HIV Care Grant Program - Part B
States/Territories Formula and
AIDS Drug Assistance Program Formula and ADAP Supplemental Awards

Announcement Type: New
Announcement Number: HRSA-13-158

Catalog of Federal Domestic Assistance (CFDA) No. 93.917

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2013
Modified on 10/24 to include Texas, Oklahoma, and Vermont as eligible ADAP Supplemental Grantees.
Modified on 11/21 to increase page limit to 90 pages.

Application Due Date: January 4, 2013

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: October 1, 2012
Date of Issuance: October 1, 2012

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Executive Summary

The Ryan White HIV/AIDS Program Part B Application Funding Opportunity Announcement (FOA) is provided to assist applicants in preparing their fiscal year (FY) 2013 single-grant application for funds under Part B 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). 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.

This FOA contains application instructions for most Part B-related funding, including:

- Part B Formula funding (Part B base)
- AIDS Drug Assistance Program funding (ADAP)
- Minority AIDS Initiative (MAI)
- ADAP Supplemental funding
- Emerging Communities funding
- Pacific Island Jurisdictions Part B funding

It also communicates information on current and new program initiatives, and provides background information on reporting requirements and other forms of documentation that will be required from grantees post-award.

As required by the Ryan White HIV/AIDS Program legislation, the Part B grant awards for FY 2013 will be determined based on living cases of HIV/AIDS as reported to and confirmed by the Director of the Centers for Disease Control and Prevention (CDC) and submitted to the Health Resources and Services Administration (HRSA). This FOA requires applicants to report on the numbers of HIV and AIDS cases in their jurisdictions.

In FY 2013, formula awards will be based ONLY on name-based data. Names-based reporting is defined as the number of living names-based cases of HIV/AIDS reported to and confirmed by CDC as of December 31 of the most recent calendar year for which data is available.

The National HIV/AIDS Strategy (NHAS)
In July 2010, the White House released the National HIV/AIDS Strategy (NHAS). The 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 utilized. 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 Part B Early Identification of Individuals with HIV/AIDS (EIIHA) requirement and the Centers for Disease Control and Prevention’s (CDC) Enhanced Comprehensive HIV Prevention Plan (ECHPP) are two Federal initiatives that support the NHAS.

The HIV/AIDS Bureau (HAB) recognizes that States and Territories have used Part B grant funds to develop and/or expand systems of care to meet the needs of Persons Living with HIV/AIDS (PLWH/A) within their borders. This includes HAB and grantee efforts to estimate and assess Unmet Need and the number of individuals who are unaware of their HIV/AIDS status, States/Territories, and to ensure that essential core medical services have been adequately addressed when setting priorities and allocating funds. At the same time, the CDC has ongoing initiatives that may identify significant new numbers of PLWH/A that will be seeking services. This requires careful reassessment of how States/Territories will ensure access to primary care and medications as well as the provision of critical support services necessary to maintain individuals in systems of care. A list of CDC initiatives can be found at: http://www.cdc.gov/hiv/topics/prev_prog/index.htm.

CDC estimates that of the 1.1 million adults and adolescents at the end of 2006 living with HIV, 21% of infected persons do not know their HIV status. The ultimate NHAS goal is to inform all HIV positive 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 US through enhanced prevention efforts. The Part B EIIHA legislative requirement calls for grantees to identify HIV positive individuals who are unaware of their HIV status and bring them into care. This FOA requires the grantee to provide a description of the strategy, plan and data for reaching this goal within their jurisdiction. A comprehensive description regarding EIIHA requirements can be found in section (4) of this FOA.

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 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, care services. A set of common indicators is being catalogued within 7 domains: 1) HIV testing; 2) Late HIV diagnosis; 3) Initial linkage to HIV medical care; 4) Retention/engagement in HIV medical care; 5) 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.

New to This Year’s Grant Application:

- Unmet Need: The Unmet Need section of this FOA has been revised to include an outcomes section to assess the effectiveness of unmet need activities.
- Early Identification of Individuals with HIV/AIDS (EIIHA): The EIIHA section of this FOA has been revised to include an evaluation section to assess the effectiveness of the activities implemented.
Clinical Quality Management (CQM): The CQM section of this FOA has been revised to address current issues regarding Clinical Quality Management. Part B Women, Infants, Children and Youth (WICY): Grantees planning to submit a Prospective WICY Waiver Request must submit their Waiver Request with their Part B application. The Prospective WICY Waiver Request should be uploaded as Attachment 9. Please refer to the Part B Guidelines for Implementing the Minimum Expenditure Requirement to Provide Services for WICY, which was updated and distributed to grantees in March 2012. Regarding the Epidemiology narrative and table, both items should be included in Attachment 4. In addition, the Unmet Need Framework and Narrative should be included in Attachment 6.

In accordance with the Paper Reduction Act, and steps taken by HAB for administrative simplification programs applying for 2013 Part B Supplemental (X08) funds, the Epidemiology table and narrative provided in Attachment 4 of this application will be provided to the 2013 Part B Supplemental Objective Review Committee (ORC) reviewers for the purpose of scoring the Epidemiology Data section (Criterion 1) of the 2013 Part B Supplemental application. The 2013 Part B Supplemental Funding Opportunity Announcement will not request Epidemiology Data, as the information provided in Attachment 4 of this application will be used for scoring purposes.

In accordance with the Paper Reduction Act, and steps taken by HAB for administrative simplification, programs applying for 2013 Part B Supplemental (X08) funds, the Unmet Need Framework and narrative provided in Attachment 6 of this application will be provided to the 2013 Part B Supplemental ORC reviewers for the purpose of scoring the Unmet Need section (Criterion 2) of the 2013 Part B Supplemental application. The 2013 Part B Supplemental Funding Opportunity Announcement will not request Unmet Need data, as the information provided in Attachment 6 of this application will be used for scoring purposes.

Usage of Ryan White funds for HIV testing: Section 2612(d)(2)(A) of the PHS 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 following conditions are met: 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. 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. When proposing to use Ryan White funds for testing under Early Intervention Services for Part B, the other EIS program components; counseling, referral, linkage, and health literacy must be present. Stand-alone HIV testing programs using Ryan White Part B funds are not allowed.

Awards and Match Information - Please include the following information as Attachment 11:
Does the State have a limit on what it can match for the Formula Award?
  ▪ If so, what is the maximum dollar amount the State can match for Formula Award?

Is the State applying for ADAP Supplemental?
  ▪ If so, is the State requesting ADAP Supplemental Match waiver?
  ▪ Does the State have a limit on what it can match for ADAP Supplemental?
    ▪ If so, what is the maximum amount the State can match for ADAP Supplemental?

Is the State declining MAI funds?

Is the State requesting a 75/25 waiver?

- In FY 2013, formula awards will be based ONLY on name-based data. Name-based reporting is defined as the number of living names-based cases of HIV/AIDS reported to CDC as of December 31 of the most recent calendar year for which data is available.

- Part B grantees must submit an estimated carryover request NO LATER THAN JANUARY, 31 (with an automatic extension to the first workday following January 31, should it be a weekend or holiday). Failure to submit a timely estimated carryover request to HRSA will result in a grantee being ineligible to receive Ryan White HIV/AIDS Program Part B Formula carryover funds when the final FFR is submitted.
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I. Funding Opportunity Description

1. Purpose

Part B funding is used to assist States and Territories in developing and/or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families living with HIV. As such, it supports the National HIV/AIDS Strategy (NHAS) goals of: reducing HIV incidence, increasing access to care and optimizing health outcomes, and reducing HIV-related health disparities.

A comprehensive HIV/AIDS continuum of care includes the following core medical services: outpatient and ambulatory health services, AIDS Drug Assistance Program (ADAP) treatments, AIDS pharmaceutical assistance (local), oral health care, early intervention services, health insurance premium and cost sharing assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services and medical case management, including treatment adherence services and substance abuse outpatient care. These services assist PLWH/A in accessing treatment of HIV infection that is consistent with HHS Treatment Guidelines. The guidelines include ensuring access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections as well as combination antiretroviral therapies. The current HHS Treatment Guidelines are available at www.aidsinfo.nih.gov.

Comprehensive HIV/AIDS care beyond these core medical services also includes access to support services: case management (non-medical), child care services, emergency financial assistance, food bank/home delivered meals, health education/risk reduction, housing services, legal services, linguistic services, medical transportation services, outreach services, psychosocial support services, referral for health care/supportive services, rehabilitation services, respite care, residential substance abuse services and treatment adherence counseling. This continuum of care may include only those supportive services that enable individuals to access and remain in primary medical care.

2. Background

This program is authorized by the PHS Act as amended, Sections 2611-23, (42 U.S.C. 300ff-21-31b), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87). The U.S. Department of Health and Human Services (DHHS) administers the Part B program through the Health Resources and Services Administration (HRSA), the HIV AIDS Bureau (HAB), Division of State HIV/AIDS Programs (DSHAP).

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant to States/Territories as defined by Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87).
2. Summary of Funding

This program will provide funding for Federal fiscal year 2013. Approximately 1.3 billion dollars is expected to be available to fund fifty-nine (59) Part B grantees. The project period is **one** year.

Notification of awards will be sent to the Chief Elected Official (CEO) or to the delegated administrative agency responsible for dispersing Part B Grant Program funds. Title XXVI of the PHS Act was reauthorized on October 30, 2009 effective retroactively to September 30, 2009.

Part B funding is available through several forms: the formula grant (i.e., Part B base award, MAI and ADAP Earmark award for HIV/AIDS-related medications); the ADAP Supplemental award; and the Emerging Communities award.

Part B formula/base, ADAP and Emerging Communities awards are based on the number of reported living cases of HIV/AIDS cases in the State or Territory in the most recent calendar year as confirmed by CDC submitted to HRSA. Similarly, for grantees applying for MAI formula funds, awards are based on the number of reported and confirmed living minority cases of HIV/AIDS for the most recent calendar year submitted to HRSA. The most recently completed calendar year ended December 31, 2011. Supplemental ADAP grants are awarded to states demonstrating severe need for medications.

In FY 2013, formula awards will be based ONLY on name-based data. Names-based reporting is defined as the number of living names-based cases of HIV/AIDS reported to CDC as of December 31 of the most recent calendar year for which data is available.

Please note that the Secretary may reduce the amounts of grants under Part B to a State/Territory or political subdivision of a State/Territory for a fiscal year if, with respect to such grants for the second preceding fiscal year, the State/Territory or subdivision fails to prepare audits in accordance with the procedures of Section 7502 of Title 31, United States Code. See PHS Act Sec. 2682(a).

To ensure timely notification of the release of the FY 2013 Part B awards and other important documents relating to the Part B grant, States/Territories must forward personnel, address, and e-mail or telephone changes immediately to the appropriate Grants Management Specialist listed on the State’s or Territory’s most recent Notice of Award.

III. Eligibility Information

1. Eligible Applicants

The following States and Territories are eligible to apply for program funding: all 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Territories of the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands.

States must designate a lead State/Territory agency that will be responsible for administering all assistance received; conducting a needs assessment and preparing a State/Territory plan;
preparing all applications; receiving notices regarding programs; and collecting and submitting to the Secretary every two years all audits from grantees within the State, including an audit regarding funds expended.

2. Cost Sharing/Matching

States meeting the criteria established in Section 2617(d)(1) of the PHS Act for State match, are required to match their FY 2013 Part B Formula (base), ADAP, and Emerging Community awards as follows. Matching funds are required from States with more than one percent of the total U.S. AIDS cases reported to the CDC during the previous two Federal fiscal years (i.e., 2010 and 2011). These matching funds can either be in the form of cash or in-kind resources, and can be provided either directly or through donations to the State from public or private entities, in proportion to their Part B funding. The match begins at $1 in State funds for every $5 in Federal funds and increases to $1 in State funds for every $2 in Federal funds in later years (Section 2617). Matching funds for ADAP supplemental treatment drug grants are required in an amount equal to $1 for each $4 of Federal funds provided in the supplemental grant. [See Section 2618(a)(2)(F)(ii)(III).] The law also provides for a waiver of the ADAP supplemental match pursuant to the language in the statute. Applicants requesting a waiver should include this request in the narrative related to the ADAP Supplemental. Part B MAI funds are exempt from the matching requirements.

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.

Maintenance of Effort
Grant funds shall not be used to take the place of current funding for activities described in the application. The grantee must agree to maintain non-Federal funding for HIV-related activities at a level which is not less than expenditures for such activities during the fiscal year prior to receiving the grant [see Section 2617(b)(7)(E)] (i.e., for the FY 2013 application, not less than the level of expenditures during FY 2012).

Applicants must submit with their FY 2012 Part B application a report detailing the year-to-year HIV-related expenditures by the State/Territory for the previous two complete fiscal years in Attachment 2. The report must include:

1. Documentation (or worksheet) proving that the overall level of HIV-related expenditures has been maintained year-to-year for the previous two complete fiscal years (i.e., 2010 and 2011), and
2. A brief narrative explaining any changes in the data set where HIV-related expenditures have been reduced or where the purpose of an HIV-related expenditure has changed.

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 DGPWaivers@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 moved to SAM

Effective July 30, 2012

The Central Contractor Registration (CCR) transitioned to the System for Award Management (SAM) on July 30, 2012. For any registrations in process the data that has been submitted to CCR 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 received an e-mail notification from CCR when the expiration date was extended. The registrant will then receive standard e-mail reminders to update their record based on the 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 SAM registration is a pre-requisite to the successful submission of grant applications!

During this transition, some things to consider are:

• When does the account expire?
• Does the organization 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 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: SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). Grants.gov will reject submissions from applicants with expired registrations. Please don’t wait until the last minute to register in SAM. According to the SAM Quick Guide for Grantees (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 application deadline.

Applicants that fail to allow ample time to complete registration with SAM 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

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 90 pages when printed by HRSA. The total file size may not exceed 10 MB. The 90-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 90-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 90-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.

<table>
<thead>
<tr>
<th>Application Section</th>
<th>Form Type</th>
<th>Instruction</th>
<th>HRSA/Program Guidelines</th>
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<tbody>
<tr>
<td>Application for Federal Assistance (SF-424)</td>
<td>Form</td>
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<tr>
<td>Project Summary/Abstract</td>
<td>Attachment</td>
<td>Can be uploaded on page 2 of SF-424 - Box 15</td>
<td>Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.</td>
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<td>Additional Congressional District</td>
<td>Attachment</td>
<td>Can be uploaded on page 3 of SF-424 - Box 16</td>
<td>As applicable to HRSA; Counted in the page limit.</td>
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<td>Project Narrative Attachment Form</td>
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<td>Project Narrative</td>
<td>Attachment</td>
<td>Can be uploaded in Project Narrative Attachment form.</td>
<td>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.</td>
</tr>
<tr>
<td>SF-424A Budget Information - Non-Construction Programs</td>
<td>Form</td>
<td>Pages 1–2 to support structured budget for the request of Non-construction related funds.</td>
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<tr>
<td>Budget Narrative Attachment Form</td>
<td>Form</td>
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<td>Budget Narrative</td>
<td>Attachment</td>
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<td>Additional Performance Site Location(s)</td>
<td>Attachment</td>
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<td>Attachments Form</td>
<td>Form</td>
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<tr>
<td>Attachment 1-15</td>
<td>Attachment</td>
<td>Can be uploaded in Other Attachments form 1-15.</td>
<td>Refer to the attachment table provided below for specific sequence. Counted in the page limit.</td>
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- To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
- Merge similar documents into a single document. Where several documents are expected in the attachment, ensure that a table of contents covers page is included specific to the attachment. The Table of Contents page will not be counted in the page limit.
- Limit the file attachment name to under 50 characters. Do not use any special characters (e.g., %, /, #) or spacing in the file name or word separation. (The exception is the underscore (_) character.) Attachments will be rejected by Grants.gov if special characters are included or attachment names exceed 50 characters.

<table>
<thead>
<tr>
<th>Attachment Number</th>
<th>Attachment Description (Program Guidelines)</th>
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<tbody>
<tr>
<td>Attachment 1</td>
<td>Organizational Chart(s)/Staffing Plan, brief description of the positions and responsibilities in regards to the Part B grant, FTE equivalent of all key staff and personnel</td>
</tr>
<tr>
<td>Attachment 2</td>
<td>ADAP Funding Sources Table and MOE Documentation</td>
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<tr>
<td>Attachment 3</td>
<td>The FY 2013 Part B Agreements and Assurances (see Appendix A)</td>
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<tr>
<td>Attachment 4</td>
<td>HIV/AIDS Epidemiology Table and Narrative</td>
</tr>
<tr>
<td>Attachment 5</td>
<td>Implementation Plan (includes MAI, if applicable)</td>
</tr>
<tr>
<td>Attachment 6</td>
<td>Unmet Need Framework and Narrative</td>
</tr>
<tr>
<td>Attachment 7</td>
<td>FY 2013 Core Medical Services Waiver Request</td>
</tr>
<tr>
<td>Attachment Number</td>
<td>Attachment Description (Program Guidelines)</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Attachment 8</td>
<td>EIIHA Matrix</td>
</tr>
<tr>
<td>Attachment 9</td>
<td>WICY Prospective Waiver (if applicable)</td>
</tr>
<tr>
<td>Attachment 10</td>
<td>EIIHA - HIV Testing &amp; Awareness Data</td>
</tr>
<tr>
<td>Attachment 11</td>
<td>Awards and Match Information</td>
</tr>
<tr>
<td>Attachments 12-15</td>
<td>Other Attachments, as necessary</td>
</tr>
</tbody>
</table>
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 is 93.917.

**DUNS Number**
All applicant organizations (and sub-recipients 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](http://fedgov.dnb.com/webform) or call 1-866-705-5711. Please include the DUNS number in form SF-424 - 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 SAM in order to conduct electronic business with the Federal Government. 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 SAM registration is active and the Marketing Partner ID Number (MPIN) is current. Information about registering with SAM can be found at [https://www.sam.gov](https://www.sam.gov). Please see Section IV of this funding opportunity announcement for **IMPORTANT NOTICE: CCR to be moved to SAM effective 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
Please complete Sections A, B, E, and F of the SF-424A Budget Information – Non-Construction Programs form included with the application kit for each year of the project period, and then provide a line item budget using Section B Object Class Categories of the SF-424A.

In Section B, budget categories are limited to four columns. The four required columns are:
1) **Administration** - This column should include all funds allocated to the following grant activities: grantee administration, planning and evaluation, and quality management;

2) **ADAP** - This column should include all funds allocated to the following grant activities: ADAP;

3) **Consortia** - This column should include all funds allocated to consortia and emerging communities; and

4) **Direct Services** - This column should include all funds allocated to the following grant activities: state direct services, home and community-based care, MAI, and health insurance continuation.

**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 sub-awards/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:

<table>
<thead>
<tr>
<th>Individual’s actual base full time salary:  $350,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% of time will be devoted to project</td>
</tr>
<tr>
<td>Direct salary</td>
</tr>
<tr>
<td>Fringe (25% of salary)</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

**Amount that may be claimed on the application budget due to the legislative salary limitation:**

<table>
<thead>
<tr>
<th>Individual’s base full time salary adjusted to Executive Level II:  $179,700</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% of time will be devoted to the project</td>
</tr>
<tr>
<td>Direct salary</td>
</tr>
<tr>
<td>Fringe (25% of salary)</td>
</tr>
<tr>
<td>Total amount</td>
</tr>
</tbody>
</table>

**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. 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 B grantee administrative costs may not exceed 10% of the total grant award. Planning and Evaluation costs may not exceed 10% of the total grant award. Collectively, Grantee Administration, and Planning and Evaluation may not exceed 15% of the total award. Grantees may allocate up to 5% of the total grant award, or $3,000,000 (whichever is less) for Clinical Quality Management. In the case of entities and subcontractors to which the chief elected official of an eligible area allocates amounts received by the official under a grant under this part, the official shall ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).

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.

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

*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 sub-recipients that entities receiving sub-awards must be registered in SAM (See Section IV of this document for more 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/](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.

**Payer of Last Resort:**
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 with 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, basic health plans, and private insurance. Subcontractors providing Medicaid eligible services must be Medicaid certified.

Program Income: HHS Grants Regulations require grantees and/or subgrantees to collect and report program income. The program income shall be returned to the funded 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.

Direct payments include charges imposed by recipients and sub-recipients for Part B services as required under Section 2617(c) of Program legislation, such as enrollment fees, premiums, deductibles, cost sharing, co-payments, co-insurance, or other charges. As specified on the Part B Notice of Award (NoA), program income must be “Added to funds committed to the project or program and used to further eligible project or program objectives.” Grantees are responsible for ensuring that sub-recipients have systems in place to account for program income, and for monitoring to ensure that sub-recipients are tracking and using program income consistent with grant requirements. See the HHS Grants Policy Statement at ftp://ftp.hrsa.gov/grants/hhsgrantspolicystatement.pdf, the Part B NoA, and 45 CFR 92.25.

Drug rebates are not considered part of the grant award and are not subject to the unobligated balances provision. Part B grantees must report Program Income on the SF-425 (Federal Financial Report) long form, however, rebate funds must not be included on the SF-425 as part of the reported unobligated balance, and thus, must not be requested at any time for carry over. Drug rebate information should be included in the “comments” section of the SF-425.
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. Biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included in Attachment 1. 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.

Also in Attachment 1, the staffing plan must include an organizational chart which should depict the administrative structure responsible for the administration of the Part B grant. Also submit a staffing plan for the ADAP, if administered separately. Applicants must provide a listing of all key staff and personnel. This listing should include a brief description of the positions and responsibilities in regards to the Part B grant.

vi. Assurances
Complete Application Form SF-424B – Assurances for Non-Construction Programs provided with the application package. Additionally, the FY 2013 Ryan White HIV/AIDS Part B Program Agreements and Assurances are included in Appendix A. These Assurances must be signed by the Governor or Authorized Designated Official of the State/Territory. The HIV/AIDS Part B Program Assurances (Appendix A) should be submitted as Attachment 3 of the grant application.

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
- List of all grant program funds in this application (e.g. Formula [Base & ADAP], ADAP Supplemental, MAI, Emerging Communities, and Pacific Island Jurisdictions).
The information below should be followed by brief paragraphs that provide, in this order:

1) General demographics of the State/Territory;
2) Demographics of HIV/AIDS populations in the State/Territory;
3) Geography of the State/Territory with regard to communities affected by HIV/AIDS and the location of HIV/AIDS services in relation to those communities;
4) Description of the continuum of care offered in the State/Territory, including relevant information about ADAP, primary medical care services, how HIV primary care services are delivered, and how clients are supported in accessing and remaining in care;
5) Description of any ADAP restrictions (such as waiting lists, capitations on medications or expenditures, cost shares, or co-pays, etc.).

The project abstract must be single-spaced and limited to one page in length.

ix. Program 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.

(A) FY 2013 Part B Formula Grant Application

This Section is to be completed by the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands and Guam

1) Grantee Administration and Accountability
The purpose of this section is to demonstrate the extent to which the Chief Elected Official in the State/Territory has met the legislative requirements to disburse funds quickly, closely monitor their use, and to ensure that the State/Territory has complied with the Ryan White HIV/AIDS Program legislative mandates for payer of last resort, maintenance of effort (MOE), and the minimum expenditure requirement to provide services to Women, Infants, Children and Youth (WICY).

(a) Program Organization
Provide a description of how Part B funds are administered in the State/Territory with reference to the positions described in the budget, budget narrative, and the organizational chart included in Attachment 1.

(b) Fiscal and Program Monitoring
HRSA/HAB holds grantees accountable for the expenditure of funds awarded under Part B, and expects grantees to monitor fiscal and programmatic compliance with all contracts and other agreements for HIV/AIDS services in the State/Territory, including contracts with consortia. Grantees are also required to have on file a copy of each contractor’s procurement documents (contracts), and fiscal and programmatic site visit reports. Provide a narrative that describes the following:
(1) The process used to separately track formula/base, ADAP Base, ADAP Supplemental (if applicable), Emerging Communities (if applicable) and MAI (if applicable) grant funds; and the unobligated and carryover funds for each of these grant fund categories as applicable. Include information about the data system(s) utilized to track funds.
(2) Description of process and mechanisms used to ensure that providers funded through multiple Ryan White parts (i.e. Parts A, B, C, D, or F) are able to distinguish which clients are served by each individual funding stream, in order to accurately track clients and expenditures and avoid duplication of services.
(3) The process used for fiscal and program monitoring, including the type and frequency of required reports;
(4) The process and timeline for corrective actions when a fiscal or program–related concern is identified;
(5) The process, including a timeline, for receiving vouchers or invoices from providers/subcontractors;
(6) The process, including a timeline, for issuing payments to providers/subcontractors, from receipt of voucher/invoice to reimbursement;
(7) The steps taken by the grantee to implement the National Monitoring Standards since the official release in April 2011.
(8) The total number of contractors, including consortia, funded in FY 2012.
(9) The number and percentage of contractors that received a fiscal and/or programmatic monitoring site visit as of December 2012, as well as the total number expected to be completed by the end of the budget period on March 31, 2013.
(10) Were there improper charges by contractors or other findings in FY 2012?
   i) If so, please summarize the corrective actions planned or taken to resolve these findings.
(11) The number of contractors that received technical assistance (TA) during FY 2012.
   i) Please describe the types of TA, scope, and timeline.
(12) The number and percentage of eligible contractors compliant with audit requirements in OMB Circular A-133.
(13) Were there any findings in subcontractors’ A-133 audit reports?
   i) Describe the measures taken by the grantee to ensure that subcontractors have taken appropriate corrective action.
(14) For those applicants with consortia, describe the State’s monitoring requirements for consortia in relation to their contractors and subcontractors, including how those requirements and processes have been revised to comply with the National Monitoring Standards.

e Fiscal Staff Accountability

(1) Describe the role and responsibilities of program and fiscal staff in ensuring adequate reporting, reconciliation, and tracking of program expenditures.
(2) Describe the process and coordination methods used by program and fiscal staff to ensure adequate and accurate tracking, reporting, and reconciliation of program expenditures and program income.
   Example: The program and fiscal staff’s meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures,
unobligated balances broken out by grant component (i.e., base, ADAP, ADAP Supplemental, Emerging Communities, MAI, carryover, rebates), and program income;

(3) The applicant should include an organizational chart for fiscal staff, if fiscal staff members are not part of the Part B program staff personnel. Include in Attachment 1.

(d) Third Party Reimbursement/Payor of Last Resort

Summary: The Ryan White HIV/AIDS Program is the payer of last resort, and grantees must ensure that alternate sources of payment are pursued. Grantees are expected to coordinate effectively with third party payers to ensure that costs are recovered for services provided to eligible/covered individuals. Third party sources include Medicaid, Children’s Health Insurance Programs (CHIP), Medicare (including the Part D prescription benefit) and private insurance, including Pre-existing Condition Insurance Programs (PCIP). Subcontractors providing Medicaid eligible services must be Medicaid certified. In addition, the applicant must ensure that program income is tracked, monitored and expended consistently with grant requirements.

Note: The Indian Health Service is exempt from the payer of last resort provision.

Provide a narrative that describes the following:

(1) The client eligibility criteria for clients who are supported with Ryan White HIV/AIDS Part B Program services. Also indicate if, in addition to this eligibility determination process, the State/Territory verifies eligibility or conducts certification of clients with other programs including Medicaid, State Pharmacy Assistance Programs (SPAP), and Children’s Health Insurance Programs (CHIP) every six months.

(2) How contractors/subcontractors document that clients have been screened for and enrolled in eligible programs such as Medicare, Medicaid, private health insurance or other programs to ensure that Part B funds are the payer of last resort, as well as the frequency of this screening.

(3) The process used by the State/Territory to ensure that all contractors/sub-contractors, including consortia contractors/subcontractors, are accessing, receiving, tracking and documenting third party reimbursement. Also describe the contract language or other mechanism to ensure that this takes place;

(4) Please describe any long standing policies and/or recent changes to your State Medicaid program which have impacted, or may impact the Ryan White program. (i.e. changes in eligibility, charges to clients, etc.)

i) Describe the impact these changes have had, or may have in the future, on the Ryan White program. (i.e. increased enrollment in Ryan White services, increased usage of ADAP, etc.)

(5) How grantee monitors the tracking and expending of any program income.

(e) Women, Infants, Children and Youth Proportionate Spending
Grantees are required to use a proportionate amount of their grant dollars to provide services to women, infants, children and youth (WICY) living with HIV/AIDS, unless a waiver is obtained. Grantees demonstrate compliance with the WICY expenditure requirement in their annual progress report, as outlined in the most recent Guidelines for Implementing the Minimum Expenditure Requirement to Provide Services to Women, Infants, Children and Youth.

(1) Describe the method used by the State/Territory to document that it meets the legislative requirement for proportionate spending on services to women, infants, children and youth. For States/Territories with Consortia, describe how the State ensures compliance with WICY expenditure requirements. Please include prospective WICY waiver requests in Attachment 9 (if applicable).

2) HIV/AIDS Epidemiology

Purpose: The purpose of this section is to describe the HIV/AIDS epidemic in the State/Territory. Section 2617 (b) (2) of the PHS Act states that the application for Part B funds shall contain a determination of the size and demographics of the population of people with HIV/AIDS in the State. Please note that both the Epidemiology table and narrative should be included as Attachment 4.

Important Note: For programs applying for 2013 Part B Supplemental (X08) funds, the Epidemiology table and narrative provided in Attachment 4 of this application will be provided to the 2013 Part B Supplemental Objective Review Committee (ORC) reviewers for the purpose of scoring the Epidemiology Data section (Criterion 1) of the Part B Supplemental application. The 2013 Part B Supplemental Funding Opportunity Announcement will not request Epidemiology data. The information provided in Attachment 4 of this application will be used for scoring purposes.

(a) Table
Summarize in a table format the living cases of HIV disease through December 31, 2011 identifying the AIDS and HIV (non-AIDS) prevalence by demographic group and exposure category. Place the table in Attachment 4 of the application and clearly label the data sources.

(b) Narrative
Based on the latest State HIV/AIDS Epidemiologic Profile, provide a narrative description of any trends or changes in the State’s/Territory’s HIV disease prevalence over the past two calendar years (01/01/10-12/31/11). Place the narrative in Attachment 4 of the application. Use the following indicators to provide a comparative description of the HIV disease prevalence by demographic characteristics and exposure category in the State including:

(1) the number of people living with HIV (non-AIDS),
(2) the number of people living with AIDS, and
(3) the number of new AIDS cases reported within the last two calendar years.
3) Unmet Need

**Definition:** Unmet Need is defined as the number of individuals for which there is no evidence of any of the following three components of HIV primary medical care during a specified 12 month time frame: viral load (VL) testing, CD4 count, or provision of anti-retroviral therapy (ART). Unmet Need is further defined as the need for HIV-related health services by individuals with HIV who are aware of their HIV status, but are not receiving HIV primary health care.

**Important Note:** For programs that plan on applying for 2013 Part B Supplemental (X08) funds, the Unmet Need Framework and narrative provided in this application will be provided to the 2013 Part B Supplemental Objective Review Committee (ORC) reviewers for the purpose of scoring the Unmet Need section (Criterion 2) of the Part B Supplemental application. The 2013 Part B Supplemental Funding Opportunity Announcement will **not** request Unmet Need data. The information provided in [Attachment 6](attachment:6) of this application will be used for scoring purposes.

(a) Provide an updated estimate of unmet need in your jurisdiction, using the HRSA/HAB Unmet Need Framework, please include a copy of the framework in [Attachment 6](attachment:6) of this application. The framework must include the following: 1 values, 2 all data sources, and 3 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: [ftp://ftp.hrsa.gov/hab/unmetneedpracticalguide.pdf](ftp://ftp.hrsa.gov/hab/unmetneedpracticalguide.pdf).

(b) Provide an Unmet Need Narrative description of the following, please include the Unmet Need narrative in [Attachment 6](attachment:6):

1. **Estimation methods:** The methods used to develop the unmet need estimates, reasons for choosing this method, revisions or updates from the FY 2012 estimate, any limitations, and any cross program collaboration that occurred.

2. **Assessment of unmet need:** Summarize the findings or results of studies on the demographics of populations and special populations that comprise the unmet need estimate. The Summary should include the following:
   
   i. The demographics and location of people who are aware of their HIV/AIDS status but are not in care;
   
   ii. A description of the trends associated with the past 5 years regarding Unmet Need.
   
   iii. An assessment of service needs, gaps, and barriers to care for people not in care;

3. **Addressing unmet need:** Describe any activities your State/Territory has carried out or is planning to address unmet need to include the following activities designed to link those aware of their HIV status into core medical services:
   
   i. Outreach activities; Early Intervention Services, Health Education and Risk Reduction,
   
   ii. Continuum of Care Activities;
iii. Collaboration with Ryan White and non-Ryan White funded entities, including Prevention.

iv. Efforts to find individuals aware of their HIV status but are not in care and get them into primary care; and

v. How the results of the Unmet Need Framework were used in planning and decision making regarding priorities, resource allocations, and adapting the system of care.

4. **Unmet Need Outcomes:** Describe the outcome of your program’s FY 2011 Unmet Need activities to include the following:

   i. The number of individuals who are aware of their HIV positive status but were not in care who have now been linked to care.
   
   ii. Describe how your program’s Unmet Need activities impact service utilization.

   iii. Describe the challenges your program has encountered in linking the Unmet Need population to care.

       1. Describe how these challenges are being addressed.

4) **Early Identification of Individuals with HIV/AIDS (EIIVA)**

   The purpose of this section is to describe the 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:

   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.

   **Usage of Ryan White funds for 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.

When proposing to use Ryan White funds for testing under Early Intervention Services for Part B, the other EIS program components; counseling, referral, linkage, and health literacy must be present. Stand-alone HIV testing programs using Ryan White Part B funds are not allowed.

**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.

**Note:** All Ryan White funded EIIHA activities may be reported under but are not limited to Early Intervention Services (EIS), Outreach Services, Medical and Non-Medical Case Management Services, and Outpatient Ambulatory Services. If the activities and/or services needed to implement an EIIHA strategy/plan are funded by a source other than Ryan White, then list the funding source associated with each activity.

4) 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. (i.e., correctional facilities, CBO’s, hospitals, etc.)

(c) Describe how EIIHA activities and strategies will be incorporated into the program’s Requests 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 the Ryan White Program in promoting routine HIV testing within the State according to CDC guidelines.

(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 HRSA/HAB Special Projects 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 8. 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 State
   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 (MSM)
   ➢ Substance Abusers/IVDU
   ➢ African Americans
   ➢ Hispanics
   ➢ Caucasians
   ➢ Women
   ➢ Men
   ➢ Youth
   ➢ Heterosexuals
   ➢ Immigrants

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

4) b. Plan (Activities, Methods, and/or Means utilized to implement the strategy)
**Note:** All Ryan White funded EIIHA activities may be reported under but are not limited to Early Intervention Services (EIS), Outreach Services, Medical and Non-Medical Case Management Services, and Outpatient Ambulatory Services. If the activities and/or services needed to implement an EIIHA strategy/plan are funded by a source other than Ryan White, then list the funding source associated with each activity.

**IMPORTANT:** Ryan White 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 which 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 which obstruct awareness** of HIV status, as well as associated timeline and responsible party for each activity.

(b) For each **TARGET group** listed in the EIIHA Matrix, describe the respective **activities to address Cultural Challenges which obstruct awareness** of HIV status, as well as associated timeline and responsible party for each activity.

(3) **Describe the actions taken to promote routine HIV screening in the State.**

(a) Describe your coordination with other organizations to promote routine HIV screening.

(b) Describe the role of Early Intervention Services in promoting routine HIV screening.

(c) Describe the role of Outreach in promoting routine HIV screening.

(4) **Identifying, Informing, Referring, and Linking (I,I,R,L)**

**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 when each essential activity will 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 Parts with regard to *identifying* individuals unaware of their HIV status.
   a. Describe progress from the previous fiscal year.

iii) Describe how this 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 when each essential activity will 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 Parts with regard to *informing* individuals unaware of their HIV status.
   a. Describe progress from the previous fiscal year.

iii) Describe how this 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 when each essential activity will 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 Parts with regard to referring newly aware individuals to appropriate Supportive Services.
   a. Describe progress from the previous fiscal year.

iii) 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.
   a. Describe progress from the previous fiscal year.

(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 into the continuum of care.
   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 each of these essential activities is implemented according to the timeline described.

ii) Describe how the applicant will coordinate with other Ryan White 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 this 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 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 each of these essential activities is implemented according to the timeline described.

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 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 each of these essential activities is implemented according to the timeline described.

vi) Describe the efforts to address legal barriers, including local and state laws and regulations, to routine HIV screening.
4) 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 as of December 31\textsuperscript{st}, **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.)

1. **Formula:**

   \[
   \text{National Proportion Undiagnosed HIV (21\%) = } p
   \]

   \[
   \text{Number of individuals diagnosed with HIV and living as of December 31, } 2010 = N
   \]

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

2. **Example:**

   \[
   \text{National Proportion Undiagnosed} = 21\%
   \]

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

*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 your RW 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, & local funds** as of December 31\textsuperscript{st} **2011**. Please include the below **HIV Testing & Awareness Data** as **Attachment 10**.

(a) Report the following.

1. **total number of HIV tests conducted** (as reported above).
2. **total number informed** of their HIV status (HIV positive and HIV negative).
3. **total number NOT informed** of their HIV status (HIV positive and HIV negative).
4. **total number of HIV positive tests**.
5. total number of HIV positive informed of their HIV status.
6. total number of HIV positive referred to medical care.
7. total number of HIV positive linked to medical care.
8. total number of HIV positive NOT informed of their HIV status.
9. total number of negative tests.
10. total number of HIV negative informed of their HIV status.
11. total number of HIV negative referred to services.
12. 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 & Federal funds at the end of 2011.

4) d. Evaluation of EIIHA Activities

(1) Describe how the EIIHA activities which have been implemented to date have directly attributed to linking unaware HIV positive individuals to care.

(a) Describe the challenges associated with linking unaware HIV positive individuals to care.

1. Describe how these challenges are being addressed.

5) Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas (MSAs) Most Affected by HIV/AIDS (ECHPP)

The purpose of this CDC initiative is to facilitate the development and implementation of ECHPPs 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 optimal coordination of HIV prevention, care, and treatment services to maximize their impact in reducing new HIV infections within that jurisdiction. For more information on ECHPP please refer to: [http://www.cdc.gov/hiv/nhas/echpp/index.htm](http://www.cdc.gov/hiv/nhas/echpp/index.htm)

**Important Note:** Only states which encompass the following Eligible Metropolitan Areas (EMA’s) must respond to the two questions below:

<table>
<thead>
<tr>
<th>New York City, NY</th>
<th>Philadelphia, PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles, CA</td>
<td>Houston, TX</td>
</tr>
<tr>
<td>Washington, DC</td>
<td>San Francisco, CA</td>
</tr>
<tr>
<td>Chicago, IL</td>
<td>Baltimore, MD</td>
</tr>
<tr>
<td>Atlanta, GA</td>
<td>Dallas, TX</td>
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<tr>
<td>Miami, FL</td>
<td>San Juan, PR</td>
</tr>
</tbody>
</table>
(a) Identify the NHAS goals that are supported by the collaborative efforts of the Part B program and the ECHPP initiative.  *(NHAS goals are described in the Executive Summary on page i.)*

(b) Describe the planned activities of the Part B program in collaborating with the EMA’s ECHPP initiative. Please include a timeline for each activity, as well as responsible parties.

6) Clinical Quality Management

**Purpose:** The purpose of this section is to describe the State’s/Territory’s overall clinical quality management (CQM) program for Part B (including ADAP) and to describe how the results of the Part B CQM activities are being or have been used to improve service delivery in the State/Territory.

**Summary:** Clinical Quality Management (CQM) data play a critical role in helping to identify needs and gaps in services as well as in helping to ensure the delivery of quality services to clients. Information gathered through the CQM program as well as client-level health outcomes data should be used as part of the State/Territory 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 processes for administering the grant at the programmatic and fiscal levels.

The Ryan White legislation requires that Part B grantees “provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service 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% of the amount of the grant or $3,000,000 for the activities associated with a clinical quality management program, and states CQM is not counted towards the administrative expense cap (Sec. 2618 (b)(3)(E)).

**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 State. 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/deliverhivaidscare/habperformmeasures.html](http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html)

Links to the HHS HIV/AIDS guidelines (formerly called the Public Health Service guidelines), the Ryan White legislation, and the resources and technical assistance available to grantees with respect to improving the quality of care and establishing
6) a. Description of CQM Program

(I) Provide a narrative that describes the State/Territory’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) Clinical quality management 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; and
   v) Specific quality improvement projects that are currently being implemented within the State/Territory. Describe how CQM data have been used to improve and/or change service delivery in the State/Territory, including strategic long-range service delivery planning.

6) b. Data for Quality and Program Reporting

(I) Name and describe the Management Information System(s) (MIS) within the State/Territory used for data collection and reporting operations;
(2) Describe what CQM data have 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 stakeholders; and

(4) Describe the grantee’s current client level data collection capabilities Ryan White Service Report (RSR), including the percentage of providers that are able to report client level data. For calendar years 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.

6) c. Description of the ADAP CQM Program

Describe how the data collected has been used to improve or change service delivery in the State/Territory. Please include the following:

(1) How the ADAP Advisory Committee uses CQM data;
(2) How the State/Territory makes decisions to add new FDA approved drugs while ensuring that ADAP funds are not depleted before the end of the fiscal year. Please describe the tools and methods used to make these decisions;
(3) How the ADAP Advisory Committee develops Standards of Care and/or best practices for medication distribution. Identify the decision making process and/or by-laws governing the Advisory Committee.
(4) How the Grantee works closely with their regional AIDS Education and Training Center (AETC) to develop continuing medical education program(s) for all health care practitioners to ensure that clients receive medication therapies consistent with the current DHHS Treatment Guidelines.

7) Needs Assessment and Public Advisory Planning Process

Purpose: The purpose of this section is to describe the Needs Assessment process and ensure that public health agencies receiving Part B grants have established a public advisory planning process that includes public hearings, as required by Section 2617(b)(7)(A) of the PHS Act. The public advisory planning process should help the grantee in developing and implementing the Comprehensive Plan and should include individuals living with HIV, other Ryan White HIV/AIDS Program grantees, other Federal and local stakeholders, and community leaders. Federally recognized Indian tribes, as represented in the state, must also be represented in the planning process.

(a) Needs Assessment

(1) Describe the needs assessment process, including who participated in the process and how participation from PLWHA was obtained.
(2) Describe how both the comprehensive plan and the Statewide Coordinated Statement of Need (SCSN) submitted to HRSA during FY 2012 were used as part of this year’s needs assessment process.

(b) Public Advisory Planning Process

(1) Describe your Public Advisory Planning process and the participating parties including persons living with HIV/AIDS, other Ryan White HIV/AIDS Program grantees, other general and local stakeholder and community leaders.

8) Planned Services and Implementation Plan

Purpose: The purpose of this section is to present the FY 2013 HIV/AIDS service plan, with specific attention to ensuring access to a comprehensive continuum of HIV/AIDS care. The plan must also demonstrate how the State/Territory will reduce or eliminate service and health outcome disparities among historically underserved populations.

Summary: All Part B funds are subject to Section 2612(b) (1) of the PHS Act, requiring that not less than 75 percent of the funds (excluding funds used for grantee administration, planning, evaluation, and clinical quality management) be used to provide core medical services that are needed in the State or Territory for individuals with HIV/AIDS who are identified and eligible under the Ryan White HIV/AIDS Program’s 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](http://edocket.access.gpo.gov/2008/E8-13102.htm). This waiver request process has been approved by the Office of Management and Budget (OMB) under the paperwork Reduction Act of 1995 (OMB number 0915-0307). A core medical services waiver request should be included as Attachment 7.

(a) Table: FY 2013 Implementation Plan

In a table, list each service category and amounts for all Part B funding sources to include: Part B Formula funding, AIDS Drug Assistance Program (ADAP), Minority AIDS Initiative (MAI), ADAP Supplemental (if applicable), and Emerging Communities (if applicable) that will be allocated for each service category in FY 2013. Do not include any administrative processes. The table should be placed in Attachment 5.

(1) For each service category listed:

i) Objective/s: List objectives for new or continued services. Each objective should describe the specific activities associated with the service being provided.

ii) Service Unit Definition: Provide the name and definition of the unit of service to be provided (e.g. one round-trip bus ride, one prescription).

iii) Quantity: Provide the number of people to be served and service units to be provided during the grant year. Section 3a) List the number of people to be
served; 3b) List the total number of service units to be provided to that number of
individuals.

iv) Time Frame: Indicate the estimated duration of the activity relating to the
objective listed.

v) Funds: Provide the approximate amount of Part B funds to be used to provide this
service. Where multiple objectives exist beneath one service goal, break out the
estimated amount of funding by each individual objective listed.

vi) Outcome: Select a minimum of two objectives and list planned client level
outcomes/indicators to be tracked and include benchmarks for each.

(b) Narrative: FY 2013 Implementation Plan

(1) Provide a narrative that describes the following:

i) How the activities described in the plan will provide increased access to the HIV
continuum of care;

ii) How the activities in the plan address unmet need and reduce the number of persons
out of care;

iii) How the activities in the plan address individuals who are unaware of their HIV
status with regard to identifying them, making them aware of their status, referring
them to care, and linking them to care;

iv) How the activities described in the plan will ensure geographic parity in access to
HIV/AIDS services throughout the State or Territory;

v) How the activities described in the plan will address the needs of emerging
populations;

vi) How the activities described in the plan will ensure that PLWH/A remain engaged in
HIV/AIDS primary medical care and adhere to HIV treatments;

vii) How the State/Territory will ensure that resource allocations for services to women,
infants, children, and youth (WICY) are in proportion to the percentage of the
States/Territories HIV disease cases represented by each population (WICY tables
will be provided by HRSA);

viii) Briefly describe how proposed FY 2013 allocations address significant issues and
core service needs identified in the most recent SCSN and Comprehensive Plan.

ix) How the services and their goals and objectives relate to the goals of the Healthy
People 2020 initiative, particularly the objectives related to HIV listing under the tab
“2020 topics and objectives”. Copies of the Health People 2020 may be obtained
from the Superintendent of Documents or downloaded at: www.healthy
people.gov/2020/default.aspx

(c) FY 2013 MAI Planning and Implementation

*Purpose:* The purpose of this section is to provide a narrative description of the implementation
plan for the State/Territory to increase racial and ethnic minority populations participation in
Part B ADAP through MAI-funded education and outreach services. Please indicate in
Attachment 11 whether your program intends to decline MAI funds.
(1) Provide a description of your FY 2013 MAI planning process in terms of:

   i) How program results and data generated from previous MAI-funded outreach/education and/or other Part B funded outreach activities were evaluated and used to increase racial and ethnic minority population participations in Part B ADAP.

   ii) How persons living with HIV/AIDS, particularly minority individuals, provided input into the MAI planning process.

(2) Coordination of MAI Services and Funding Streams

   **Summary:** Part B MAI planning efforts should be coordinated with all other local funding streams for HIV/AIDS to:

   - Ensure that Ryan White HIV/AIDS Program funds are the payer of last resort;
   - Maximize education and outreach efforts to link racial and ethnic minorities to ADAP; and
   - Reduce duplication of services and efforts.

   i) Describe how the following have been taken into consideration and how they will be coordinated with Part B MAI funds:
      a. Education and outreach services provided by other Ryan White programs within the State/Territory that are intended to increase access to ADAP.
      b. Education and outreach services funded by other Federal, State, and Local resources, such as CDC Prevention Services, Medicaid, Medicare Part D, and substance abuse and mental health treatment services.

(3) MAI Plan Narrative and ADAP Capacity

Please describe the following:

   i) Based on the FY 2013 MAI Annual plan, discuss the following:
      a. How education and outreach services will be provided, in terms of:
         i. Geographic locations;
         ii. Types of agencies and staff to provide services;
         iii. Coordination with existing services and providers;
         iv. Involvement of targeted minority populations in implementation of plan.

   ii) Provide an update of current ADAP utilization data and the capacity of the ADAP to absorb additional clients (specify the number) reached through MAI-funded services.

   iii) To the extent that ADAP resource constraints may exist, describe the plan to ensure that clients not currently enrolled in ADAP are linked to other medication/treatment resources in a timely manner.
iv) Describe the plan for assuring the quality of MAI-funded education and/or outreach services in relation to the FY 2013 Part B/ADAP CQM plan.

(B) FY 2013 AIDS Drug Assistance Program (ADAP) Grant Application

This Section is to be completed by the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam and eligible Pacific Island Jurisdictions

The purpose of this section is to describe the State/Territory’s AIDS Drug Assistance Program (ADAP). In addition, states and territories that had a waiting list in FY 2012 or anticipate instituting an ADAP waiting list for FY 2013 will be required to respond to the questions listed in sections (3), (4), and (5) of this application.

ADAP pays for medications to treat HIV disease, insurance continuation for eligible clients, and services that enhance access, adherence, and monitoring of drug treatment. Patient eligibility is determined by the State or Territory and includes both financial and medical eligibility criteria. Financial eligibility is usually determined as a percentage of the Federal Poverty Level (FPL). Medical eligibility is the diagnosis of HIV-infection (symptomatic or asymptomatic). Patients must also provide proof of current state residency as well as proof of being uninsured or under-insured. ADAPs are required to recertify client eligibility every six months.

An ADAP waiting list is a mechanism used to limit access to the ADAP when funding is not available to provide medications to all eligible persons requesting enrollment in that State. The ADAP verifies overall eligibility for the program and places eligible individuals on a waiting list, as necessary, prioritized by a pre-determined criterion. The ADAP manages the waiting list to bring clients into the program as funding becomes available.

Despite appropriation increases, steady growth in the number of eligible clients combined with rising costs of complex HIV/AIDS treatments sometimes results in states experiencing greater demand for ADAP services than available resources can cover. In these instances, ADAPs have implemented waiting lists for program services and medications.

The FOA makes a distinction between two categories of cost-containment measures (CCMs): 

Cost-cutting measures: Any measures taken that restrict/reduce enrollment (financial eligibility reductions below 300 percent of the Federal Poverty Level (FPL), capped enrollment) or that reduce benefits (formulary reductions with respect to antiretroviral medications and medications to treat opportunistic infections or complications of HIV disease), and are instituted out of necessity due to insufficient resources and/or to avoid starting a waiting list. ADAP emergency relief funding may be requested to address/reverse (completely or partially) “cost-cutting” CCMs.

Examples of “cost-cutting” measures: Reductions in ADAP financial eligibility below 300 percent of the Federal Poverty Level (FPL), capped enrollment, formulary reductions in with
respect to antiretroviral medications and/or medications to treat opportunistic infections and complications of HIV disease, or restrictions with respect to ADAP insurance eligibility criteria (i.e., below 300% of FPL).

**Cost-saving measures:** Any measures taken to improve the cost-effectiveness of ADAP operations, which are required to achieve, improve, and/or maximize HRSA recommended cost-saving strategies that all states should be working to achieve and/or maximize regardless of financial status. States may request ADAP emergency relief funding to implement “cost-saving” CCMs.

Examples of “cost-saving” measures: Improved systems and procedures for back billing Medicaid, improved client recertification processes, Part B Program structural or operational changes such as expanding insurance assistance, purchase of insurance, collection of 340B rebates for insurance co-pays, deductibles, co-insurance, TrOOP expenditures, and CMS data-sharing agreements.

HRSA has prioritized the following cost containment strategies through its monitoring and technical assistance efforts: purchase of insurance, collection of 340B rebates for insurance co-pays, deductibles, co-insurance and TrOOP expenditures, back billing of Medicaid, and CMS data-sharing agreements, 6-month re-certification, and controlling ADAP administrative costs.

1) ADAP Program Description

(a) **Agency Oversight/Administration**
Provide a narrative that identifies any changes in the management/administration of the ADAP from FY 2012, and any proposed changes for FY 2013. Include an organizational chart if the ADAP is administered by a different agency. Place this chart in **Attachment 1**.

(b) **ADAP Funding Resources**
Provide a table that lists all sources of funds for the ADAP program (including State funds, other Ryan White HIV/AIDS Program funds, and State or Federal Drug Rebates) expected for FY 2013, as well as any anticipated funding shortfalls. The table should be included as **Attachment 2**.

(c) **Formulary**
**Summary:** The current statute requires that all States/Territories determine the formularies from the list of core classes of antiretroviral medications established by the Secretary. FDA-approved antiretroviral drug classes currently available include: Entry and Fusion Inhibitor, Non-nucleoside Reverse Transcriptase Inhibitor, Nucleoside Reverse Transcriptase Inhibitor, and Protease Inhibitor. Please refer to Section 2616(c)(1) of the PHS Act.

(1) Provide a narrative that discusses any limitations or barriers that affect the inclusion of these drug classes on your ADAP formulary.
(2) If your program reduced the number of medications available in the core classes, please describe the process your agency utilized to reduce those medications, and the role of the ADAP Advisory Committee in the reduction process.

2) Client Utilization of ADAP Services

(a) For States and Territories that implemented any “cost-cutting” measures to the ADAP (i.e., waiting lists, enrollment limits, expenditure caps, formulary reductions, etc.) at any point during FY 2012, please describe the rationale for these restrictions and the processes used to both establish and remove them.

(b) Provide a narrative that explains how ADAP clients in outlying or rural areas access ADAP services.

(c) In light of MAI Outreach, EIIHA activities, and CDC’s enhanced prevention initiatives, provide a narrative that discusses any increases in program enrollment and the subsequent impact on utilization of ADAP resulting from these initiatives.

3) This section is to be completed by States that implemented a Waiting list in 2012

(a) What factors (e.g. state general fund cuts, increased enrollment, increased costs of medications or insurance premiums, etc.) contributed to the decision to implement an ADAP waiting list?

(b) Describe how stakeholders (e.g. ADAP Advisory Body, PLWH/A, providers) were involved in the decision to begin a waiting list. Describe the process you employed to communicate the implementation of a waiting list to stakeholders, providers, PLWHA, case managers and eligibility specialists.

(c) What preventative measures and cost containment measures were implemented prior to implementing an waiting list (e.g. formulary reduction, reducing the federal poverty level (FPL) requirement, cutting support or core medical services funding, data sharing agreement with CMS, back-billing Medicaid, and purchasing of insurance)?

(d) Describe the process your program has employed for training and informing PLWH/A, doctors, providers, eligibility specialist and case managers about the availability of medications through the Pharmaceutical Manufacturer Patient Assistance Programs.

(e) Are all clients on the waiting list screened for ADAP eligibility? How often are they rescreened for ADAP eligibility?

(f) Is your waiting list based on the clinical acuity of PLWH/A’s health or based on the model of "first come, first serve"?

(1) Please provide a description of your State ADAP waiting list initiation protocol.
(g) Describe the process of how PLWH/A on the current ADAP waiting lists are transitioned into the ADAP when openings arise.

(1) How are PLWH/A and providers informed?

(h) Describe how your program coordinates with other Ryan White programs in the State to ensure that ADAP eligible PLWH/A have access to medications.

(1) How is this communicated and monitored by your program?

(i) What challenges are clients, case managers, doctors, eligibility specialists and providers facing in enrolling clients on Patient Assistance Programs?

(1) What steps has your program taken to assist in meeting these challenges?

(j) What is the average length of time (i.e. 1 month, 3 months, etc.) that an ADAP eligible PLWHA stays on the current waiting list?

(k) How many ADAP eligible PLWHA do you estimate will be on the waiting list at the end of the 2012 grant year?

(l) How many ADAP eligible PLWHA do you estimate will be on the waiting list during the 2013 grant year?

4) If your program anticipates implementing an ADAP waiting list during the 2013 grant year, please describe the following:

(a) What factors (e.g. state general fund cuts, increased enrollment, increased costs of medications or insurance premiums, etc.) are contributing to the decision to implement an ADAP waiting list?

(b) Describe how stakeholders (ADAP Advisory Body, PLWH/A, providers) will be involved in the decision to begin a waiting list. Describe the process you will employ to communicate the implementation of a waiting list to stakeholders, providers, PLWHA, case managers and eligibility specialists.

(c) What preventative measures and cost containment measures are being implemented prior to implementing an ADAP waiting list (e.g. formulary reduction, reducing the income eligibility, cutting support or core medical services funding, data sharing agreement with CMS, back-billing Medicaid, and purchasing of insurance)?

(d) What efforts has your program undertaken to prevent the waiting list?

(e) Describe the process that will be used to train and inform consumers, doctors, providers, eligibility specialists and case managers about the availability of medications through the Pharmaceutical Manufacturer Patient Assistance Programs.
(f) How many ADAP eligible PLWH/A do you project will be on the waiting list during the 2013 grant year?

(g) Describe your plans to coordinate with other Ryan White programs in the State to ensure that ADAP eligible PLWH/A will have access to medications.

5) ADAP Cost Saving Strategies

Summary: ADAP grantees are required to use every means at their disposal to secure the best price available for all products on their ADAP formularies in order to achieve maximum results with these funds. As covered entities, ADAPs are eligible to participate in the 340B Drug Pricing Program under section 340B of the PHS Act. Funds received as a result of participating in the 340B Drug Pricing Program Rebate Option shall be returned to the Ryan White Program. Grantees are expected to coordinate effectively with third party payers to ensure that costs are recovered for services provided to eligible/covered individuals. Third party sources include Medicaid, Children’s Health Insurance Programs (CHIP), Medicare (including the Part D prescription benefit) and private insurance. Subcontractors providing Medicaid eligible services must be Medicaid certified. The Ryan White HIV/AIDS Program is the payer of last resort, and grantees must ensure that alternate sources of payment are pursued. Grantees are required to determine client eligibility and to recertify eligibility every six months. In addition, the applicant must ensure that program income is used consistently with ADAP requirements.

(a) All 340B Participating ADAPs

For States/Territories that participated in the 340B Drug Pricing Program during FY 2012, respond to the following questions specific to the cost-saving practices used:

(1) 340B Direct Purchase

i) Describe the State/Territory’s cost-saving practices and distribution process for FY 2012.

ii) Provide the name and type of pharmaceutical provider currently used;

iii) Describe the State/Territory mechanisms for monitoring the contract or subcontract.

(2) If your program utilizes HRSA’s Prime Vendor Program/HealthCare Purchasing Partners International (HPPI), provide the name of the wholesaler the contractor uses.

(3) 340B Rebate Option

i) Describe the pharmacy network used in FY 2012 for distribution (e.g., national drug chain, mail order, state health department pharmacies, local pharmacies, university or disproportionate share hospital pharmacy), including the number of contract pharmacies used.

ii) Describe any negotiated discounts on the purchase price of drugs, dispensing fees, administrative fees, and additional services for the coming year.
iii) Describe how the State/Territory ensures that manufacturer’s rebates are applied, consistent with Section 2616(g) of the PHS Act.

**Note:** Funds received as a result of participating in the 340B Drug Pricing Program Rebate Option shall be returned to the operating budget of the Part B program, with priority given to activities in ADAP.

**(b) For ADAPs Using Either the 340B Direct Purchase or 340B Rebate Options**

(1) Describe all other non-340B cost-saving strategies that the State/Territory used in FY 2012, as well as strategies planned for FY 2013 to secure the best price and maximize ADAP resources, such as other supplemental rebates and/or discounts received from pharmaceutical manufacturers in FY 2012.

**(c) Non-340B Participating ADAPs**

(1) For States/Territories that did not participate in the 340B Drug Pricing Program during FY 2012: Describe all of the cost-saving strategies used by your ADAP during FY 2012, including any non-340B supplemental rebates and/or discounts received from pharmaceutical manufacturers.

(2) Explain how these strategies are equal to or less expensive than participating in the 340B Drug Pricing Program.

**(d) ADAP Linkages**

(1) Discuss how the ADAP coordinates with third-party payers (e.g., State Medicaid program or private insurance) to assure that ADAP is the payer of last resort.

(2) Describe any third-party payer limitations that restrict access to HIV pharmaceutical therapies and describe ADAP mechanisms to address gaps or limitations in services.

(3) Describe how the ADAP coordinates with Part A, Part C, and Part D grantees to provide comprehensive and equitable pharmacy benefits across the state.

(4) Briefly describe how the ADAP utilizes or coordinates with manufacturer’s Patient Assistance Programs (PAP) and clinical trials.

**(e) Medicare (including Medicare Part D Prescription Drug Benefit)**

(1) Describe the policies and procedures established by the State/Territory with respect to the use of Part B ADAP and/or base funds (e.g., State Health Insurance Continuation Program (HICP), HIV Care Consortia) to cover Medicare Part D out-of-pocket costs (premiums, deductibles, coinsurance, and/or co-pays) for low-income beneficiaries who meet the State/Territory’s ADAP eligibility criteria.

(2) With regard to each Part B program component that will cover Medicare Part D costs, discuss briefly how the State’s policies take into account:
i) Client eligibility in relation to eligibility for the program/service, e.g. ADAP, consortia-funded insurance continuation;

ii) Costs and resources, including administrative costs;

iii) Any limits established with respect to eligible Prescription Drug Plans (PDPs) (i.e. PDPs that do not have a ‘donut-hole,’ do not exceed a certain premium cost, and/or meet certain drug coverage criteria);

iv) How the program (i.e., ADAP, consortia) will coordinate with eligible PDPs to track and account for these payments;

v) Competing access issues such as capped ADAP enrollment and/or waiting lists; and

vi) The current or expected impact of the Medicare Part D Prescription Drug Benefit on program components (i.e. ADAP, State Health Insurance Continuation).

(3) For each program component that will cover Medicare Part D beneficiary cost-sharing, identify the number of clients the State/Territory anticipates serving that will be Medicare eligible and the projected amount of FY 2013 funds to be spent on these clients.

(4) With regard to the Part B ADAP and/or State HICP, identify all sources other than the ADAP Earmark to be used to help cover beneficiary out-of-pocket costs (e.g., Part B base funds allocated for ADAP, contributions from the State, Part A and/or other Ryan White HIV/AIDS Program funded programs to the ADAP or HICP); for each additional funding source, indicate if the funds were allocated specifically for the purpose of covering Medicare Part D beneficiary costs and/or to support the ADAP program generally.

(5) With regard to the use of Part B HIV Care Consortia funds to cover beneficiary Medicare Part D costs, discuss how the State/Territory will assure consistency statewide with respect to:

i) Client eligibility for coverage of Part D out-of-pocket costs;

ii) Coordination with eligible PDP’s to track payments.

(f) ADAP Funded Health Insurance

Summary: HAB Policy Notice 07-05 allows States and Territories to use ADAP funds to purchase health insurance. In accordance with HAB’s Policy Notice 07-05, prior to the use of ADAP funds for the purchase of health insurance States must provide HAB with the methodology used by the State to ensure that each of the criteria listed within Policy Notice 07-05 are met. States may use this application as the Notification of Intent. HAB Policy Notice 07-05 can be found at: http://hab.hrsa.gov/manageyourgrant/policiesletters.html
(1) For States/Territories with existing ADAP-funded health insurance programs, please describe:

i) The use of ADAP funds to purchase insurance in FY 2012 and any anticipated changes for FY 2013;

ii) The anticipated amounts of ADAP funds to be used for health insurance, the types of insurance(s) that will be purchased, and the number of projected clients to be served.

(2) For those States/Territories establishing new insurance programs during FY 2013, please provide a narrative description of:

i) How the State/Territory will ensure that the health insurance to be purchased includes a formulary that is as comprehensive as the current ADAP formulary;

ii) How the State/Territory will ensure the cost effectiveness of the health insurance to be purchased exceeds the cost effectiveness of keeping clients on traditional ADAP;

iii) The anticipated amounts of ADAP funds to be used for health insurance (i.e. premiums, co-pays and deductibles) and types of insurance(s) that will be purchased using ADAP funds as well as the number of projected clients to be served;

iv) How the program will account for, and report on, funds used to purchase and maintain insurance policies for eligible clients, including covering any costs associated with these policies (e.g., premiums, co-payments, or deductibles) to ensure that the Ryan White HIV/AIDS Program is the payer of last resort;

v) How the program coordinates with any existing program utilizing Part B funds for the purchase of health insurance; and

vi) How the implementation of this program will impact the ADAP (e.g., the expansion of formulary or the decrease in waiting list).

(g) Flexibility Policy as it Relates to Access, Adherence and Monitoring Services

Summary: HAB Policy Notice 07-03 established guidelines for allowable ADAP-related expenditures under the Ryan White HIV/AIDS Program for services that improve access to medications, increase adherence to medication regimens, and help clients monitor their progress in taking HIV-related medications. The policy provides grantees with greater flexibility in the use of ADAP funds. States may request to redirect up to 5% under this policy, and up to 10% in extraordinary circumstances. The amount that a grantee can request to be redirected is in addition to the aggregate of 15% of ADAP funds allowed for administrative, planning and evaluation costs. This does not include funds under other Parts that may be used to purchase medications. An example of an extraordinary circumstance would be identifying a targeted population with low adherence rates (e.g. substance abusers, homeless persons).
Note: Those States/Territories applying to use ADAP funds under the Flexibility Policy in FY 2013 for access, adherence, and monitoring services should reply to this section. In order to be eligible the States/Territories cannot have any program restrictions (i.e., cost sharing or waiting list).

(1) Discussion of Proposed Program
   i) If you plan to redirect a portion of ADAP funding to pay for services under the ADAP Flexibility Policy, provide a narrative description that includes the:
      a. Proposed services to be funded (access, adherence, monitoring);
      b. Amount of ADAP funds that will be redirected to pay for the referenced services;
      c. Methodology used to determine the cost of the proposed services;
      d. The total projected expenditures for each service, and the unit cost (e.g. cost for billable hours for adherence and access services, lab services, etc.);
      e. The number of clients who will directly benefit from each of the proposed services;
      f. How the program will monitor the proposed services to ensure that there are no limitations to accessing the State ADAP;
      g. How the ADAP will ensure that comprehensive coverage of antiretroviral and opportunistic infection medications is maintained;
      h. How the ADAP will report on the use of redirected funds under the Flexibility Policy;
      i. How the ADAP will redirect funds back to the ADAP funding stream should it become necessary to maintain the core purpose of ADAP.

(C) Pacific Island Jurisdictions’ FY 2013 Part B Grant Application

This Section should be completed only by eligible applicants listed below.

Eligible Jurisdictions:
Republic of the Marshall Islands
Federated States of Micronesia
Republic of Palau
American Samoa
The Commonwealth of the Northern Mariana Islands

Note: For those territories that are eligible to apply for the ADAP Supplement Grant Application, please refer to and complete the FY 2013 ADAP Supplemental Grant Application Section.
1) The Territory’s Organizational Structure

(a) Describe the Territory’s health care delivery system, including the health centers responsible for providing services to low income populations in general.

(b) Describe where HIV/AIDS related services are provided, including relevant laboratory diagnostic facilities.

   (1) Include organizational charts in Attachment 1 in order to illustrate the relationships among the Territory-level agencies involved in HIV care.
   (2) Highlight any changes that occurred over the past year.
   (3) Highlight changes planned for the next year.

(c) Within the Territory’s structure, identify the proposed entity or entities responsible for managing and administering Part B programs, including ministry or department, unit, staff, fiscal agents, and planning/advisory/evaluation bodies. Highlight any changes that occurred over the past year or that are planned for the next year.

   (1) Identify the entity responsible for financial management of the Part B program, including ministry or department.
   (2) Describe the relationship between the entity responsible for financial administration and the entity responsible for program administration.
   (3) Identify which entity is responsible for grant-related fiscal reporting and financial monitoring, and how these entities work together to fulfill grant-related reporting and monitoring responsibilities.

2) Epidemiological Information

Purpose: The purpose of this section is to describe the HIV/AIDS epidemic in the Territory. Section 2617 (b) (2) of the PHS Act states that the application for Part B funds shall contain a determination of the size and demographics of the population of people with HIV/AIDS in the Territory. Please note that both the Epidemiology table and narrative should be included as Attachment 4.

Important Note: For programs that plan on applying for 2013 Part B Supplemental (X08) funds, the Epidemiology table and narrative provided in Attachment 4 of this application will be provided to the 2013 Part B Supplemental Objective Review Committee (ORC) reviewers for the purpose of scoring the Epidemiology Data section (Criterion 1) of the 2013 Part B Supplemental application. The 2013 Part B Supplemental Funding Opportunity Announcement will not request Epidemiology data, as the information provided in Attachment 4 of this application will be used to scoring purposes.

(a) Table

Summarize in a table format the living cases of HIV disease through December 31, 2011 identifying the AIDS and HIV (non-AIDS) prevalence by demographic group and exposure category. Place the table in Attachment 4 of the application and clearly label the data sources.
(b) Narrative
Based on the latest HIV/AIDS Epidemiologic Profile, provide a narrative description of any trends or changes in the Territory’s HIV disease prevalence over the past two calendar years (01/01/10-12/31/11). Place the narrative in Attachment 4 of the application. Use the following indicators to provide a comparative description of the HIV disease prevalence by demographic characteristics and exposure category in the State including:

(1) the number of people living with HIV (non-AIDS),
(2) the number of people living with AIDS, and
(3) the number of new AIDS cases reported within the last two calendar years.

3) HIV/AIDS Care System

(a) Describe the Territory’s continuum of care in 2013, including HIV/AIDS services provided in the Territory (i.e., primary medical care, supportive services that enable individuals to access and remain in primary care, and other health and supportive services that promote health and enhance quality of life).

(b) Outline the strategy for identifying individuals with HIV/AIDS who do not know their status, making such individuals aware of their status, and enabling such individuals to access services. Focus your response using the below guidelines.

(1) The strategy should include discrete goals.
(2) Timetable for achieving the goals, and be coordinated with other community stakeholders.

(c) Describe the current availability and capacity of HIV/AIDS resources and services to provide HIV/AIDS care, planned capacity development activities in the Territory, and/or capacity development needs. Discuss any disparities in access or services among affected subpopulations or communities.

(d) Describe efforts to inform individuals living with HIV/AIDS about services and to engage individuals in HIV/AIDS care.

(e) Specifically address how the Medicaid program, if applicable in the Territory provides services to people living with HIV/AIDS, including eligibility, and which HIV/AIDS services are covered by Medicaid.

(f) Describe how the Part B program coordinates with Federal- and Territory-funded HIV prevention efforts, including any planned linkages and joint planning mechanisms.

(g) Describe how HIV counseling and testing services are designed to facilitate access to care for persons testing positive for HIV. In addition, describe any other linkages with early intervention services.
4) Clinical Quality Management Program

**HAB’s Definition of Quality**: “Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations.” Evaluations of the quality of care should consider: (1) the quality of the inputs; (2) the quality of the service delivery process; and (3) the quality of outcomes, in order to continuously improve systems of care for individuals and populations.

Clinical Quality Management (CQM) data play a critical role in helping to identify needs and gaps in services as well as in helping to ensure the delivery of quality services to clients. Information gathered through the CQM program as well as client-level health outcomes data should be used as part of the Territory 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 processes for administering the grant at the programmatic and fiscal levels.

(a) The HAB has established the following minimum expectations of Ryan White HIV/AIDS Program grantees regarding quality management. At a minimum, grantees are expected to:

1. Establish and implement a quality management plan;
2. Establish processes for ensuring that services are provided in accordance with Department of Health and Human Services (DHHS) treatment guidelines and standards of care; and
3. Incorporate quality-related expectations into Requests for Proposals (RFPs) and Part B contracts, if applicable.

(b) Provide a narrative which describes how the Territory ensures the quality of HIV care provided to persons living with HIV/AIDS (PLWH/A). Discuss how Part B funded services, including support services, are improving HIV-related clinical health outcomes of PLWH/A in the Territory.

5) Planning Mechanisms

(a) Identify the planning entity and mechanism the Territory uses to make decisions about Part B funds. Discuss the participation of PLWH/A in the planning process, including what the Territory is doing to encourage and support their participation in this process.

(b) Describe how decisions to allocate dollar amounts to the five program areas — HIV Care Consortia, Home and Community-Based Care, Health Insurance Coverage, Provision of Treatments, and Direct Services — will be made.

(c) Discuss how allocation decisions are made between geographically or politically separate, and who is involved in making these decisions.

6) Ryan White HIV/AIDS Program Coordination of Planning and Services

(a) Coordination with other Federal Programs:
(1) Describe how the Part B program coordinates HIV/AIDS funding and service delivery with non-Ryan White HIV/AIDS Program programs.

i) Examples include: coordinating with other HRSA funded programs (including Maternal and Child Health, Migrant Health Programs, and Community Health Clinics); CDC (Prevention, Surveillance, STD programs); Medicaid (including Medicaid managed care); Medicare; Veterans Affairs programs; Territory funds; and other programs/initiatives (such as substance abuse prevention and treatment services or Territory social, welfare, and immigration services).

ii) For those Territories eligible for Global AIDS Funds, describe any ongoing or planned activities the Territory is participating in through the Global AIDS Fund and how these activities are coordinated with the Part B program.

7) Implementation Plan for FY 2013

**Summary:** The Ryan White HIV/AIDS Program requires that grantees funded under Part B use not less than 75 percent of grant funds, after reductions for Program Administration and Quality, for core medical services that are needed in the service area. Core medical services are defined as follows: 1) Outpatient and ambulatory health services; 2) AIDS Drug Assistance Program treatments in accordance with Section 2616 of the PHS Act; 3) AIDS pharmaceutical assistance (local); 4) Oral health care; 5) Early Intervention Services; 6) Health insurance premium and cost sharing assistance for low-income individuals in accordance with Section 2615; 7) Home health care; 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 2612(c) 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 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; 7) Legal Services; 8) Linguistic Services; 9) Medical Transportation Services; 10) Outreach Services; 11) Psychological Support Services; 12) Referral for health care/supportive services; 13) Rehabilitation Services; 14) Respite Care and 15) Treatment Adherence Counseling; and 16) Residential substance abuse treatment. All services provided by or through consortia are considered as support services.

(a) Table: FY 2013 Implementation Plan:

In a table, list each service category and amounts for all Part B funding sources to include; Part B Formula funding, AIDS Drug Assistance Program (ADAP), Minority AIDS Initiative (MAI), ADAP Supplemental (if applicable), and Emerging Communities (if applicable) that will be allocated for each service category in FY 2013. Do not include any administrative processes. The table should be placed in Attachment 5.
(1) For each service category listed:

(a) Objective/s: List objectives for new or continued services. Each objective should describe the specific activities associated with the service being provided.

(b) Service Unit Definition: Provide the name and definition of the unit of service to be provided (e.g. one round-trip bus ride, one prescription).

(c) Quantity: Provide the number of people to be served and service units to be provided during the grant year. Section 3a) List the number of people to be served; 3b) List the total number of service units to be provided to that number of individuals.

(d) Time Frame: Indicate the estimated duration of the activity relating to the objective listed.

(e) Funds: Provide the approximate amount of Part B funds to be used to provide this service. Where multiple objectives exist beneath one service goal, break out the estimated amount of funding by each individual objective listed.

(f) Outcome: Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked and include benchmarks for each.

**Note: Program objectives do not include administrative processes, and should not be included on this table.**

(b) Provide a narrative that describes the following:

1. How the Territory will allocate funds to the core medical and supportive services as described above. If funds are not allocated to these core medical services, provide a narrative description of how the core medical services are being funded through other sources;

2. How the activities described in the plan will assure geographic parity in access to HIV/AIDS services throughout the Territory;

3. How the activities described in the plan will ensure that PLWH/A remain engaged in HIV/AIDS primary medical care and adhere to HIV treatments; and

4. How the services and their goals and objectives relate to the goals of the Healthy People 2020 initiative, particularly the objectives related to HIV listed under the tab “2020 topics and objectives”. Copies of the Healthy People 2020 may be obtained from the Superintendent of Documents or downloaded at: http://www.healthypeople.gov/2020/default.aspx

(D) ADAP Supplemental Grant Application

*This section should be completed only by eligible applicants as listed below.*

1) States/Territories Eligible to Apply for an ADAP Supplemental Treatment Drug Grant

**Summary:** The process for determining States and Territories with demonstrated severe need was based on a review of existing program limitations, as reported in the ADAP Quarterly Report (AQR). The following States/Territories below are determined to be eligible to apply in
FY 2013 for program funding based on program limitations (i.e., enrollment cap, waiting list and capped expenditures) reported in the ADAP 4th Quarterly Report (April 30, 2012). Additional States may become eligible based on requirements for maintaining a core list of drugs and/or identifying an unanticipated increase in clients.

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Section 2618(a)(2)(F)(ii) of the PHS Act, states that five percent of the AIDS Drug Assistance Program (ADAP) appropriation will be reserved as supplemental funding to purchase medications for States and Territories with demonstrated severe need. This funding will be available to States and Territories based on one of the following criteria:

- **Financial requirement of Federal Poverty Level (FPL) <200 percent;**
- **Limited formulary compositions for all core classes of antiretroviral medications;**
- **Waiting list, capped enrollment or expenditures;**
- **An unanticipated increase of eligible individuals with HIV/AIDS.**
(a) Eligibility Criteria

(1) To receive this grant States/Territories must satisfy the following criteria:

i) States/Territories must have obligated 75 percent of their FY 2012 Part B award within 120 days of receipt of grant funds and have reported on the FY 2012 interim Federal Financial Report (FFR), within 150 days after receipt of grant funds. States/Territories that fail to obligate 75 percent of the FY 2012 Part B grant award in this timeframe, or fail to submit the FFR on time, will be ineligible for FY 2013 ADAP supplemental funds.

ii) States/Territories must use ADAP supplemental funds to provide HIV/AIDS-related medications or the devices needed to administer them, and shall coordinate the use of such funds with the amounts otherwise provided under section 2616 of the PHS Act (ADAP) in order to maximize drug coverage.

(b) Application Requirements

(2) States and Territories applying for these funds must describe the severity of need for ADAP supplemental funds using the factors below. The narrative should:

i) Describe any ADAP eligibility restrictions.

ii) Identify the barriers in meeting the requirement for maintaining a minimum drug list that includes all currently available Food and Drug Administration (FDA)-approved antiretroviral drug classes. The current statute requires that all States/Territories determine the formularies from the list of core classes of antiretroviral medications established by the Secretary. FDA-approved antiretroviral drug classes currently available include: Entry and Fusion Inhibitor, Non-nucleoside Reverse Transcriptase Inhibitor, Nucleoside Reverse Transcriptase Inhibitor, and Protease Inhibitor.

iii) Identify the number of eligible individuals to whom a State or Territory is unable to provide therapeutics to treat HIV/AIDS.

iv) Discuss any unanticipated increase in service utilization and program costs (i.e. due to the addition of a new drug or class of drug, or to an unexpected increase in eligible individuals with HIV/AIDS.)

v) If you are requesting a waiver to the match pursuant to Section 2618(a)(2)(F)(ii)(III) of the PHS Act, please submit this request along with the other application information.

(E) Emerging Communities FY 2013 Grant Application
This section should be completed only by eligible applicants as listed below.

1) Eligible Jurisdictions
The following Metropolitan Statistical Areas (MSAs) are eligible:

- Albany-Schenectady-Troy, New York
- Augusta-Richmond County, Georgia/South Carolina
- Bakersfield, California
- Birmingham-Hoover, Alabama
- Buffalo-Niagara Falls, New York
- Charleston, South Carolina
- Cincinnati-Middletown, Ohio/Kentucky/Indiana
- Columbia, South Carolina
- Jackson, Mississippi
- Lakeland, Florida
- Louisville, Kentucky/Indiana
- Milwaukee-Waukesha-West Allis, Wisconsin
- Oklahoma City, Oklahoma
- Philadelphia, Pennsylvania/New Jersey/Wilmington, Delaware/Maryland
- Pittsburgh, Pennsylvania
- Port St. Lucie-Fort Pierce, Florida
- Providence-New Bedford-Fall River, Rhode Island/Massachusetts
- Raleigh-Cary, North Carolina
- Richmond, Virginia
- Rochester, New York
- Sarasota-Bradenton-Venice, Florida
- Wilmington, Delaware

The following States are responsible for applying for the above Emerging Communities:
Alabama, California, Delaware, Florida, Georgia, Kentucky, Mississippi, New York, North Carolina Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Virginia, Wisconsin

2) Program Authority and Eligibility

**Summary:** The Emerging Communities Supplemental Grant award is authorized under Section 2621 of PHS Act. It is intended to enable eligible States to provide comprehensive services of the type described in section 2612(a) of the PHS Act to supplement the services otherwise provided by the State under a grant under Part B in emerging communities within the State that are not eligible to receive grants under Part A. An eligible State shall agree that the grant will be used to provide funds directly to emerging communities in the State, separately from other funds under this title that are provided by the State to such communities.

Grantees with Jurisdictions that were classified as an Emerging Community (EC) are eligible to apply for these funds. Emerging Communities continue their eligibility for these funds so long as they meet the statutory requirements. Areas must meet the statutory incidence requirements (cumulative AIDS cases reported to and confirmed by the Director of the Centers for Disease
Control and Prevention during the most recent period of 5 calendar years for which such data are available). An Emerging Community must have between 500-999 cumulative AIDS cases during the most recent 5 years. In the alternative, areas can retain their eligibility by meeting the savings provisions of the Ryan White Program legislation. That is, they must not have fallen below, for three consecutive years, the required incidence level already specified AND required prevalence level (cumulative total of living cases of AIDS reported to and confirmed by the Director of the Centers for Disease Control and Prevention as of December 31 of the most recent calendar year for which such data are available). Areas are notified by letter when they fall within the savings provisions of the Ryan White Program legislation. According to the past eligibility numbers, all the above ECs will be eligible in FY 2013.

3) Emerging Community Requirements

(a) Please describe the following:

(1) How the State will disseminate Emerging Community funds within the Emerging Community itself;
(2) How the State maintains its commitment of local resources, both financial and in-kind;
(3) How the State will maintain HIV-related activities at a level that is equal to not less than the level of such activities in the Emerging Community for the one year period preceding the fiscal year for which the state is applying to receive the grant; and
(4) How the State utilizes the funds in a manner that is immediately responsive and cost effective.

4) Planning and Utilization of Emerging Community Funds

(a) Please describe how the planning process for the Emerging Community funds meets the following requirements. (A State with multiple Emerging Communities should describe each Emerging Community planning process separately, if the process differs.)

(1) The allocation of the funds is based in accordance with the local demographic incidence of AIDS including appropriate allocations for services for infants, children, women and families with HIV/AIDS;
(2) Affected communities and people living with HIV/AIDS are included in the planning process; and
(3) The proposed services are consistent with the local needs assessments and the most recent Statewide Coordinated Statement of Need.

(b) Describe how, as a result of the planning process, the Emerging Community funds will be used. A State with multiple Emerging Communities should describe the use of funds for each Emerging Community separately. Please describe:

(1) What services were provided in Fiscal Year 2012 using Emerging Community funds?
(2) What services will be provided in Fiscal Year 2013?
Note: The 75% core medical services requirement does not apply to Emerging Community funds.

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

Attachment 1: Organizational Chart(s)/Staffing Plan, brief description of the positions and responsibilities in regards to the Part B grant, FTE equivalent of all key staff and personnel. (Note: Biographical sketches and or resumes are NOT required.)

Attachment 2: ADAP Funding Sources Table and MOE Documentation

Attachment 3: The FY 2013 Part B Agreements and Assurances (see Appendix A)

Attachment 4: HIV/AIDS Epidemiology Table and Narrative

Attachment 5: Implementation Table, (including MAI, if applicable)

Attachment 6: Unmet Need Framework and Narrative

Attachment 7: FY 2013 Core Medical Services Waiver (if applicable)

Attachment 8: EIIHA Matrix

Attachment 9: Prospective WICY Waiver

Attachment 10: EIIHA - HIV Testing & Awareness Data

Attachment 11: Award and Match Information

3. Submission Dates and Times

Application Due Date
The due date for applications under this funding opportunity announcement is January 4, 2013 at 8:00 P.M. EST. 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**

HIV Care Grant Program Part B is not subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100.

**5. Funding Restrictions**

The DSHAP will be strictly enforcing the Ryan White HIV/AIDS Health Care Services Program authorizing statute, which states:

Section 2618(c)(1)(B)--Expedited Distribution,-
- **IN GENERAL.**- Not less than 75 percent of the amounts received under a grant awarded to a State under this part shall be obligated to specific programs and projects and made available for expenditure not later than –
  (A) In the case of succeeding fiscal years (FY), 120 days after receipt of such amounts by the State.

Section 2618(d)--Reallocation-
(2) Any portion of a grant made to a state under section 2611 for a fiscal year that has not been obligated as described in subsection (c) ceases to be available to the State or Territory and shall be made available by the Secretary for grants under Section 2620, in addition to amounts made available for such grants under section 2623(b)(2).

Part B grant funds **cannot** be used for:

- International travel.
- Construction; however, 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. This includes the cost of amusements, social activities and related incidental costs.
- Fundraising expenses.
- Lobbying expenses.
- Pre-Exposure Prophylaxis (PrEP).
- Syringe Services Programs (SSPs).

Reminder: The Part B legislation defines Grantee Administration to include indirect costs. If a grantee chooses to charge an indirect cost to the grant, they must apply for and obtain an HHS negotiated indirect cost rate through HHS’s Division of Cost Allocation (DCA); the total amount allocated for Grantee Administration (including indirect costs) may not exceed the 10% Administrative cap. Sub-grantees cannot request an HHS negotiated indirect cost rate under this grant through the HHS Division of Cost Allocation. For further information regarding allowable costs, please refer to: [http://hab.hrsa.gov/manageyourgrant/policiesletters.html](http://hab.hrsa.gov/manageyourgrant/policiesletters.html)

For other non-allowable costs can be found in the OMB circulars, available at [http://www.whitehouse.gov/omb/circulars_default](http://www.whitehouse.gov/omb/circulars_default).

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 sub-awards/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 the System for Award Management (SAM). 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 SAM “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 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 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 their application by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking an application can be found at https://apply07.grants.gov/apply/checkApplStatus.faces. Be sure the application is validated by Grants.gov prior to the application deadline.

V. Application Review Information

1. Review Criteria

Applications will be reviewed for complete submission of required information as outlined in the 2013 Part B Funding Opportunity Announcement.

2. Review and Selection Process

Part B formula awards are not subject to the Objective Review Committee process. All applications will be reviewed internally by grants management officials (business and financial review) and Division of State HIV/AIDS Programs staff (technical review).

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of April 1, 2013.

VI. Award Administration Information

1. Award Notices

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

National Monitoring Standards
As a Condition of Award, grantees are required to implement The National Monitoring Standards at both the grantee and provider/sub-recipient levels. To help our grantees meet this challenge, HRSA has developed 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.

Pre-Existing Condition Insurance Plan (PCIP)
Ryan White funds may be used to pay the premiums, co-pays and deductibles for clients that are enrolled in a PCIP, just as they may for Medicare Part D or other health insurance. Ryan White funds may not be used to pay for administrative costs associated with PCIP. Please refer to HAB’s “Pre-existing Condition Insurance Plan and the Use of Ryan White Funds” dear colleague letter dated March 15, 2011 for further details at: http://hab.hrsa.gov/manageyourgrant/policiesletters.html.

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 provider that generated the income and used to support allowable program costs including additional 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.

Direct payments include charges imposed by recipients and sub-recipients for Part B services as required under Section 2617(c) of Program legislation, such as enrollment fees, premiums, deductibles, cost sharing, co-payments, co-insurance, or other charges. As specified on the Part B Notice of Award (NoA), program income must be “Added to funds committed to the project or program and used to further eligible project or program objectives.” Grantees are responsible for ensuring that sub-recipients have systems in place to account for program income, and for monitoring to ensure that sub-recipients are tracking and using program income consistent with grant requirements. See the HHS Grants Policy Statement at ftp://ftp.hrsa.gov/grants/hhsgrantspolicystatement.pdf, the Part B NoA, and 45 CFR 92.25.
Drug rebates are not considered part of the grant award and are not subject to the unobligated balances provision. Part B grantees must report Program Income on the SF-425 (Federal Financial Report) long form, however, rebate funds must not be included on the SF-425 as part of the reported unobligated balance, and thus, must not be requested at any time for carry over. The total amount of drug rebates received during the reporting period should be identified under line 12 Remarks of the FFR with attachment(s) as necessary.

3. Reporting

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

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

b. **Payment Management Requirements**
   Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant or cooperative agreement. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to [http://www.dpm.psc.gov](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](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) **Progress Report(s).** Submission and HRSA approval of your Progress Report(s) triggers the budget period renewal and release of subsequent year funds. 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. All Ryan White core service and support service providers are required to submit client-level data for Calendar Year (CY) 2011. Please refer to the HIV/AIDS Program Client Level Data website at [http://hab.hrsa.gov/manageyourgrant/clientleveldata.html](http://hab.hrsa.gov/manageyourgrant/clientleveldata.html) for additional information. Information regarding the ADAP Quarterly Report will be provided in your Notice of Award. Further information can be found at: [http://hab.hrsa.gov/manageyourgrant/adr.html](http://hab.hrsa.gov/manageyourgrant/adr.html)
3) **Final Report.** 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](https://grants.hrsa.gov/webexternal/home.asp).

4) **Consolidated List of Contracts (CLC).** Include the list of contracts for all providers receiving Ryan White CARE Act funding/contracts. The CLC must be submitted through the HRSA Electronic Handbook (EHB) using the format provided in that system as a component of the Program Terms Report.

5) **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 NoANotice of Award.

d. **Transparency Act Reporting Requirements**
   New awards (“Type 1”) issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier sub-award of $25,000 or more in Federal funds and executive total compensation for the recipient’s and sub-recipient’s five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (FFATA details are available online at [http://www.hrsa.gov/grants/ffata.html](http://www.hrsa.gov/grants/ffata.html)). Competing continuation awardees, etc. may be subject to this requirement and will be so notified 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
Grants Management Specialist
Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting

Heather Hauck, MSW, LICSW  
Director, Division of State HIV/AIDS Programs  
HIV/AIDS Bureau  
Health Resources and Services Administration  
5600 Fishers Lane  
Rockville, MD 20857  
Tel: 301-443-3613  
Fax: 301-443-8143  
Email: hhauck@hrsa.gov

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

Grants.gov Contact Center  
Telephone: 1-800-518-4726  
E-mail: support@grants.gov  
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

VIII. Other Information

1. HIV/AIDS Clinical Performance Measures  
The HIV/AIDS Bureau has developed HIV/AIDS Clinical Performance Measures for Adults and Adolescents and a companion guide to assist grantees in the use and implementation of the core
clinical performance measures. Information on Performance Measures can be found at: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

2. ADAP Quality Management
ADAP quality management requirements have been incorporated into the Clinical Quality Management section of this Funding Opportunity Announcement.

3. Allowable Uses of Funds
For most up to date listing of allowable uses of funds, refer to HAB Policy Notice 10-02: “Eligible Individuals and Allowable Uses of Funds for Discretely Defined Categories of Services” reissued April 8th, 2010. HAB Policy Notice 10-02 is available online at: http://hab.hrsa.gov/manageyourgrant/policiesletters.html.

4. National Monitoring Standards

5. 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://www.hhs.gov/asrt/og/grantinformation/apptips.html.
Appendix A:

FY 2013 AGREEMENTS AND ASSURANCES
Part B Grant Program

I, the Governor, or Authorized Designated Official, of the State or Territory of ______________________________________, hereinafter referred to as "State," assure that:

1. Pursuant to Section 2612¹
   a.) Section 2612(a)
   Amounts provided will be expended on core medical services, support services, and administrative expenses only.

   b.) Section 2612(b)(1)
   Unless a waiver is obtained, not less than 75 percent of the portion of the grant remaining after reserving amounts for administration, planning/evaluation and quality management will be used to provide core medical services that are needed in the State for individuals with HIV/AIDS who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

   c.) Section 2612(d)(2)
   Entities providing Early Intervention Services (EIS) will ensure that the following conditions have been met:
   - Federal, State and local funds are otherwise inadequate for the EIS an entity proposes to provide; and,
   - The entity will supplement, not supplant other funds available to the entity for the provision of providing EIS for the fiscal year involved.

   d.) Section 2612(e)
   For each of such populations in the eligible area, the State will use 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 is obtained from the Secretary.

   f.) Section 2612(f)
   No amounts received under the grant will be used to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.

2. Pursuant to Section 2613
   Section 2613(b)

¹ All statutory references are to the Public Health Service Act, unless otherwise specified.
All required assurances will be obtained from applicants who apply to the State for assistance to provide consortia services.

3. Pursuant to Section 2615

   Section 2615(b)

   Assistance will not be used to pay any costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools); or to pay any amount expended by a State under title XIX of the Social Security Act.

4. Pursuant to Section 2616

   a.) Section 2616(c)(1)

   The therapeutics included on the list of classes of core antiretroviral therapeutics established by the Secretary are at a minimum the treatments provided by the State.

   b.) Section 2616(g)

   Any drug rebates received on drugs purchased from funds provided under the grant are applied to activities supported under Part B, with priority given to AIDS Drug Assistance Program activities.

5. Pursuant to Section 2617

   a.) Section 2617(b)(4)

   The State shall designate a lead State agency that will:

   - Administer all assistance received under Part B;
   - Conduct the needs assessment and prepare the State plan;
   - Prepare all applications for assistance under Part B;
   - Receive notices with respect to programs under Title XXVI;
   - Every two years, collect and submit to the Secretary all audits, consistent with Office of Management and Budget circular A133, from grantees within the State, including audits regarding funds expended in accordance to Part B; and
   - Carry out any other duties determined appropriate by the Secretary to facilitate the coordination of programs under Title XXVI.

   b.) Section 2617(b)(6)

   The public health agency that is administering the grant for the State periodically convenes a meeting that includes individuals with HIV/AIDS, members of a federally recognized Indian tribe as represented in the State, representatives of grantees under each of the Ryan White HIV/AIDS Program, providers, public agency representatives, and if applicable, entities on Part A Planning Councils, in developing the statewide coordinated statement of need (SCSN).

   c.) Section 2617(b)(7)(A)

   The public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes individuals with HIV/AIDS, members of a federally recognized Indian tribe as represented in the State, representatives of grantees under each Part of Title XXVI of the Public Health Service Act, providers, public
agency representatives, Part A Planning Councils (or other planning body), in developing the comprehensive plan and commenting on the implementation of such plan.

d.) Section 2617(b)(7)(B)(i)
HIV-related health care and support services delivered pursuant to a program established with assistance provided under Part B will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual living with HIV/AIDS, to the maximum extent practicable.

e.) Section 2617(b)(7)(B)(ii)
Such services will be provided in a setting that is accessible to low-income individuals living with HIV/AIDS.

f.) Section 2617(b)(7)(B)(iii)
Outreach to low-income individuals living with HIV/AIDS will be provided to inform them of the services available under Part B.

g.) Section 2617(b)(7)(B)(iv)
If using amounts provided under the grant for health insurance coverage, the State will submit a plan that assures that
- such amounts will be targeted to individuals who would not otherwise be able to afford health insurance coverage; and
- income, asset, and medical expense criteria will be established and applied by the State to identify those individuals who qualify for assistance under such a program; and that information concerning such criteria will be made available to the public.

h.) Section 2617(b)(7)(C)
The State will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under Part B.

i.) Section 2617(b)(7)(D)
The State will permit and cooperate with any Federal investigations undertaken regarding programs conducted under Part B.

j.) Section 2617(b)(7)(E)
The State will maintain HIV-related activities at a level that is equal to not less than the level of such expenditures by the State for the one-year period preceding the fiscal year for which the State is applying to receive a grant under Part B.

k.) Section 2617(b)(7)(F)
Grant funds are not utilized to make payments 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 health benefits program, or
- by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services).

l.) Section 2617(b)(7)(G)
Entities within areas in which activities under the grant are carried will maintain appropriate relationships with entities in the area serviced that constitute key points of access to the health care system for individuals with HIV/AIDS (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, STD clinics, HIV counseling and testing sites, mental health programs, and homeless shelters) and other entities under Section 2612(c) and 2652(a) (eligible to apply for Part B Early Intervention Service Grants) for the purpose of facilitating early intervention for individuals newly diagnosed with HIV/AIDS and individuals knowledgeable of their HIV status but not in care;

m.) Section 2617(b)(8)
The State will develop a comprehensive plan describing:

- The estimated number of individuals within the State with HIV/AIDS who do not know their status;
- Activities undertaken by the State to find such individuals and to make them aware of the their status;
- The manner in which the State will provide undiagnosed individuals who are made aware of their status with access to medical treatment for their HIV/AIDS;
- Efforts to remove legal barriers, including State laws and regulations, to routine testing.

n.) Section 2617(c)
The State will comply with the statutory requirements regarding imposition of charges for services, for those providers who charge for services.

o.) Section 2617(d)(1)
If subject to the matching requirement detailed in Section 2617(d), non-Federal contributions will be made available (either directly or through donations from public or private entities).

6. Pursuant to Section 2618
a.) 2618(a)(2)(F)(ii)
States and Territories applying for ADAP Supplemental Treatment Drug Grants will make available non-Federal contributions (directly or through donations from public or private entities) in an amount equal to $1 for each $4 of Federal funds awarded, unless a waiver is obtained.

b.) 2618(b)(3)(A-D)
The State will comply with the limitations of grant funds for administration; planning and evaluation; and quality management activities. In the case of contractors (including Consortia), the State will ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10% (without regard to whether particular entities expend more than 10% for such expenses).
c.) 2618(b)(3)(E)(i)
The State will provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under this grant are consistent with the most recent Public Health Service guidelines for treatment of HIV/AIDS and related opportunistic infections, 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.

d.) 2618(c)(1)
The State will ensure that 75% of Part B funds will be obligated within 120 days of the start date of the grant award, and that if such funds are not obligated, they will be made available promptly to the Secretary for reallocation.

7. Pursuant to Section 2622
The State will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

8. 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.

9. 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.

___________________________________  Date____________________
Signature

________________________________________
Title

_______________________________________
Address
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.

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).

**Supportive services:** Any service that keep HIV negative individuals negative and HIV positive individuals in care. HIV negative individuals are not eligible for RW funded services. HIV positive individuals may be referred to Ryan White funded services or non-Ryan White 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 sero-status 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.

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

*Example EIIHA Matrix 1.2*

<table>
<thead>
<tr>
<th>P1.</th>
<th>ALL Individuals in [INSERT YOUR PROJECT AREA HERE] who are Unaware of their HIV Status (<em>HIV Positive &amp; Negative – Tested &amp; Untested – Publically &amp; Privately Tested</em>)</th>
</tr>
</thead>
</table>

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