures must be able to assess: 1) to what extent the program objectives have been met, and 2) to what extent these can be attributed to the project.

#### **Grantee Administration and Accountability**

- a. The clarity and completeness of the description of the local agency responsible for the grant and identifies the entity responsible for administering the Part A Program. Included

should be the department, unit, staffing levels (FTEs, including any vacancies), fiscal and/or management agents, planning and evaluation bodies, and in-kind support staff. .

- b.** The strength and feasibility of the steps to be taken by the TGA in 2013 to implement the National Monitoring Standards.
- c.** The process to be used to separately track Formula, Supplemental, MAI, and carry over funds, including information on the data systems utilized.
- d.** The clarity and completeness of the description of the TGA's planned processes and requirements for reporting and monitoring rates of utilization of funds by contractor/subcontractor (sub-recipient), including what types of actions the grantee will take if contractors/subcontractors are non-compliant with programmatic and fiscal reporting. This should include a discussion of:
  - 1) The process that will be used to ensure timely monitoring and redistribution of unexpended funds;
  - 2) The process that will be used in fiscal and program monitoring, including frequency of reports;
  - 3) The planned frequency of fiscal and programmatic monitoring site visits during the 2013 program year;
  - 4) The process and timelines for corrective actions if a fiscal or programmatic-related concern is identified;
  - 5) The planned frequency of fiscal audits; and
  - 6) The plan to respond to any improper charges or other audit findings
- e.** The clarity and completeness of the description of the process to be used for reporting and reconciling program expenditures with fiscal staff. This should include a discussion of:
  - 1) The process of receiving vouchers or invoices from contractors/subcontractors.
  - 2) The process of payments made to contractors/subcontractors, from receipt of voucher/invoice to reimbursement.
  - 3) The role and responsibilities of program and/or fiscal staff in reporting and reconciling program expenditures; the applicant should include an organizational chart for fiscal staff, if fiscal staff is not within the program staff personnel.
  - 4) The process and coordination of program and/or fiscal staff in ensuring adequate reporting, reconciliation, and tracking of program expenditures.
- f.** The clarity and completeness of the description of how the TGA assures that clients who are eligible for third-party payments (including Medicaid and Medicare) enroll in these programs and that Ryan White HIV/AIDS Program funds are used only as a payor of last resort. This should also include a discussion of:
  - 1) The process to be used by grantee to ensure that contractors (sub-recipients) are monitoring third party reimbursement. Also describe the contract language or other mechanism to ensure that this takes place.
  - 2) How subcontractors document that clients have been screened for and enrolled in eligible programs (i.e., Medicare, Medicaid, private health insurance or other programs) to coordinate benefits and to ensure that Ryan White HIV/AIDS Program funds are the payor of last resort; and how the grantee monitors the appropriate tracking and use of any program income.

- g. The applicant describes how the TGA will consider cost when allocating and dispersing funds for HIV services.

**Criterion 5: PLANNING AND RESOURCE ALLOCATION (5 Points)**

- a. The applicant describes a planning and allocation process that demonstrates that PLWH will be encouraged to fully and actively participate and that their needs and preferences will be addressed as well as the needs of those not in care and those from historically underserved populations.
- b. The applicant demonstrates that a variety of current data sources will be used in the planning and allocation processes to consider any gaps in the TGA's funding of core medical services and to allocate the necessary TGA funds to address these service gaps. If funding was not allocated to the core medical services, the applicant provides a description of how the core services will be met through other sources.
- c. The applicant discusses how changes and trends in the HIV/AIDS epidemiology data will be considered in the allocation decision.
- d. The applicant provides a list of all services to be funded in FY 2013. The list should also include the funding allocations for each service.
- e. The applicant documents how the proposed use of the FY 2013 funds is consistent with the most recent SCSN.
- f. Funding for Core Medical Services –  
Submission of a table that lists all the planned services for FY 2013 that address the 75 percent core medical services allocation requirement. The Planned Services Table and the Core Medical Services Waiver request (if applicable) should be included as **Attachment 8.**

**Criterion 6: SUPPORT REQUESTED (5 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.

**Budget and Maintenance of Effort (MOE) Documentation**

- a. The reasonableness and completeness of the SF 424A with the required categories.
- b. The clarity and strength of the budget justification with descriptions that explain the amounts requested for each line in the budget.
- c. The clarity and completeness of the documentation describing how the TGA will meet the MOE legislative requirement as supported by the MOE Table included with the application. The clarity and completeness of the list of core medical services and support services budget elements and a description of the tracking systems that will be used to document the elements. The clarity and completeness of the list of the entities and/or departments of local government reporting eligible HIV-related expenditures and a description of the methodology that will be used to track and report on the MOE.

**Note:** *The final budget and MOE will be approved by HRSA/HAB after the award amounts are determined.*

**Criterion 7: SPECIFIC PROGRAM CRITERIA (5 Points):**

**Clinical Quality Management (CQM)**

- a. The clarity and completeness of the description of the overall purpose and goal(s) of the CQM Program that meets the legislative requirements for CQM stated in the Part A FOA.
- b. The applicant describes the process to be used to assess the current clinical quality management activities in the TGA.
- c. The applicant makes it clear that a formal process for overseeing and managing the CQM Program will be established and will identify the roles of the staff or committee responsible for the CQM Program including the resources allocated for the program.
- d. The applicant demonstrates that the administrative agency has a plan to monitor and conduct periodic assessments of its CQM Program and describes specific activities that will be implemented to assess the quality of services provided by providers/ subcontractors. These should include such activities as ensuring that clinical practices adhere to HHS/PHS guidelines and that other health services provided by providers/ subcontractors adhere to the TGA established standards of care (if developed within the TGA).
- e. The applicant clearly identifies the specific indicators for primary medical care and medical case management that will be monitored by service category.
- f. The clarity and completeness of the description of the data collection strategy including how data will be collected, what data has been collected to date, and the results.
- g. The applicant demonstrates that an information loop will be established between the administrative agency and PC or community planning process regarding CQM findings. The narrative clearly suggests that the PC or community planning process will consider the quality efforts as a component of the priority setting and resource allocation process within the TGA.

**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 Section V. 1 Review Criteria 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 March 1, 2013.

## **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 merits 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 NoA sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the grant, 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 agency's Authorized Representative, and reflects the only authorizing document. It will be sent prior to the start date of March 1, 2013.

### **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 Sub-awards 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 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/hhsgrantspolicy.pdf>. 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 NoA).

## **Non-Discrimination Requirements**

To serve persons most in need and to comply with Federal law, services must be widely accessible. Services must not discriminate on the basis of age, disability, sex, race, color, national origin or religion. The HHS Office for Civil Rights provides guidance to grant and cooperative agreement recipients on complying with civil rights laws that prohibit discrimination on these bases. Please see <http://www.hhs.gov/ocr/civilrights/understanding/index.html>. HHS also provides specific guidance for recipients on meeting their legal obligation under Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin in programs and activities that receive Federal financial assistance (P. L. 88-352, as amended and 45 CFR Part 80). In some instances a recipient's failure to provide language assistance services may have the effect of discriminating against persons on the basis of their national origin. Please see <http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html> to learn more about the Title VI requirement for grant and cooperative agreement recipients to take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency.

## **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>.

## **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 incorporate diversity within specific cultural groups including but not limited to cultural uniqueness within Native American populations, Native Hawaiian, Pacific Islanders, and other ethnic groups, 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? \(AHRQ\)Health Information Technology \(HHS\)](#)

### 3. Reporting

The successful applicant under this FOA must comply with the following reporting and monitoring activities:

a. **Audit Requirements**

Comply with audit requirements of the 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>;

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 according to the following schedule: <http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrschedule.pdf>. 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 NoA.
2. **Ryan White Services Report.** Acceptance of this award indicates that the grantee assures that it will comply with data requirements of the Ryan White Services Report (RSR) and that it will mandate compliance by each of its contractors and subcontractors. The RSR captures information necessary to demonstrate program performance and accountability. (<http://hab.hrsa.gov/manageyourgrant/careware.html>).
3. **Client level Data Report.** All Ryan White HIV/AIDS Program core services and support services providers are required to submit Client-Level Data for Calendar Year (CY) 2013. Please refer to the HIV/AIDS Program Client Level Data website at <http://hab.hrsa.gov/manageyourgrant/techdataassistance.html> for additional information.
4. **Final Report(s).** A final report is due within 90 days after the project period ends. The final report collects program-specific goals and progress on strategies; core performance measurement data; impact of the overall project; the degree to which the grantee achieved the mission, goal and strategies outlined in the program; grantee objectives and accomplishments; barriers encountered; and responses to summary questions regarding the grantee's overall experiences over the entire project period. The final report must be submitted on-line by awardees in the Electronic Handbooks system at <https://grants.hrsa.gov/webexternal/home.asp>.

5. **Consolidated List of Contracts (CLC).** Include the list of contracts for all providers receiving Ryan White HIV/AIDS Program funding/contracts. The CLC must be submitted through the HRSA Electronic Handbook (EHB) using the format provided in that system.
6. **Women, Infants, Children and Youth (WICY).** Grantees must report expenditures for WICY for the previous budget year within 150 days of the end of the grant year as mandated by the Ryan White HIV/AIDS Program.
7. **Tangible Personal Property Report.** If applicable, the awardee must submit the Tangible Personal Property Report (SF-428) and any related forms. The report must be submitted within 90 days after the project period ends. Awardees are required to report all federally-owned property and acquired equipment with an acquisition cost of \$5,000 or more per unit. Tangible personal property means property of any kind, except real property, that has physical existence. It includes equipment and supplies. Property may be provided by HRSA or acquired by the recipient with award funds. Federally-owned property consists of items that were furnished by the Federal Government. Tangible personal property reports must be submitted electronically through EHB. More specific information will be included in the NoA.

## VII. Agency Contacts

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

Karen Mayo  
Lead Grants Management Specialist  
HIV/AIDS and Rural Health Bureau  
HRSA Division of Grants Management Operations, OFAM  
5600 Fishers Lane, Room 11-103  
Rockville, MD 20857  
Telephone: (301) 443-3555  
Fax: (301) 594-4073  
E-mail: [kmayo@hrsa.gov](mailto:kmayo@hrsa.gov)

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

Steven R. Young, MSPH  
Director, Division of Metropolitan HIV/AIDS Programs  
HIV/AIDS Bureau, HRSA  
5600 Fishers Lane, Room 7A-55  
Rockville, MD 20857  
Telephone: (301) 443-9091  
Fax: (301) 443-5271  
Email: [SYoung@hrsa.gov](mailto:SYoung@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, 7 days a week, excluding Federal holidays at:

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

Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Call Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Contact Center  
Telephone: (877) 464-4772  
TTY: (877) 897-9910  
E-mail: [CallCenter@HRSA.GOV](mailto:CallCenter@HRSA.GOV)

## **VIII. Other Information**

### **1. National Monitoring Standards**

The HAB/DSS Program, Fiscal and Universal National Monitoring Standards for Ryan White HIV/AIDS Program Part A and B Grantees, are available at:  
<http://hab.hrsa.gov/manageyourgrant/granteebasics.html>.

### **2. Program Integrity Initiative**

The Program Integrity Initiative is designed to target the greatest risks of fraud, waste and abuse; reduce those risks by enhancing existing program integrity operations; share new and best program integrity practices; and measure the results of our efforts. The purpose of this message is to inform you of the HRSA efforts toward strengthening program integrity in our own Agency.

## **IX. Tips for Writing a Strong Application**

HRSA has designed a technical assistance webpage to assist applicants in preparing applications. Resources include help with system registration, finding and applying for funding opportunities, writing strong applications, understanding the review process, and many other topics which applicants will find relevant. The website can be accessed online at:  
<http://www.hrsa.gov/grants/apply/index.html>.

In addition, a concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at  
<http://dhhs.gov/asfr/ogapa/grantinformation/apptips.html>.

## Appendix A

### FY 2013 AGREEMENTS AND COMPLIANCE ASSURANCES Ryan White HIV/AIDS Treatment Extension Act of 2009 Part-A Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area \_\_\_\_\_, (hereinafter referred to as the EMA/TGA) assure that:

**Pursuant to Section 2602(a)(2)<sup>1,2</sup>**

The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

**Pursuant to Section 2602(a)(2)(B)**

The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last 5 years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

**Pursuant to Section 2602(b)(4)**

The EMA/TGA Planning Council will determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

**Pursuant to Section 2603(c)**

The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

**Pursuant to Section 2603(d)**

The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council.

**Pursuant to Section 2604 (a)**

The EMA/TGA will expend funds according to priorities established by the Planning Council, and for core medical services, support services, and administrative expenses only.

**Section 2604(c)**

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<sup>1</sup> All statutory references are to the Public Health Service Act, unless otherwise specified.

<sup>2</sup> The five new TGAs (Baton Rouge, Charlotte, Indianapolis, Memphis, Nashville and Columbus) are exempted from these requirements, but must provide a process for obtaining community input as described in **Section 2609(d)(1)(A)**.

The EMA/TGA will expend not less than 75 percent of service dollars for core medical services, unless waived by The Secretary.

**Pursuant to Section 2604(f)**

The EMA/TGA will, for each of such populations in the eligible area use, from the grants made for the area under Section 2601(a) for a FY, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS, unless a waiver from this provision is obtained.

**Pursuant to Section 2604(g)**

The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by The Secretary.

**Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)**

The EMA/TGA will expend no more than 10 percent of the grant on administrative costs, and in accordance with the legislative definition of administrative activities and the allocation of funds to entities and subcontractors, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

**Pursuant to Section 2604(h)(5)**

The EMA/TGA will establish a CQM Program that meets HRSA requirements and that funding for this program shall not exceed the lesser of 5 percent of program funds or \$3 million.

**Pursuant to Section 2604(i)**

The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

**Pursuant to Section 2605(a)**

With regard to the use of funds,

- a. funds received under Part A of Title XXVI of the PHS Act will be used to supplement, not supplant, state funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease;
- b. during the grant period, political subdivisions within the EMA/TGA will maintain at least their prior FY's level of expenditures for HIV related services for individuals with HIV disease;
- c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV related services as required in the above paragraph; and
- d. documentation of this MOE will be retained.

**Pursuant to Section 2605(a)(3)**

The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating EIS for individuals diagnosed as being HIV positive.

**Pursuant to Section 2605(a)(5)**

The EMA/TGA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA/TGA.

**Pursuant to Section 2605(a)(6)**

Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any state compensation program, insurance policy, or any Federal or state health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

**Pursuant to Section 2605(a)(7)(A)**

Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

**Pursuant to Section 2605(a)(7)(B)**

Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

**Pursuant to Section 2605(a)(7)(C)**

A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

**Pursuant to Section 2605(a)(8)**

The EMA/TGA has participated in the Statewide Coordinated Statement of Need (SCSN) process initiated by the state, and the services provided under the EMA/TGA’s comprehensive plan are consistent with the SCSN.

**Pursuant to Section 2605(a)(9)**

The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

**Pursuant to Section 2605(a)(10)**

The EMA/TGA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

**Pursuant to Section 2605(e)**

The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

**Pursuant to Section 2681(d)**

Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

**Pursuant to Section 2684**

No funds shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

\_\_\_\_\_  
Signature

Date\_\_\_\_\_

\_\_\_\_\_  
Title

## Appendix B

### **EIIHA-Related Definitions:**

Please note: each of the following definitions should be taken in the context of the EIIHA initiative

- **Unaware of HIV Status:** Any individual who has **NOT** been tested for HIV in the past **12-months**, any individual who has **NOT** been informed of their HIV result (HIV positive or HIV negative), and any HIV positive individual who has **NOT** been informed of their **confirmatory** HIV result.

**Note:** The **12-month** time period is intended to be utilized as a **means to establish a threshold** for the purpose of assisting in the identification of individuals unaware of their HIV status, and is exclusive to Early Identification of Individuals with HIV/AIDS (EIIHA) initiative.

The **12-month** time period is **NOT** intended to be utilized as a recommended testing frequency, or for the purpose of assessing risk to HIV. For recommended HIV testing frequencies and risk assessments please refer to CDC guidelines.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

- **Identifying HIV Unaware:** The **categorical breakdown** of the overall unaware population into **groups** (*Parent Groups & Target Groups*), which allow for the overall EIIHA strategy to be **customized based on the Priority Needs and Cultural Challenges of each Target Group**, for the purposes of identifying, counseling, testing, informing, referring, and linking (*if HIV positive*) these individuals into medical care. See “**EIIHA Matrix Overview**” section below.
- **Informing HIV Unaware:** Informing an HIV negative individual, post-test, of their appropriate HIV screening result. Informing an HIV positive individual, post-test, of their **confirmatory** HIV result.
- **Referral:** The provision of timely, appropriate, and pre-established guidance to an individual that is designed to refer him/her to a specific medical care/supportive service provider for the purpose of accessing medical care/supportive services after the individual has been informed of their HIV status (positive or negative).

**Note:** Supportive services are any service that keeps HIV negative individuals negative and HIV positive individuals in care. HIV negative individuals are **not eligible** for Ryan White HIV/AIDS Program funded services. HIV positive individuals may be referred to Ryan White HIV/AIDS Program funded services or non-Ryan White HIV/AIDS Program funded services.

- **Linkage to Medical Care:** The post-referral verification that medical care was accessed by an HIV positive individual being referred to medical care (*i.e., Confirmation that the first scheduled medical care appointment occurred*).
- **Priority Needs:** Behavioral and environmental needs associated with a specific Target Group, which obstruct access to care.

- **Cultural Challenges:** Challenges that result from the cultural norms of a specific Target Group that obstruct access to care.
- **Parent Groups:** Large and diverse HIV unaware groups which ensure all relevant Target Groups are encompassed in the scope of the targeted unaware population. Parent Groups allow for the gradual breakdown of the overall unaware population into smaller, more specific groups for the purpose of identifying groups that can be more effectively targeted.
- **Target Groups:** Highly specific groups of HIV unaware individuals whose *Priority Needs* and *Cultural Challenges* may be readily distinguishable from other Target Groups under the same Parent Group, and can be effectively targeted.
- **Medical Care:** A medical visit which entails at least one of the following; CD4 count, viral load, or an HIV-related prescription for medication.

### **EIIHA Matrix Overview**

**Summary:** The EIIHA Matrix is a strategic tool designed to *identify and strategically organize* the HIV unaware population in a manner that encompasses all individuals unaware of their HIV status within a project area. The EIIHA Matrix begins by listing the *largest and comprehensive* groups of HIV unaware individuals, called “*Parent Groups*”, and then breaks those larger groups down into *smaller more specific groups*, called “*Target Groups*.” **Target Groups are the groups which the strategy and plan should address.**

All of the groups listed in the EIIHA Matrix are currently **Unaware** of their HIV status, however, the factors contributing to each group’s lack of serostatus awareness may vary. Describing each Target Group’s unique *Priority Needs* and *Cultural Challenges* will facilitate customized approaches to ensure that each Target Group is made aware of their HIV status.

<p><b><u>Important Note:</u></b> DO NOT include numerical values in the EIIHA Matrix.</p>
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**Example EIIHA Matrix 1.2**

<b>P1. ALL Individuals in [INSERT YOUR PROJECT AREA HERE] who are Unaware of their HIV Status (HIV Positive &amp; Negative – Tested &amp; Untested – Publically &amp; Privately Tested)</b>							
<b>P2. Tested in the Past 12 Months</b>				<b>P3. Not Tested in the Past 12 Months</b>			
<b>P4. Individuals Not Post-Test Counseled (HIV positive &amp; HIV negative)</b>		<b>T3. Received Preliminary HIV Positive Result Only – No Confirmatory Test</b>		<b>P5. High Risk Individuals</b>		<b>P7. Moderate &amp; Low Risk Individuals</b>	
<b>T1. Tested Confidentially</b>	<b>T2. Tested Anonymously</b>			<b>P6. MSM</b>	<b>T4. Partners of HIV+ Individuals</b>	<b>T5. Not Tested in Past 24 Month</b>	<b>T6. Not Tested in Past 48 Month</b>
				<b>T8. MSM Ages 40-65</b>	<b>T9. MSM of Color Ages (18-40)</b>	<b>T10. Transgender (M-F)</b>	<b>T11. Substance Abusers (crystal meth, etc)</b>