

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

HIV/AIDS Bureau  
Division of Community Based Programs

***Ryan White HIV/AIDS Program Part D  
Grants for Coordinated HIV Services and Access to Research  
for Women, Infants, Children, and Youth (WICY)***

**Announcement Type: New  
Announcement Number: HRSA-12-073**

**Catalog of Federal Domestic Assistance (CFDA) No. 93.153**

**FUNDING OPPORTUNITY ANNOUNCEMENT**

Fiscal Year 2012

**Application Due Date: March 16, 2012**

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

**Release Date: January 19, 2012  
Issuance Date: January 19, 2012**

**Modified on 1/30/2012 to indicate that current Part D WICY grantees may apply for a ceiling amount of up to \$500,000 per year or their FY 2011 base funding amount, whichever is greater.**

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Authority: Sections 2671 and 2693 of Title XXVI of the Public Health Service Act (42 U.S.C. 300ff-71 et seq.), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 P.L. 111-87

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# I. Funding Opportunity Description

## 1. Purpose

The purpose of this funding opportunity announcement (FOA) is to solicit applications from organizations throughout the U.S. and its territories to provide family-centered primary medical care to women, infants, children, and youth (WICY) living with HIV/AIDS **when payments for such services are unavailable from other sources**. Funding is intended to improve access to primary HIV medical care for HIV-infected women, infants, children, and youth through the provision of coordinated, comprehensive, culturally and linguistically competent services.

The entire Ryan White HIV/AIDS Program Part D is being re-competed through this FOA in order to respond to the changing HIV epidemiology and the National HIV/AIDS Strategy with the goal of providing comprehensive health care services for the WICY populations in areas of greatest need for services. Part D grantees are expected to provide HIV primary care, specialty medical care, and support services to the clients they serve. For the purpose of implementing programs funded by Part D, HIV primary medical care refers to outpatient or ambulatory care, including behavioral health, nutrition, and oral health services. Family-centered care refers to services that address the health care needs of the persons living with HIV in order to achieve optimal health outcomes. Specialty care refers to specialty HIV care and specialty medical care such as obstetrics and gynecology, hepatology, and neurology. Support services may include the following:

- (1) Family-centered care including case management.
- (2) Referrals for additional services including—
  - (A) referrals for inpatient hospital services, treatment for substance abuse, and mental health services; and
  - (B) referrals for other social and support services, as appropriate.
- (3) Additional services necessary to enable the patient and the family to participate in the program established by the applicant pursuant to such subsection including services designed to recruit and retain youth with HIV.
- (4) The provision of information and education on opportunities to participate in HIV/AIDS-related clinical research.

### **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 (PLWH) 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> Based on the HIV/AIDS Bureau's (HAB's) evaluation and the NHAS, a change in the focus of the Ryan White HIV/AIDS Program Part D is necessitated. The NHAS and recent research findings emphasize the importance of effectively using scarce resources to provide clinical care and treatment to PLWH and to ensure that those resources are being directed to the populations most in need. There have been significant changes in the HIV epidemiologic trends in the U.S. Effective antiretroviral (ARV) drugs for therapy and prophylaxis have been discovered and are widely available. In addition, the Affordable Care Act promises improved healthcare insurance coverage. Transmission of HIV from mother to infant has decreased tremendously with universal prenatal HIV testing and ARV prophylaxis. Today, children comprise only about 1 percent of the HIV epidemic in the United States. Women, especially women of color, now comprise 25 percent of all people living with HIV (PLWH) in the U.S. The greatest increases in HIV incidence are occurring in adolescents and young adults with 34 percent of new HIV infections in those ages 13-29. Additionally young Black males having sex with males (MSM) represent the most impacted racial/ethnic group. (Prejean, *PLoS ONE* 2011, [www.ncbi.nlm.nih.gov/pubmed?term=Prejean%2C%20PLoS%20ONE%202011](http://www.ncbi.nlm.nih.gov/pubmed?term=Prejean%2C%20PLoS%20ONE%202011).)

Ryan White-funded services should ensure that newly identified PLWH, especially young African American MSM, are linked into healthcare, provided ARV medications, and retained in care.

### **Minority AIDS Initiative (MAI)**

Beginning in Fiscal Year 2000, Congress designated a portion of Ryan White HIV/AIDS Program Part D Coordinated Services for Women, Infants, Children, Youth and Families funding for the Minority AIDS Initiative (MAI). The Minority AIDS Initiative (MAI) is intended to address the disproportionate impact that HIV/AIDS has on racial and ethnic minorities and to address the disparities in access, treatment, care, and outcomes for racial and ethnic minorities, including African Americans, Alaskan Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders. The goal of MAI is to help reduce this burden by:

- Increasing the number of persons from racial and ethnic populations receiving HIV care
- Increasing the number of persons from racial and ethnic populations who stay in care

MAI funds are granted to health care organizations that provide culturally and linguistically appropriate care and services to racial and ethnic minorities. Funded Part D WICY programs will be assigned funds under the MAI by the HRSA/HAB Division of Community Based Programs (DCBP), which administers the Part D program. This assignment is based on the percentage of the WICY populations proposed to be served from racial/ethnic minority communities.

The amount of MAI funds awarded is noted under the grant specific terms section of the Notice of Award (NOA) which establishes the final funding for the budget period.

## 2. Background

This program is authorized by Sections 2671 and 2693 of Title XXVI of the Public Health Service Act (42 U.S.C. 300ff-71 et seq.), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 P.L. 111-87.

The Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA) and HAB (HIV/AIDS Bureau) are committed to meeting the national goals and principles described below. As you complete your application, consider how your program supports and helps to implement these goals and principles.

### **HRSA Goal**

The goal for all HRSA programs is to assure access to high quality health care and reduce disparities in health outcomes for recipients of services in HRSA funded programs. The result is that all persons who need care have equal access to high quality health care, regardless of the payment source.

### **HAB Guiding Principles**

HAB has identified four factors that have significant implications for HIV/AIDS care services and treatment, which should be considered as the application and program are developed and refined:

- ◆ Revise care systems to meet emerging needs,
- ◆ Ensure access to quality HIV/AIDS care,
- ◆ Coordinate Ryan White Program services with other health care delivery systems, and
- ◆ Evaluate the impact of Ryan White Program funds and make needed improvements.

### **HAB Program Requirements and Expectations for Part D Programs**

Every Part D program will:

- 1) Design and coordinate services that address the current HIV/AIDS epidemiologic data, the unmet need, and gaps in services for each of the target populations (women, youth, infants, and children living with HIV) in the proposed service area.
- 2) Demonstrate a direct linkage with CDC-funded counseling and testing activities and with Parts A and B efforts to identify diagnosed and undiagnosed HIV positive individuals in the target populations and ensure they are linked into primary medical care and retained in care.
- 3) Develop, expand, and support a comprehensive, coordinated system of HIV care which increases access to primary medical care for **each and every** target group (women, youth, infants, and children). The care in this system must be comprehensive, culturally and linguistically competent, and coordinated. Part D programs must assure their patients and clients receive state-of-the-art medical care, including behavioral health, nutrition, dental care, specialty HIV care, and specialty medical care (such as OB/GYN, hepatology, and neurology).
- 4) Recruit & retain HIV infected women in primary medical care. Address the age specific health care needs of pregnant women, women of child-bearing age, and older women. For

pregnant women, this includes care to prevent the transmission of HIV from mother to infant and processes to track the health outcomes of the births.

- 5) Recruit and retain HIV infected youth (ages 13 to 24), including behaviorally infected, in primary medical care. Demonstrate and document a transition plan for HIV positive youth moving into adult medical care. Males over the age of 24 are not eligible for Part D funded services.
- 6) Establish and maintain collaborative relationships with Ryan White funded programs, other federally funded projects, and other primary medical care providers, including community health centers, in the proposed service area. Participate in the Part B Statewide Comprehensive Statement of Need (SCSN) and ensure that Part D funded activities are consistent with the SCSN and other applicable needs assessments in the geographic area (e.g., Part A).
- 7) Establish and maintain a Clinical Quality Management (CQM) program utilizing HAB-developed Performance Measures in quality improvement activities to monitor and evaluate clinical outcomes & process improvement. Demonstrate consumer participation in program evaluation activities.
- 8) Demonstrate a direct linkage between Part D funded support services and HIV primary medical care services to women, youth, infants, and children living with HIV/AIDS. Supportive services must help patients and clients access primary HIV medical care and be linked to measurable health outcomes. Funding allocated for support services must be proportional to the number of WICY clients who will receive medical services through the proposed applicant organization. Co-location of medical and support services is strongly encouraged.
- 9) Submit the required HRSA/HAB client level data reports in coordination with other Ryan White funded providers in the proposed service area to ensure that the data is unduplicated for the PLWH served and funded services provided.
- 10) Limit administrative costs to no more than 10% of the total annual Part D award. [Administrative costs are defined in Sec. 2671 as funds that are to be used by grantees for grant management and monitoring activities, including costs related to any staff or activity unrelated to services or indirect costs.]
- 11) Ensure systems are in place to maximize collections and reimbursement for costs in providing medical care and other billable services. These systems should track program income and allow agencies to report the enhancement of HIV services resulting from such income. Part D programs are expected to use Ryan White funds as payer of last resort.
- 12) Ensure appropriate oversight and authority over all contracted services, including assuring that subcontracts adhere to Part D program requirements and expectations, including proposed work plan objectives, specification of the number of PLWH to be served per target population, appropriate data sharing, and unduplicated Ryan White data submission.

- 13) Involve consumers as partners in their own care through education about HIV infection, treatment adherence, participation in program implementation and evaluation, and self-care management.

### **Prevention of new infections by working with persons diagnosed with HIV and their partners:**

Programs are encouraged to incorporate the “Recommendations for Incorporating HIV Prevention into Medical Care of Persons Living with HIV.” These recommendations were developed jointly by the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH) and the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA). They were published by CDC as the Morbidity and Mortality Weekly Report, July 18, 2003, Volume 52, Number RR-12 ([www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm)). *(Please note: An erratum has been published for this article.)*

These recommendations describe how health care providers can help to reduce the number of new HIV infections by:

- **Screening patients for behavioral risk** through interviews or questionnaires regarding sexual and needle-sharing behaviors and screening for Sexually Transmitted Infections (STIs) and pregnancy.
- **Offering behavioral interventions** to change knowledge, attitudes, and behaviors to reduce personal risk of transmitting or acquiring other STIs.
- **Providing partner counseling and referral services (PCRS)** which includes partner notification and suggests offering services that can help the sex and needle-sharing partners of HIV-infected patients.

Programs are encouraged to incorporate the Advancing HIV/AIDS Prevention (AHP) initiative developed by the CDC to further decrease perinatal transmission. These strategies encourage clinicians to offer rapid HIV testing to pregnant women in labor with an unknown HIV status and/or undocumented prenatal HIV screening consistent with CDC and American College of Obstetrics and Gynecology (ACOG) recommendations ([www.cdc.gov/HIV/topics/perinatal](http://www.cdc.gov/HIV/topics/perinatal)).

### **Program Reviews**

HRSA evaluates its programs through use of the Government Performance and Results Act (GPRA) Modernization Act of 2010, and the active use of performance data to monitor achievement toward meeting HRSA’s strategic goals. HAB has identified specific measures under the Government Performance and Results Act (GPRA) and overarching performance measures used to demonstrate progress in meeting the needs of uninsured and underinsured individuals. Information regarding these measures can be found in HRSA’s FY 2012 Online Performance Appendix, a companion document of the FY 2012 Performance Budget – Congressional Justification (<http://www.hrsa.gov/about/budget/performanceappendix2012.pdf>).

The GPRA measure specific to the Part D program is:

### **Goal III: Building Healthy Communities**

**Sub-Goal: Lead and collaborate with others to help communities strengthen resources that improve health for the population.**

**Annual Measure:**

- 1) Number of female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. Note: Female clients counted are age 13 and above.

The overarching Ryan White HIV/AIDS Program performance measures look at performance of grantees across all programs/Parts and include the following performance measures relevant to the Part D program:

**Goal I: Improve Access to Quality Health Care and Services****Sub-Goal: Strengthen health systems to support the delivery of quality health services.****Annual Measure:**

- 1) Number of persons who learn their serostatus from Ryan White HIV/AIDS Program programs.

**Sub-Goal: Promote innovative and cost-efficient approaches to improve health.****Annual Measure:**

- 1) Percentage of Ryan White HIV/AIDS program-funded primary medical care providers that will have implemented a quality management program.

**Goal IV: Improve Health Equity****Sub-Goal: Reduce disparities in quality of care across populations and communities.****Annual Measure:**

- 1) Proportion of racial/ethnic minorities in Ryan White HIV/AIDS Program-funded programs served.
- 2) Proportion of women in Ryan White HIV/AIDS-funded programs served.
- 3) Proportion of new Ryan White HIV/AIDS program HIV-infected clients who are tested for CD4 count and viral load.

**Division of Community Based Programs (DCBP) Program Related Site Visits**

The purpose of a program related site visit is to assess the progress of each grantee and provide guidance and technical assistance to address areas of deficiency or areas in need of improvement. DCBP may conduct site visits to evaluate program compliance and implementation. The site visit provides an opportunity to assess program objectives, changes in the fiscal environment (such as addition or loss of other funds), and changes in clinical treatment for HIV.

**Improving Quality**

The National Quality Strategy (NQS), released in June 2011, defines three broad aims: 1) Better Care, 2) Healthy People/Healthy Communities, and 3) Affordable Care. In supporting actions to address the priorities, the intention of the National Strategy is “to create a new level of cooperation among all the stakeholders seeking to improve health and health care for all Americans” ([www.ahrq.gov/workingforquality/nqs/](http://www.ahrq.gov/workingforquality/nqs/)).

The PHS Act requires recipients of funding under the Ryan White HIV/AIDS Part D program to establish clinical quality management programs to:

- 1) Assess the extent to which HIV health services are consistent with the most recent HHS guidelines for the treatment of HIV disease and related opportunistic infections, and
- 2) Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

HAB has defined quality as follows:

“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 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.”

Your Clinical Quality Management (CQM) program should ensure that systematic and continuous processes are in place for planning, implementing, and evaluating improvement strategies. If other organizations provide primary care for your organization via subcontract, you are responsible for assuring that CQM systems are in place at those organizations. Your subcontracts must include provisions regarding monitoring and CQM, and you may require regular data sharing and reporting from your subcontractors on this issue. It is a program expectation of the Ryan White HIV/AIDS Program, that grant funding spent on clinical quality management will be kept to a reasonable level.

The three-fold purpose of CQM is to ensure:

- Funded services adhere to established HIV clinical practice standards and HHS guidelines.
- Strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access and adherence with HIV medical care.
- Available demographic, clinical, and health care utilization information is used when developing and adapting programs to address changing trends in the epidemic.

All Part D CQM programs must include quality goals and performance measures. HRSA/HAB encourages grantees to select HAB-developed performance measures that are most important to their agencies and the populations they serve. Coordination of care within and across health care systems is encouraged to ensure seamless care for the populations served. HRSA/HAB has developed HIV Performance Measures for use in monitoring the quality of care provided. Grantees are encouraged to identify areas for improvement and to include these in their quality management plans. The HAB HIV Performance Measures can be found at <http://hab.hrsa.gov/deliverhivaidscares/habperformmeasures.html>.

In addition to clinical outcomes, your CQM program also must have:

- Designated leaders and accountability.
- Routine data collection and analyses of data on measurable outcomes.
- A system for ensuring that data are fed back into your organization’s quality improvement process to assure goals is accomplished.
- Consistency, to the extent possible, with other programmatic quality improvement activities, such as The Joint Commission (TJC), Medicaid, and other HRSA funded programs.

HAB also encourages grantees to conduct continuous quality improvement (CQI) for the administrative and fiscal components of their organization.

For all subcontractors and vendors a mechanism must be in place to ensure care and services meet HHS guidelines (available at <http://www.aidsinfo.nih.gov/>), standards of care or best practices, as applicable, based on services funded.

Applicants may wish to expand their knowledge of CQM programs. The following sites can provide entry points:

**HRSA/HAB Quality Tools:** <http://hab.hrsa.gov/deliverhivaidscares/qualitycare.html>

**The National Quality Center:** <http://www.nationalqualitycenter.org>

**HIVQUAL-US Program:** <http://hivqualus.org>

## **II. Award Information**

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

Funding will be provided in the form of a grant.

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

This program will provide funding during Federal fiscal years 2012 - 2014. Approximately \$70,000,000 is expected to be available annually to fund approximately 200 grantees.

Applicants currently funded as Part D WICY grantees may request an amount up to \$500,000 per year or their FY 2011 base funding amount; whichever is greater; however, the amount requested must correlate to the number of HIV infected WICY clients who will be enrolled in and receiving medical and social services directly from the applicant organization and the costs of providing such care. Applicants who are not currently a Part D WICY grantee may apply for a ceiling amount of up to \$500,000 per year, so long as the budget is correlated to the number of HIV infected WICY clients who will be enrolled in and receiving medical and social services directly from the applicant organization and the cost of providing such care. Funding amounts will be based upon the levels of underserved WICY to be provided with proposed services (primary HIV medical care and core medical services).

This announcement is inviting applications for project periods up to three (3) years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be for up to three (3) years. Based upon the availability of appropriated funds for Part D during the first year, awardees may be given 11 months of funding beginning on August 1, 2012, which would be specified in the Notice of Award (NOA). Funding beyond the first year is dependent on the availability of appropriated funds for Part D in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal Government.

### **III. Eligibility Information**

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

Eligible organizations are public or nonprofit private entities (including a health facility operated by or pursuant to a contract with the Indian Health Service) that propose to provide primary medical care (directly or through contracts or memoranda of understanding) for women, infants, children, and youth living with HIV/AIDS. Organizations may include State and local governments, their agencies, and Indian Tribes or tribal organizations with or without Federal recognition. Community-based and faith-based organizations are also eligible to apply.

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

Cost Sharing/Matching is not required for this program.

#### **3. Other**

Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.2* will be considered non-responsive and will not be considered for funding under this announcement.

#### **HAB Expectations Post Award**

Clinical care, diagnostic services, periodic medical evaluations, and therapeutic measures to treat HIV/AIDS must be provided to patients within 90 days from award start date. The ability to provide primary medical care includes hiring clinical staff, providing HIV primary medical care, and having the capability to bill for services. When services are provided through contracts, grantees must be able to provide a copy of the contracts signed by both parties to HRSA within 60 days of award. These must document the total number of HIV positive patients to be served; the number of HIV positive pregnant and non-pregnant women, children, youth, and exposed infants to be served by the program; Medicaid eligibility of the medical providers; agreements that providers will comply with Part D legislative and program requirements, including data sharing, submission of Ryan White unduplicated data reports, and participation in CQM activities.

#### **Medicaid Provider Status and Clinic Licensure:**

All applicants, including proposed subcontractors, should document Medicaid provider status for all primary medical care providers and case management agencies. Applicants should also document for their primary medical care providers and case management agencies that they are fully licensed to provide clinical and case management services, as required by their State and/or local jurisdiction. If clinic licensure is not required in your jurisdiction, describe how that can be confirmed in State regulation or other information. This information is required each year.

You must also ensure that Medicaid billable services are billed to Medicaid. Ryan White HIV/AIDS Program funds are expected to be used as funding **payer of last resort**, i.e., after billing Medicaid, Children's Health Insurance Program (CHIP), other public/private health insurance resources, and after billing clients for allowable costs using a sliding fee scale. **Ryan**

**White HIV/AIDS Program funds cannot be used to supplement payments by Medicaid, Medicare, or other insurance programs.**

**Drug Discounts:**

If your program provides medications for patients, you may be able to get lower prices for your drugs through the 340B program of HRSA's Healthcare Systems Bureau. Detailed program information is available on-line at [www.hrsa.gov/opa/](http://www.hrsa.gov/opa/).

For more information, contact:

Office of Pharmacy Affairs  
5600 Fishers Lane,  
Parklawn Building, mail stop 10C-03  
Rockville, MD 20857  
1-800-628-6297

## **IV. Application and Submission Information**

### **1. Address to Request Application Package**

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

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

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

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

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

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

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

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

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

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

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

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

### **Application Format Requirements**

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

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

### **Application Format**

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

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

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

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

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

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

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Required — Program-specific Line Item Budget for Year One
Attachment 2	If Applicable — Current Negotiated Indirect Cost Rate Agreement
Attachment 3	Required — Staffing Plan for entire HIV program
Attachment 4	Required — Position Descriptions for Key Personnel
Attachment 5	Required — Signed, scanned Part D Agreements and Assurances
Attachment 6	Required --- Proof of Non-profit status (e.g. 501 ( c)(3) certificate)
Attachment 7	Required — Documentation of Medicaid provider status and clinic licensure status, if applicable
Attachment 8	Required — Map of Service Area with proposed Part D provider(s) and other HIV service providers marked
Attachment 9	Optional — Letter or Memoranda of Agreement from regional AIDS Education & Training Center (AETC)
Attachment 10	Required — List of all Provider Organizations which have signed contracts and/or Memoranda of Agreement with a brief description of the covered activities, if applicable
Attachment 11	Required — Work Plan Summary (for entire 3 year project period)
Attachment 12	Required — Organizational Chart
Attachment 13-15	Optional Attachments submitted by the applicant

## **Application Format**

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

Complete Application Form SF-424 provided with the application package. Prepare according to instructions provided in the form itself. Important note: enter the name of the **Project Director** in 8. f. "Name and contact information of person to be contacted on matters involving this application." If, for any reason, the Project Director will be out of the office, please ensure their email Out of Office Assistant is set so HRSA will be aware if any issues arise with the application and a timely response is required. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.153.

### **Item 2 Type of Application**

Please check "New."

### **Item 4 Applicant Identifier**

Enter Not Applicable.

### **Item 5a Federal Entity Identifier**

Enter Not Applicable.

### **Item 5b Federal Award Identifier**

Please leave this item blank. **Do not include any grant numbers.**

### **DUNS Number**

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

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

### **Item 14 Areas Affected by Project**

List the specific areas to be served by this project.

### **Item 15 Descriptive Title of Applicant's Project**

Fill in the required title and attach the Project Abstract.

### **Item 17 Proposed Project**

The start date should be August 1, 2012. The end date should be **June 30, 2015**.

### **Item 19 Application Subject to Review By State Under Executive Order 12372 Process**

This program is subject to intergovernmental review. Some states require that you submit a copy of your Federal grant applications to a Single Point of Contact (SPOC) at the state government level. If your state participates in the SPOC review process, enter the date you sent the copy of your Ryan White HIV/AIDS Program grant application to the SPOC office. A list of states and territories that currently participate in the SPOC review process can be downloaded from the internet at: [http://www.whitehouse.gov/omb/grants\\_spoc](http://www.whitehouse.gov/omb/grants_spoc).

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

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

#### **iii. Budget**

Complete Application Form SF-424A Budget Information – Non-Construction Programs provided with the application package.

Please complete Sections A, B, E, and F, and then provide a line item budget for each year of the project period. In Section A, use rows 1-3 to provide the budget amounts for the three years of the project. Please enter the amounts in the “New or Revised Budget” column- not the “Estimated Unobligated Funds” column. In Section B Object Class Categories of the SF-424A, provide the object class category breakdown for the annual amounts specified in Section A. In Section B, use column (1) to provide category amounts for Year 1 and use columns (2) through (3) for subsequent budget years.

***Program-specific line item budgets:*** In order to evaluate applicant adherence to Part D WICY legislative budget requirements, applicants must submit a separate program-specific line item budget for **Year 1 of the proposed project period** and upload it as an attachment to your application as **Attachment 1**. In subsequent years, the program specific line budget will be submitted in the annual non-competing progress report. It is recommended that you present your line item budget in table format, listing the program category costs (Medical Services, Clinical Quality Management, Support Services, and Administration Costs) across the top and object class categories (Personnel, Fringe Benefits, etc) in a column down the left hand side. Under Personnel, please list each position by **position title** and name, with annual salary, percent of Full Time Equivalency (FTE), and salary charged to the grant. Equipment, supplies and contractual should each have individual items listed separately. The amount requested on the SF424A and the amount listed on the line-item budget must match. The budget must relate to the activities proposed in the Project Narrative and the Work Plan and must reflect the primary medical care services to be provided with Part D funding.

Your program specific line item budget should reflect allocations for a 12 month period. You must **provide a consolidated budget that reflects all costs for proposed activities, including those for contractors**. The program specific line-item budget should list costs separately for each line item category.

**Contracts-You must also provide an itemized budget and a narrative justification for each subcontract.** Separate program budgets must be established with all subcontractors and care must be taken to ensure there is no duplication of effort. **Provide a separate line-item budget for each subcontractor using the same format as that of the consolidated line-item budget for the grantee of record.** The line-item budget for each subcontractor should list costs separately for each line item, utilizing the same object class categories (Personnel, Fringe Benefits, etc.) as those for the consolidated budget in a column down the left hand side. Administrative costs of subcontractors should be itemized in the line-item budget and budget justification narrative, and should be limited to 10% of the contracted amount. Note that the total of all administrative costs for the grantee and its contractors are subject to the 10% limitation on administrative costs of the total Part D award. The total amount listed in each subcontractor budget should match the total amount listed for that agency on the grantee of record consolidated line-item budget.

The Part D budget is composed of the following: (1) Standard Form 424A for Non-Construction Programs, provided with the application package; (2) the program-specific Line-Item Budget; (3) the Budget Justification; and (4) the Staffing Plan. The program-specific line item budget and justification should include only the request for federal Part D funds. Please refer to item *vi* for instructions on creating the Staffing Plan.

### **Allowable Costs**

Part D funds are for the purpose of providing outpatient/ ambulatory medical care and services which assist in the optimization of health outcomes for women, infants, children, and youth (WICY) living with HIV/AIDS. HAB expects Part D programs to be designed to meet the HIV medical needs of WICY populations first. Funding may also be used for relevant Core Medical Services and Support Services which support and optimize the delivery of HIV medical care, when allocated in a proportional manner to the number of WICY clients who will receive medical care. Limited support services, such as transportation, childcare, support groups, and translation services, may be offered to affected family members when those services are for the benefit of, and being utilized by, the HIV positive person at the same time. The Part D Program divides the allowable costs among four Part D Cost Categories. These categories are **Medical Service Costs, Clinical Quality Management Costs, Support Service Costs, and Administrative Costs.**

**Medical Service Costs** are those costs associated with providing primary medical care and related core medical services for HIV-infected women, infants, children, and youth. Medical Service costs may include:

- ◆ Salaried personnel, contracted personnel or visit fees associated with the provision of primary medical care, specialty and subspecialty care, referrals for health and support services, and adherence monitoring/education services provided by licensed or certified health professionals. Types of providers typically included are Obstetrics/Gynecology physicians, mid-level practitioners, nurses, pharmacists, dentist, dental hygienists, medical assistants, nutritionists, behavioral health/substance abuse service professionals, referral coordinators, and specialists/ sub-specialists.
- ◆ Lab, x-ray, and other diagnostic tests related to HIV and co-morbid conditions
- ◆ Pharmaceutical assistance for HIV-related medications, vaccines
- ◆ Oral health care services
- ◆ Mental health services

- ◆ Substance abuse outpatient care
- ◆ Medical nutrition therapy
- ◆ Reimbursement for transportation costs for clinical staff traveling to medical service sites

**Clinical Quality Management Costs** are those costs required to maintain a clinical quality management (CQM) program to ensure that medical services are consistent with the most recent HHS guidelines for the treatment of HIV/AIDS and related opportunistic infections; and that improvements in the access to and quality of HIV health services are addressed.

**The Ryan White HIV/AIDS Program has established the program expectation that clinical quality management expenses must be kept to a reasonable level.** CQM costs may include:

- ◆ Continuous Quality Improvement (CQI) activities
- ◆ Clinical quality management coordination
- ◆ Data collection for clinical quality management purposes (collect, aggregate, analyze, and report on measurement data)
- ◆ Consumer Involvement to improve services
- ◆ Staff training/technical assistance (including travel and registration) to improve services – this includes the Annual Clinical Update, the every other year All Grantee Meeting, and annual Ryan White Services Report (RSR) training update
- ◆ Participation in the Part B Statewide Coordinated Statement of Need (SCSN) process and local planning bodies and other local meetings
- ◆ Electronic Medical Records: Data analysis for CQM, software and hardware upgrades (such as “bridges,” links, imports) necessary to facilitate CQM activities

**Support Service Costs** are those costs for services which are needed for individuals with HIV/AIDS to achieve their HIV medical outcomes. Support Service costs may include:

- ◆ Case management, including medical, non-medical, and family-centered
- ◆ Transportation to medical appointments
- ◆ Translation services, including interpretation services for deaf persons
- ◆ Services that assist women in accessing and remaining in HIV medical care, such as child care during medical appointments,
- ◆ Patient education and educational materials, in conjunction with and proportional to the funded medical care
- ◆ Outreach to recruit and retain women, infants, children, and youth with HIV, which is proportionate to unmet need and the HIV epidemiologic data, and is not already supported by CDC or other Ryan White funds for the proposed service area
- ◆ Financial assessment/eligibility counselors (staff whose role is to determine client eligibility for Medicaid and other insurance programs and assist them to apply)
- ◆ Staff who assist clients with linkage, engagement, and retention in HIV care.

**Administrative Costs** are **those costs not associated with service provision directly to clients.** By law, no more than 10 percent of the federal Part D budget can be allocated to administrative costs. Staff activities that are administrative in nature should be allocated to administrative costs. Additionally, the administrative and indirect costs for sub-contractors under the Part D grants do not lose their administrative nature by being part of a contract, and

are **included in the limitation of administrative costs**. Examples of Administrative activities subject to the 10 percent cap include:

- ◆ Routine grant administration and monitoring activities, including the receipt and disbursement of program funds; accounting and billing functions; preparation of routine programmatic and financial reports; and compliance with grant conditions and audit requirements.
- ◆ Personnel costs and fringe benefits of staff members responsible for the management of the project (such as the Project Director and program coordinator), non-CQI program evaluation, non-CQI data collection/reporting, supervision, and other administrative, fiscal, or clerical duties (including clinic receptionist)
- ◆ Contracts for services awarded as part of the grant – such as development of RFPs, review of proposals, and monitoring contracts through onsite visits
- ◆ Electronic Medical Records: Maintenance, Licensure, Annual Updates, Data Entry
- ◆ Facility support costs, including medical waste removal and linen services
- ◆ Costs which could qualify as either indirect or direct costs but are charged as direct costs, such as: rent, occupancy, utilities, telecommunications (telephones, toll-free lines, cell phones, pagers, fax, internet), and postage
- ◆ Liability insurance
- ◆ Office supplies
- ◆ Audits
- ◆ Payroll-Accounting services
- ◆ Computer hardware and software (unrelated to CQM)
- ◆ Program evaluation, including data collection for evaluation

Applicants should review the HAB Policy Notice 10-02 for allowable uses of Ryan White funds (<http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html>) and the HAB Policy Notice 11-02 for guidance on contracting with for-profit entities (<http://hab.hrsa.gov/manageyourgrant/pinspals/habpl1102.pdf>).

**Salary Limitation:**

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

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

Individual’s <i>actual</i> base full time salary: \$350,000	
50% of time will be devoted to project	
Direct salary	\$175,000
Fringe (25% of salary)	\$43,750

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

**iv. Budget Justification**

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant **must** submit one-year budgets for each of the subsequent budget periods within the requested project period (total 3 years) at the time of application. Line item information must be provided to explain the costs entered in the SF-424A. Be very careful about showing how each item in the “other” category is justified. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period. The budget justification **MUST** be concise. Do NOT use the justification to expand the project narrative.

**Budget for Multi-Year Award**

This announcement is inviting applications for project periods up to three (3) years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be for up to three (3) years. Submission and HRSA approval of your Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the three-year project period is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government. Successful applicants will be required to submit a program specific line item budget and budget justification narrative with the annual Progress Report.

Include the following in the Budget Justification narrative:

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

Sample:

Name	Position Title	% of FTE	Annual Salary	Amount Requested
J. Smith	Chief Executive Officer	50	\$179,700*	\$89,850
R. Doe	Nurse Practitioner	100	\$75,950	\$75,950

D. Jones	Data/AP Specialist	25	\$33,000	\$8,250
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\*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. Grantees are expected to include in their budgets travel expenses **for up to two persons to attend the Ryan White HIV/AIDS Program All-Grantee Meeting every other year, one clinician to attend the Annual HIV Clinical Update Meeting, and one staff member who is involved in data reporting to attend the annual Ryan White Services Report (RSR) training update.** In the year that the All-Grantee Meeting is not held, another HRSA meeting or continuing education conference may be substituted. The RSR training is usually offered at two sites, one in the east and one in the west, in the fall. In November 2012, the All-Grantee Meeting will be held in Washington, D.C.

Transportation costs for clinical staff traveling to provide care are included in Medical Services, and for patients to attend medical appointments in Support Services. Travel for conferences and training is included in CQM. All other travel should be listed under Administrative expenses.

*Equipment:* List equipment costs and provide justification for the need of the equipment to carry out the program’s goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of \$5,000 or more and a useful life of one or more years).

*Supplies:* List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. Remember, they must be listed separately.

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

Contractors providing services under this grant must adhere to the same requirements as the grantee. All legislative and program requirements that apply to grantees also apply to subrecipients of their awards. The grantee is accountable for the subrecipient’s performance

of the project, program, or activity, the appropriate expenditure of funds under the award; and the other obligations of the Part D award. Grantees are required to annually monitor all subcontractors. Subcontractors must also report and validate program expenditures in accordance with budget categories to determine legislative mandates are met.

*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. Please note that “employee lease agreements” and other agreements which support staff of another organization to work on the grant are contractual. They cannot be included in the Other category.

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

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

*Do not use this application as a means to apply for an indirect rate cost agreement.*

Indirect costs are awarded only to organizations that have a federally-negotiated indirect cost rate agreement that covers the activities to be funded. If your program has an approved indirect cost rate and you have included indirect costs in your budget, you must include a copy of the latest negotiated cost agreement that covers the period for which funds are requested must be submitted as an attachment to the application (**Attachment 2**).

**Indirect costs must be no more than the federally approved indirect cost agreement, and is for the grantee of record (not for any subcontractors). Applicants wishing to claim indirect costs must limit the amount to no more than 10% of the total annual award amount, including all administrative expenses.**

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

*This section counts toward the page limit and is scored in Criterion 5: Resources/Capabilities and Criterion 6: Support Requested.*

Applicants **must submit a staffing plan** as **Attachment 3**. The applicant should provide a justification for the plan that includes education and experience qualifications and a rationale for the amount of time being requested for each staff position. The staffing plan should include elements of biographical sketches and job descriptions, such as education, training, HIV experience and expertise, language fluency, and experience working with the cultural and

linguistically diverse WICY populations that will be served by the proposed HIV program. The staffing plan should describe all positions to be funded by Part D, as well as key staff whether or not paid by the Part D grant. Key staff includes, at a minimum, the program coordinator, the medical director, the person who will lead the clinical quality management activities for your program, and **all** medical care providers. The program coordinator is expected to have fiscal and programmatic authority for the oversight and day to day management of the Part D program and to be the contact person for Part D staff, and the medical director assumes responsibility for all clinical aspects of the grant. Specifically identify staff that manage the grant and monitor contractors' use of funds, provision of services, quality and data submission, whether or not they are paid under this grant. Note all sources of funding for every person listed on the Staffing Plan. You may find it helpful to supply this information in a table. **Separate biographical sketches will not be required.**

Position descriptions that include the roles, responsibilities, and qualifications of proposed Part D funded and key project staff (including those located within subcontract agencies) must be included in **Attachment 4**. Try to limit each position description to one page length.

**vi. Assurances**

Complete Application Form SF-424B Assurances – Non-Construction Programs provided with the application package. Review the Part D Agreement and Assurances located in **Appendix A**. This document must be signed by the Authorized Organization Representative (AOR), scanned, and attached to the application as **Attachment 5**. Provide proof of your organization's non-profit status (such as 501(c)(3) status as determined by the Internal Revenue Service) as **Attachment 6**.

**vii. Certifications**

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

**Medicaid Provider Status and Clinic Licensure:**

In **Attachment 7**, provide a table documenting Medicaid provider numbers and clinic licensure (where applicable) for all primary medical care providers who are involved with the Part D project and for case management agencies. Applicants should also demonstrate that these providers and agencies are fully licensed to provide clinical and case management services, as required by their state and/or local jurisdiction. If clinic licensure is not required in your jurisdiction, describe how that can be confirmed in State regulation or other information. This information is required each year.

**viii. Project Abstract**

Provide a summary of the application and attach it to item 15 of the SF-424. Since 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 applicant's organizational model of care, the funding amount requested, the population group(s) to be served, the needs to be addressed, and the proposed services.

- Please place the following at the top of the abstract:
- Project Title (FY 2012 Part D WICY Competing)

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

In the abstract, describe the following four major areas:

**1) Summary of Request:** A short statement briefly describing the applicant organization (including how long it has been in the community and how long it has served PLWHs), model of care proposed, the services to be provided, the specific service sites and geographic areas for this project, and the amount of funding requested. (Define the service area in detail—zip codes, county) also statement later in Narrative.

**2) Target Population(s):** A brief description of the target WICY populations to be served by the proposed project, including key socio-economic demographic characteristics and the percentage of racial/ethnic minority populations. Discuss how many women, youth, and children living with HIV/AIDS that you expect to serve by the end of the first year of this project period. Describe the demographics and key qualifications of your staff that relate to the proposed Part D-funded HIV services.

**3) Problems/ Challenges:** A summary of the unmet need of, gaps in service, and barriers to care for women, youth, children, and infants living with HIV in your service area that will be addressed if the proposed project is funded. Discuss any challenges you face in order to implement the proposed project and how you propose to deal with some of these challenges.

**4) Objectives:** List the major objectives for the project period as described in your Work Plan Summary.

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

#### **ix. Project Narrative**

This section provides a comprehensive framework and description of all aspects of the proposed program. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project. Please follow the instructions here closely. Remember that a group of outside reviewers will rate your proposal. Their rating guide is the Review Criteria. This rating guide is based on the required sections of the narrative.

Use the following headers for the seven (7) sections of the Program Narrative:

- 1) Introduction
- 2) Needs Assessment
- 3) Methodology
- 4) Work Plan
- 5) Resolution of Challenges
- 6) Evaluation and Technical Support Capacity
- 7) Organizational Information

▪ **INTRODUCTION**

This section should describe briefly the purpose of the proposed project. Describe the service area in which you propose to provide HIV services for the target populations. You should discuss why your agency and service area are in need of Part D funds and why you are the appropriate entity to receive funds.

▪ **NEEDS ASSESSMENT**

*This section is scored under Criterion 1: Need.*

This section outlines the needs of your community, will provide information on the impact of HIV/AIDS in your community, and should help reviewers understand the community that will be served by the proposed project.

There are four (4) components in this section:

- 1) **HIV Seroprevalence and Surrogate Markers**
- 2) **Social Context of HIV/AIDS**
- 3) **Target Populations**
- 4) **Local HIV Service Delivery System**

1) **HIV Seroprevalence and Surrogate Markers**

Use this section to provide and discuss data on the incidence and prevalence of HIV and AIDS that demonstrates the increasing burden of HIV in the proposed service area. Information needs to be requested on AIDS incidence, AIDS prevalence, HIV prevalence, and unmet need from your state grantee of record for Ryan White (RW) Part B, and from your Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA) grantee of record for RW Part A, if applicable. Remember to identify clearly the source(s) of the data that you present (state Department of Health, Centers for Disease Control and Prevention, etc).

Provide a table which clearly shows the impact of the HIV epidemic in the proposed service area. For **each** of the most recent three years, show the following information for women, infants, children and youth (WICY) in the proposed service area. Most programs will report on **2008, 2009, and 2010**. If you must include a different time period, explain why. For each of the following items provide the **total number of WICY and numbers for each target population separately**, i.e., females 25 years or older, infants less than 2 years, children between 2 and 12 years, and youth 13 to 24 years:

- the number newly reported with HIV-non-AIDS (incidence)
- the number living with HIV-non-AIDS (prevalence)
- the number newly reported with AIDS
- the number living with AIDS
- the number testing positive and overall seroprevalence for HIV testing
- You may also include the WICY-specific rates of diseases such as syphilis, gonorrhea, tuberculosis, Hepatitis C, and substance abuse that indicate a prevalence of high risk behaviors associated with HIV transmission (i.e. surrogate markers)
- Be very thorough and show all the important variables, i.e., age, gender, and exposure (perinatal versus behavioral transmission for youth)

In the narrative, discuss the HIV epidemiology in the proposed service area as compared to state or EMA/TGA data. Discuss the similarities, differences, and trends noted in such areas as race, ethnicity, gender, and exposure category. Highlight any new groups that show a rapid growth in HIV or AIDS cases. Discuss whether Ryan White Part A or B estimates of people who unaware of their HIV status or the unmet need of people who know they are HIV positive but are not in care, apply to the proposed service area. What is the estimated rate of increase or decrease in the number of reported HIV or AIDS cases for this period? In this section, give baseline numbers if you use percentages, e.g., this population grew 50 percent, from 100 to 150 people.

You may use other measures that show the impact of HIV/AIDS on your community. You should show how your area compares to other communities.

## **2) Social Context of HIV/AIDS**

Describe the racial, ethnic, social and economic characteristics of the people you propose to serve. Discuss how these conditions have an impact on the provision of HIV services in your geographical area. Provide the following information:

- The percentage of the racial/ethnic minority populations
- The percentage of the target populations that are adolescent (ages 13 to 24)
- The percentage of the target populations that are homeless
- The percentage of the target populations that are uninsured
- The percentage of the target populations using illegal drugs and/or alcohol
- The percentage of the target populations who are unemployed
- The percentage of the target populations whose primary language is not English
- The percentage of the target populations who live below 100% of the Federal Poverty Level

The statistics that you include must be specific to the proposed service area. You may also include a description of other relevant characteristics of the target populations that affect their access to primary care. These factors may include citizenship status, education (e.g., high school graduation rate), and access to transportation. Compare the rates of the target populations in the proposed service area to those of the general population in your community or geographic region (providing this information in a table is encouraged).

## **3) Target Populations**

All Part D programs are expected to provide medical services for four groups of people. The target populations are HIV infected women (females 25 years and older), HIV infected and exposed infants, HIV infected children, and HIV infected youth (WICY). Provide a table with annual statistics and characteristics of the target populations who have received medical care through your organization from 2008 and 2010. Clearly identify the date and source of the provided data and whether this data is for HIV specific or general medical services. For HIV specific population data, also provide the mode of HIV transmission (e.g., heterosexual, male to male sex, injection drug use, perinatal, etc.). In the table, include the following information as the left hand column and each year between 2008 and 2010 across the top:

- The total number of patients,
- The number of new patients,
- The total number of clients with AIDS and with HIV non-AIDS
- The total number of clients by race/ethnicity,
- The total number of clients by age ranges (0-12, 13-24, 25-64, and 65 years and older),
- The total number of clients by gender,
- The total number of clients by HIV exposure category,
- For HIV positive youth ages 13-24, list the numbers perinatally and behaviorally infected,
- The number of pregnant women overall,
- The number of adolescent (24 years and younger) pregnant females, and
- The total number of clients by insurance status for primary care services.

In the narrative, compare the WICY populations you propose to serve to the general population in your area. Identify trends that have occurred during the three year period as your organization has confronted increases or decreases among specific groups (e.g., a 10 percent increase from 200 to 220 in the number of women seeking services). If your project does not plan to serve ALL of these groups, you must explain why this is appropriate. If one group is currently well served by other medical providers, you must identify the organizations which serve that group and describe how your program will work with these organizations to coordinate comprehensive HIV medical services.

#### **4) Local HIV Service Delivery System**

##### *Description of Service System*

You must thoroughly describe the HIV care and prevention services and their funding sources available to WICY populations in the proposed service area and demonstrate how the proposed Part D activities will not duplicate other funded services.

Provide a table which includes all federal, state, and local funding sources for HIV prevention and medical care available in the proposed service area. List the providers/organizations in the first column on the left, then in separate columns to the right, the source of funding, total (HIV) funding amount along with funding amount for WICY populations, HIV or medical services provided, and, if possible, the number of unduplicated clients/patients (total and WICY) each one serves annually. This should include the following information:

- Identify all federal, state, and local funding sources including providers funded by Maternal and Child Health Block Grants (Title V of Social Security), the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH) [clinical research trials], Substance Abuse and Mental Health Services Administration (SAMHSA).
- Identify all Ryan White funded providers under Parts A, B, C, Dental Reimbursement, Community Based Dental Partnerships, and Special Projects of National Significance (SPNS). (Do not include current Part D information)
- Identify providers of primary medical services to the target populations in the proposed service area. Indicate if they receive Ryan White (RW) HIV/AIDS program or other federal funding (such as a Federally Qualified Health Center or FQHC).

You may be able to find specific information through the HHS web site Tracking Accountability in Government Grants System, <http://taggs.hhs.gov/> and the HAB Web site at <http://hab.hrsa.gov/>, and the Part A or B grantee in your area.

- If your organization currently receives Ryan White funding, describe in the narrative the funding source by RW Part (A, B, C, and F), the FY 2011 funding amount, the specific HIV services provided and funding amount for each, the total number of unduplicated persons served, the number of persons receiving outpatient ambulatory medical care (OAMC), the total number of WICY served, and the number of WICY receiving OAMC. You may find it helpful to present this information in a table format. Discuss whether the funding supports FTE salaries or visits under a fee-for-service arrangement. Describe how you will ensure that proposed Part D services will not duplicate other RW supported services.
- Describe in detail the proposed service area in which your organization will provide HIV services. Be as specific about the geographic boundaries as possible since you will be ensuring that a comprehensive, coordinated system of medical and support services is accessible to all Ryan White eligible WICY patients living with HIV in that area. Attach an area map as **Attachment 8** that shows the proposed service area.
- Describe the current **unmet health** needs, gaps in HIV primary medical care services, and the barriers to accessing care for the targeted WICY populations within the proposed service area.
- Discuss the number and characteristics of persons who know they are HIV-infected but who are not receiving HIV primary medical care. Wherever possible be specific about information on women and youth living with HIV.
- Discuss what HIV primary medical and related health care services are not available to the WICY populations.
- Provide a brief description of the impact the gaps in services have on your clients.
- If cultural/linguistic or gender gaps in services exist in your community, describe how you plan to address these gaps.
- Discuss significant barriers that impact access to care for your target populations, such as distance, culture, eligibility requirements. Describe changes in the health care delivery system that affect your delivery of HIV primary care services, e.g., managed care, Medicaid, state Children's Health Insurance Program (CHIP), insurance exchanges for low income populations, a waiting list for your state's AIDS Drug Assistance Program (ADAP), State and local funding. Provide details of health care services that are not covered or have been reduced in these programs. If your state has implemented, is implementing, or is planning to implement a Section 1115 Medicaid waiver program or other Medicaid expansion program, describe the impact of this on the proposed WICY populations and the need for Part D funding.

More information about measuring unmet need may be found at <http://hab.hrsa.gov/manageyourgrant/severityofneed/index.html> .

#### ▪ **METHODOLOGY**

*This section is scored under Review Criterion 2: Response.* Use this section to describe the methods which your organization proposes to use for each of the areas below to meet the Part D program requirements and expectations (see Background section). The minimal information you should provide in each of the sections is described below. Describe the primary care and

supportive services your organization will provide. You may provide additional information that will help reviewers understand how your services are delivered and the policies and procedures that ensure that your program maintains professional standards of care. Services must be consistent with Policy Notice 10-02 which is available at: <http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html>. Be sure to delineate which of the proposed services will be funded under Part D and how they are not duplicative of other funded HIV services.

### **Linkage to Care**

- Describe how your organization makes HIV counseling and testing available for all women and youth. Describe efforts for women who are pregnant separately. If funding under Part D is proposed, discuss how these activities will not duplicate other funded efforts (RW, CDC, or state supported) and are directed toward WICY populations at high risk for HIV infection.
- Describe current or proposed targeted and/or unique efforts to ensure that women are tested for HIV.
- Describe current or proposed targeted and/or unique efforts for testing high risk adolescents for HIV.
- Discuss how your program will link or provide primary medical care services to all WICY who test positive for HIV and how your program will monitor the rates of successful linkage to care.
- Parts A and B of the Ryan White Program have an increased emphasis on the Early Identification of Individuals with HIV/AIDS (EIIHA), which is defined as *identifying, counseling, testing, informing, and referring of **diagnosed and undiagnosed** individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to care.* Describe how you will collaborate with Part A and/or Part B programs to enroll clients identified in this effort and retain them in care.

### **Comprehensive, Coordinated Systems of Care**

HAB has re-focused the Part D program to maximize the allocation of resources to expand the access of WICY populations to HIV medical care in response to the goals of the NHAS. Applicants with experience in the provision of medical services should describe fully their capacity to deliver comprehensive health care services for each and every targeted WICY population using Part D funds without duplication of effort.

#### **1) Medical Evaluation and Clinical Care**

- Describe the proposed HIV diagnostic and therapeutic services that will be funded under this award for treating and preventing HIV infection and related conditions. Include a description of your protocols to provide care to new patients (especially women and youth) and ongoing patients. Include the frequency of medical evaluations, the provision of medications for HIV infection and opportunistic infections (prophylaxis and treatment), and the availability of adherence counseling on site.
- Describe plans for educating about, making referrals to, and enrollment in HIV clinical research trials.
- Describe the availability of laboratory services to perform CD4, viral load, and other HIV diagnostic tests. Discuss how your organization will address any financial barriers to the accessibility of these services for the proposed target populations.

- Discuss the availability of your State(s) AIDS Drug Assistance Program or other locally available pharmacy assistance programs. If there is an ADAP waiting list in your geographic area, discuss how your organization will ensure that all eligible patients will have access to HIV and HIV-related therapeutic medications, applicable vaccines, etc.
- Describe plans for staff training related to quality HIV primary care which adheres to current DHHS guidelines (<http://www.aidsinfo.nih.gov/>). Describe how training through your area's AIDS Education and Training Centers (AETC) will be made available to increase and maintain the staff's knowledge and proficiency to increase your organization's capacity to provide HIV primary care. Information about the AETC can be found at <http://hab.hrsa.gov/abouthab/parteducation.html>. You may upload a letter or memorandum of agreement from the regional AETC describing the training activities that will be provided to your organization if you are awarded Part D funds as **Attachment 9**.
- Describe the policy/procedure for after-hours and weekend coverage for urgent or emergency medical and dental care needs. Describe how coordination with admission/emergency room staff and discharge planners will occur during inpatient hospital visits to ensure referring to and retaining patients in outpatient medical care after discharge.
- Describe how referrals to specialty and subspecialty medical care and other health and social services will be provided and tracked for completion and results.

## 2) Women's Health

- Describe how your program will provide prenatal care for infected women.
- Describe how your program will teach women about drugs that can reduce the chance of HIV transmission, make sure drugs are offered, and address adherence to treatment issues.
- Discuss the services that you will provide to address the health care needs for women of child-bearing age, including family planning, chronic disease self-management, and domestic violence awareness.
- Describe the services to be provided by your program that address the health needs of peri-menopausal and menopausal women with HIV infection.
- For women who are pregnant, tell us how you will coordinate obstetric and primary HIV medical care and how you propose to continue primary medical care after delivery. Tell us how you will provide or link pediatric care to their exposed, infected, and affected children to pediatric care.
- Describe other services that you propose to provide to retain women in HIV primary care.

## 3) Adolescent Health

- Describe the HIV infected youth that you propose to serve by mode of transmission (perinatal or behavioral), age, race, and gender.
- Describe specific health care services for HIV infected youth that you propose to fund under Part D.
- Discuss how you will retain youth in care, especially any targeted or unique services.
- Discuss how your program will educate youth on basic HIV information, including therapy, treatment adherence, transmission, prevention methods, as well as sexuality, family planning, and chronic disease self-management.
- Describe your transition program to assist youth in moving into adult medical care and identify the number of youth who will be utilizing those services annually.

- 4) **Other Medical Services**- describe how the following services will be provided to your WICY populations living with HIV if listed in the proposed Part D budget.
- Oral health care (diagnostic, preventive, and therapeutic services)
  - Adherence education/counseling by a licensed clinician
  - Outpatient mental health screening, assessment, and treatment services
  - Substance abuse screening, assessment, and treatment services
  - Nutritional services
  - Describe how you will incorporate HIV prevention into medical care for persons living with HIV, including screening patients for behavioral risk, offering behavioral interventions, and providing partner counseling and referral services.
- 5) **Support Services**
- Describe how your clients will have access to support services to achieve their HIV medical outcomes, including case management services, translation, medical transportation, and any other services provided in your budget. If you are budgeting for Support Services, explain how each of the funded services will be provided and how each is linked to improving or maximizing the health outcomes of your WICY populations.
  - Describe how your program will assist clients in receiving financial support and services under Federal, State, or local programs providing health services, mental health services, social services or other appropriate services.

### **Consumer Involvement**

- Describe how consumers are or will be involved in decisions regarding their personal health care regimens.
- Describe what you propose to do to involve consumers in planning, implementing, and evaluating your program. Describe the methods you will use to keep them informed and provide feedback on their suggestions. HAB will provide resources for successful applicants to enhance consumer involvement.

### **Coordination**

- Discuss how your proposed Part D program will address the unmet need, gaps in services, and barriers to care identified in your service area.
- Describe how your organization will collaborate and coordinate activities with other HIV service providers in order to share resources, provide comprehensive services to the WICY populations, and ensure against duplication of services. Successful Part D applicants will be expected to participate in the Part B Statewide Comprehensive Statement of Need (SCSN) and other local needs assessment processes.
- Describe how the requested Part D funds will lead to the improvement of overall patient outcomes for your WICY target populations in relation to the needs identified through the local and State processes.
- Describe the organizations with whom you will collaborate to provide comprehensive services for the WICY populations and list them in **Attachment 10**.

#### ▪ *WORK PLAN*

The Work Plan is scored under Review Criterion 2: Response and Review Criterion 4: Impact. Provide a **Work Plan Summary (Attachment 11)** in a table format which focuses on measurable objectives for required areas for the entire project period (three years). Measurable objectives will be set for each area and should be listed down the left side of the table. Each year

of the proposed project period should be labeled across the top, one year for each column to the right of the objectives. You may wish to develop a more detailed work plan which includes action steps, evaluation methods, and persons responsible for internal use.

### **Work Plan Objectives:**

The Work Plan should cover four major areas, as well as any additional measurable objectives which are important in implementing your HIV Part D WICY Program. CDC Prevention activities and generic outreach activities should not be included. Please note that most objectives should refer to the number of unduplicated clients who will be receiving the service **specifically funded under the Part D WICY award**, rather than paid for by other funding sources, such as third party payers or other Ryan White HIV/AIDS Parts. If you have contractors providing these services, combined numbers for all providers should be included. Services provided by other funding sources should not be included in your work plan; address them in the relevant part of the Methodology section.

The four major areas are:

1) Access To Care

For **each year** of the proposed project period, list:

- a) The number of people to receive HIV counseling and testing **under this grant funding**
- b) The anticipated number of HIV positive tests;
- c) The number of **new HIV infected** patients to be enrolled for primary medical care

2) Comprehensive, Coordinated Primary HIV Medical Care

For **each year** of the proposed project period and **using Part D funding**, list:

- a) The total number of women, youth, and children with HIV to be provided primary medical care services
- b) The number of women (25 years and older) to be provided HIV primary medical care
- c) The number of youth (13-24) to be provided HIV primary medical care
- d) The number of HIV-infected infants and children to be provided HIV primary medical care
- e) The number of HIV indeterminate infants (0-2 years) to be followed under surveillance
- f) The number of pregnant women with HIV to be provided prenatal services
- g) The number of youth with HIV who will be transitioned into adult medical care
- h) The number of patients (specify which target populations) to be provided with treatment adherence services provided by a qualified clinician
- i) The number and type of specialty referrals

Please list the following if your program proposes to provide core medical services or support services **with Part D funds** to WICY living with HIV. Specify the number of each target population to be served each year of the proposed project period.

- a) The number of patients to be provided mental health screening, assessment, and/or treatment
- b) The number of patients to be provided with substance abuse screening and/or treatment
- c) The number of patients to be provided with oral health care
- d) The number of patients to be provided with medical nutrition screening
- e) The number of patients to be provided with medical nutrition therapy by a registered dietitian or licensed nutritionist

- f) The number of patients for each of the support services you are providing to help individuals meet their HIV medical outcomes (such as case management, medical transportation, translation services)

### 3) Clinical Quality Management Program

For **each year** of the proposed project period, list:

- a) Each HAB HIV Performance Measure that will be included in an active clinical quality improvement effort. Most programs actively work on two or three at a time. For each year of the grant, include the number or percent which describes the anticipated improvement. As an example, the percentage of persons on antiretroviral therapy with undetectable viral loads would show year one 50%, year two 55%, and year three 60% or the percentage of eligible women receiving PAP tests would show year one 40%, year two 45%, and year three 50%. Applicants planning to participate in the Part D Retention in Care Quality Collaborative should list performance measures which will be used in the project, i.e. viral load suppression, frequency of medical visits, gaps in care, and medical visits for newly enrolled clients (see Clinical Quality Management section).

### 4) Consumer Involvement

For **each year** of the proposed project period, list:

- a) The number of unduplicated consumers to be involved in planning, implementation, and evaluation of your program activities
- b) The number of consumer meetings

#### ▪ *RESOLUTION OF CHALLENGES*

*This section is scored in Criterion 2: Response.* Discuss challenges that are likely to be encountered in designing and implementing the Part D funded activities described in the Work Plan, and approaches that will be used to resolve such challenges. Also discuss any challenges your organization will have in the provision of HIV services to the targeted populations (women, infants, children, and youth) and how these will be addressed.

Describe your organization's past performance in recruiting and retaining health care providers, faculty, staff and students with demonstrated experience serving the specific target populations and familiarity with the culture(s) of the particular target groups.

#### ▪ *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

*This section is scored in Criterion 3: Evaluative Measures and Criterion 5:*

*Resources/Capabilities.* In this section, you will describe your evaluation activities including clinical quality management, as well as the information systems that support those activities.

The purpose of evaluation is to measure the results of your program. Evaluation is also a tool that provides information and feedback so that you can make appropriate adjustments to your program during the project period. Effective evaluation methods will help your organization determine the extent to which your objectives have been accomplished, as well as, the extent to which this is attributable to your program or intervention.

### **HAB Quality Expectations**

A grantee under Part D shall implement 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 purpose of a Clinical Quality Management (CQM) program is to ensure that you have a system in place for evaluating how your clinical system works and making changes where necessary. If healthcare services are being provided for your clients via subcontract, you must make sure that the sub-recipient agencies have CQM systems in place as well. Include monitoring, CQM, and regular reporting in your subcontracts.

HAB also encourages grantees to conduct continuous quality improvement (CQI) for the administrative and fiscal components of their organizations. We can provide technical assistance in this area to your project. Indicate any technical assistance needs in the area of CQM that you may have.

### **Clinical Quality Management Program Requirements:**

Describe your Clinical Quality Management program. Specifically identify the person in your staffing plan who will lead the QM activities for this grant. This person may or may not be supported by grant funds.

- Infrastructure:
  - a. Describe the program's quality goals and the resources dedicated to quality management activities.
  - b. Describe the quality management infrastructure, including the key leaders and quality committee.
  - c. Describe the role of sub-recipient partners and consumers in the QM program.
- Performance Measurement:
  - a. Identify the HIV clinical indicators that will be used to measure performance. Applicants are strongly encouraged to use the HAB-developed HIV Performance Measures that are relevant for WICY populations and can be found at <http://hab.hrsa.gov/deliverhivaidscares/habperformmeasures.html>.
  - b. Describe the data collection plan and process (e.g., frequency, key activities, responsible staff).
  - c. Describe the process for reporting and disseminating the results and findings to your organizational leadership, providers, staff, and consumers.
  - d. Describe how data will be used for quality improvement activities.
- Quality Improvement:
  - a. Provide an example of a quality improvement project that your program recently implemented and completed for a clinical indicator.
    - i. Outline the team leader, staff involved, team responsibilities, and resources allocated for the project.
    - ii. Describe the process/tools used to implement the quality improvement project.
    - iii. Describe the role of leadership in the project.
    - iv. Describe the intervention, results, and the outcome of the QI project.
  - b. Describe the 2-3 quality improvement projects that you have chosen and listed on the Work Plan (e.g. viral load suppression, retention or linkage, Pap smears, pregnant

women on HAART, youth transitioning to adult medical care). Discuss why these are important to your program and target populations.

#### **Part D Retention in Care Quality Collaborative**

HAB will be sponsoring a Part D Retention in Care Quality Collaborative during the first year of the project period, which will be managed by the National Quality Center (NQC). The purpose of this collaborative will be to strengthen quality management activities of the new Part D funded programs and to improve the systems of medical care for WICY populations.

Participation in the collaborative will include attending quarterly meetings as a member of a learning community, coaching in quality improvement activities, access to extensive CQM resources, reporting HAB designated HIV performance measures related to retention in care, and implementation of quality improvement activities.

Successful applicants for Part D funding are strongly encouraged to participate in this activity. Applicants should state in the program narrative whether or not they intend to join the collaborative. Fiscal support for participation in the collaborative will be available.

#### **Management Information Systems (MIS):**

The Ryan White Treatment Extension Act has several data requirements including the collection of medical information at the client level of service using a unique identifier, the collection of data only for funded services (those provided through Ryan White HIV/AIDS Program funding), and data transmission to HRSA/HAB electronically.

Discuss your current information system and its capacity to manage and report the required administrative and clinical data listed below.

- Ryan White Services Report (RSR) (Client Level Data)
- Track and report the extent to which the costs of HIV-related health care are paid by third party payers for health care services to be provided in the proposed Part D program
- Prevention and case finding activities summary.

If you do not have one, describe the system you propose to develop and how it will be implemented. Describe if you use or plan to implement an electronic health record (EHR).

The HIV/AIDS Bureau requires that any EHR or EHR component purchased, in whole or in part, with federal funds meet the Office of the National Coordinator for Health Information Technology (ONC) requirements for certification. To improve the quality of clinical data collected, HAB further requires that any EHR or EHR component be configured to report appropriate clinical data electronically for HAB reporting ([www.hrsa.gov/healthit/ehrguidelines.html](http://www.hrsa.gov/healthit/ehrguidelines.html)).

Additionally, the Department of Health and Human Services has released standards for the meaningful use of Electronic Health Records (EHRs). This is supported by the Centers for Medicare and Medicaid (CMS) with an incentive program for both Medicaid and Medicare providers. Clinical care providers under Ryan White Parts A [2604 (g) (1)], B [2617 (b) (7) (F)] and C [2652 (b) (1)] are required to participate in state Medicaid programs. Consequently, it is expected that such grantees and providers will begin to use a certified EHR in the provision of care (<https://www.cms.gov/EHRIncentivePrograms/>).

▪ **ORGANIZATIONAL INFORMATION**

*This section is scored in Review Criterion 5: Resources/Capabilities.* In this section, describe your organization's capacity and expertise to provide comprehensive, coordinated HIV medical services for WICY populations by describing your administrative, fiscal, and clinical operations. At a minimum, you should provide the following information:

- The history and mission of your organization. Describe the scope of current activities conducted within your organization. How does a Part D WICY project fit within the scope of this mission?
- The structure of your organization and type of agency. Include as **Attachment 12** an Organizational Chart that clearly shows the placement of the Part D program within the larger organization (HIV specific or otherwise), how your program is divided into departments, the professional staff positions that administer those departments, and the reporting relationships of the Part D funded staff within the organization.
- The number of WICY clients your organization is capable of serving. Describe your organization's experience in providing primary medical care to the targeted WICY as well as underserved populations, your community leadership, and other strengths that show that you can implement a Part D program. Include your capacity to provide or effectively link to specialty care, mental health care, substance abuse services, and psychosocial support services.
- The systems that are in place to ensure that the most recent HHS Guidelines, HIV/AIDS clinical standards and protocols are being or will be followed.
- Your knowledge of and ability to implement culturally and linguistically appropriate services. Describe all in-service training and/or learning experiences which you provide for staff and consumers, to develop this competency. Describe how this awareness of the diversity of culture and language in your target populations affects the improvement of health literacy and the delivery of quality, effective, and predictability safe healthcare services.
- Your organization's experience with the fiscal management of grants and contracts. What kind of accounting system is in place? What internal systems are used to monitor grant expenditures? How will your organization manage and monitor subcontractor performance and compliance with Part D WICY requirements?
- How Ryan White HIV/AIDS funding will be the payer of last resort and how Part D will not duplicate other funding received for the proposed services.
- Existing systems for maximizing collections and reimbursement for costs of providing medical care and other billable related services. Describe how program income is collected and tracked.
- Any discounted fee schedule that is being used and how it is implemented.
- How you verify client income for purposes of financial eligibility assessment to access all available resources to fund comprehensive health care services for the target populations.
- Your organization's participation or intent to participate in the 340B Drug Pricing Program if it purchases or reimburses for outpatient drugs. An assessment must be made to determine whether the organization's drug acquisition practices meet Federal requirements regarding cost-effectiveness and reasonableness (see 42 CFR Part 50, Subpart E, and OMB Circulars A-Section 340B of the Public Health Service Act). If the assessment shows that participating in the 340B Drug Pricing Program and its Prime Vendor Program is the most economical and reasonable manner of purchasing or reimbursing for covered outpatient drugs (as defined in section 340B), failure to

participate may result in a negative audit finding, cost disallowance or grant funding offset.

**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:** Program Specific Line Item Budget for Year One

Submit as a PDF document, not spreadsheet.

**Attachment 2:** If applicable, current Negotiated Indirect Cost Rate Agreement (not counted in the page limit).

**Attachment 3:** Staffing Plan for the entire HIV program

List all personnel who provide HIV services directly whether or not funded by Part D and specify all funding sources with the specific time and effort allocated for each source.

**Attachment 4:** Position Descriptions for Key Personnel

Describe the affiliated duties for key personnel, the qualifications needed to fill these positions, and the associated FTE. Keep each to one page in length as much as is possible.

**Attachment 5:** Part D Agreement and Assurances

This document is located in Appendix A and must be reviewed, signed by the Authorized Organization Representative (AOR), and scanned as an attachment.

**Attachment 6:** Proof of Non-Profit Status. Upload documentation of 501( c)(3) status as determined by the Internal Revenue Service.

**Attachment 7:** Documentation of Medicaid provider status and applicable facility licensure to provide clinical services. **Documentation for this application should be in the form of a table that identifies all providers' Medicaid numbers and clinic licensure status, if applicable.** Include the Medicaid provider number(s) for employed and contracted primary care and specialty care provider(s). If clinic licensure is not required in your jurisdiction, describe how that can be confirmed in State regulation or other information. This information will be required annually. Official documentation may be required prior to an award being made or in the post-award period.

**Attachment 8:** Map of Service Area, showing the location of the applicant organization and other HIV service providers in the area. Attach an area map that shows the proposed service area. Your location and the location of all HIV service primary health care providers must be indicated on the map. The HRSA Geospatial data warehouse, <http://datawarehouse.hrsa.gov/>, may be a helpful resource.

**Attachment 9:** Letter or Memoranda of Agreement from the Regional AIDS Education and Training Center. Upload a letter or memorandum of agreement from the regional AETC describing the training activities that will be provided to your organization if you are awarded Part D funds

**Attachment 10:** If applicable, a list of all provider organizations who have signed major contracts and/or memoranda of agreement, with a brief description of the services to be provided and the number of specific WICY populations to be served annually. HRSA may request copies of those agreements and/or contracts as part of post-award administration.

**Attachment 11:** Work Plan Summary. Provide a Work Plan Summary in a table format which focuses on measurable objectives for required areas for each year of the project period (three years). Measurable objectives will be set for each area and should be listed down the left side of the table. Each year of the proposed project period should be labeled across the top, one year for each column to the right of the objectives.

**Attachment 12:** Organizational Chart. The chart should clearly show the placement of the Part D program within the larger organization (HIV specific or otherwise), how your program is divided into departments, the professional staff positions that administer those departments, and the reporting relationships of the Part D funded staff within the organization

**Attachments 13-15:** Optional attachments submitted by applicant. Please note that all optional attachments count toward the 80 page limit.

**Include only letters of support which specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) Letters of agreement and support must be dated. List all other support letters on one page.**

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

#### **Application Due Date**

The due date for applications under this funding opportunity announcement is *March 16, 2012 at 8:00 P.M. ET*. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by your organization's Authorized Organization Representative (AOR) through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

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

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

### **Late applications:**

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

## **4. Intergovernmental Review**

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

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

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

## **5. Funding Restrictions**

Applicants responding to this announcement may request funding for a project period of up to 3 years. Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

- No more than 10%, including planning and evaluation of the grant, may be expended for administrative expenses, including indirect costs.
- It is a program expectation that grant funding spent on Clinical Quality Management will be kept to a reasonable level, consistent with Parts A, B, and C.
- Part D funds cannot be used to pay for clinical research or cash payments to clients.
- Ryan White HIV/AIDS Program funds cannot be used for Syringe Services programs.
- Ryan White HIV/AIDS Program funds cannot be used to supplement payments by Medicaid, Medicare or other insurance programs.
- 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).
- Construction is not allowable, unless it is minor alterations to an existing facility, to make it more suitable for the purposes of the grant program. In such cases previous authorization must be sought.
- Entertainment costs are not allowable. This includes the cost of amusements, social

activities, and related incidental costs.

- Fundraising expenses are not allowable.
- Lobbying expenses are not allowable.
- Cost of a consultant to write the application and other pre-award costs are not allowable.
- Foreign travel is not allowable.
- Other non-allowable costs can be found in the Cost Principles located at <http://www.hhs.gov/grantsnet/lawsregs/index.htm>.

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

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

## 6. Other Submission Requirements

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

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

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

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

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

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

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

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

## V. Application Review Information

### 1. Review Criteria

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

Review Criteria are used to review and rank applications. Applications will be scored on the basis of 100 points. Points will be allocated based on the extent to which the proposal addresses each of the criteria listed below. The Part D WICY Program has six (6) review criteria:

Criterion 1: Need	40 points
Criterion 2: Response	25 points
Criterion 3: Evaluative Measures	10 points
Criterion 4: Impact	5 points
Criterion 5: Resources/Capabilities	10 points
Criterion 6: Support Requested	10 points
<b>TOTAL</b>	<b>100 points</b>

#### **Criterion 1: NEED (40 points)**

*This section corresponds to the Introduction and Needs Assessment sections of the application.*

Evidence that the applicant demonstrates increasing numbers of WICY living with HIV in the proposed service area between 2008 and 2010.

The extent to which the applicant clearly demonstrates its intent to serve WICY target populations who are uninsured, underserved, vulnerable, and at high risk for HIV infection based upon the social context in the proposed service area.

The degree of detail provided in the application regarding HIV and primary care providers in the proposed service area, level of funding, services provided, and number of persons (total and WICY) served by service category.

The extent to which the applicant clearly describes unmet need, gaps in services, and barriers to care for WICY living with HIV that are currently not being addressed by HIV service providers in the service area.

The extent to which the application clearly demonstrates a need for Part D WICY funded services based on HIV epidemiologic data and current Ryan White funding/insurance coverage levels in the proposed service area.

#### **Criterion 2: RESPONSE (25 points)**

*This section corresponds to the Methodology, Work Plan Summary, and Resolution of Challenges sections of the application.*

The extent to which the applicant describes HIV counseling and testing services in the service area, all funding sources for those activities, and the processes by which newly diagnosed HIV positive WICY populations will be linked to medical care. The strength of the tracking methods for linkage to care. The extent to which the applicant **addresses the NHAS goal: to diagnose HIV infection and link to care.**

The extent to which comprehensive HIV medical care which meets DHHS guidelines are proposed for each and every WICY population, including after-hours coverage, access to antiretroviral medications/ HIV specific diagnostic tests/ specialty referrals, adherence counseling by a licensed clinician.

The appropriateness of the activities described for recruiting and retaining women and youth in HIV care. The extent to which the applicant describes coordination of services with current HIV provider organizations in order not to duplicate services. The extent to which the applicant addresses the medical needs of women at all phases of life.

The appropriateness of other medical services and support services to be funded in addressing gaps in services and barriers to care in order to increase access to HIV medical care and retain WICY populations in care. The extent to which these services will be co-located and linked directly to medical outcomes as demonstrated by appropriate work plan objectives.

The extent to which the applicant demonstrates the capacity to deliver comprehensive HIV health care services to each WICY population in the proposed service area that addresses effective linkages to medical care, retention in care, culturally sensitive services, and coordination with key provider agencies (which **addresses the NHAS goal of increasing access to care and reducing HIV-related health disparities**).

### **Criterion 3: EVALUATIVE MEASURES (10 points)**

*This section corresponds primarily to the Evaluation and Technical Support Capacity section of the application.*

The strength of the quality management infrastructure, including a description of the persons who will be involved in CQM activities, the dedicated resources for quality management activities, evidence that clear quality goals have been established and are being monitored for the effectiveness of the quality management activities and infrastructure. The extent to which consumers will be involved in the Clinical Quality Management program.

The appropriateness of the clinical indicators chosen to measure performance and the extent to which the applicant uses HAB-developed measures; the appropriateness of the quality improvement projects proposed for the target populations to be served. The extent to which the applicant describes how data are used for quality improvement activities and provides an example of a current or completed primary medical care QI project.

The extent to which the applicant demonstrates the ability to comply with reporting requirements of the program. The strength of the data collection plan and process (e.g., frequency, key activities, and responsible staff). The strength of the process for reporting and disseminating the results and findings. The appropriateness of the EHR/EMR system to be used and the capacity of that system to assist with data management, analysis, and reporting to sustain a robust HIV program.

The extent to which the applicant demonstrates the capacity to evaluate its proposed Part D program through required reporting and the effective use of quality improvement practices.

**Criterion 4: Impact (5 points)**

*This section corresponds to the overall application and Work Plan Summary sections of the application.*

The extent to which the Work Plan Summary provides objectives which are appropriate for the level of unmet need and gaps in services for the WICY populations in the proposed service area as described in the Needs section. The extent to which the objectives are consistent with the proposed budget and justification. The appropriateness of the quality management activities and objectives listed in the Work Plan as compared with the Evaluation narrative.

The extent to which the applicant proposes a project which enhances and supports the provision of comprehensive HIV services for the WICY populations in the service area without duplication or redundancy.

**Criterion 5: Resources/ Capabilities (10 points)**

*This section corresponds to the Staffing Plan, Organizational Information, and Attachments sections of the application.*

The extent to which the project personnel are qualified by training and/ or experience to provide HIV-related services, including primary medical care, for the target populations, as demonstrated by the details presented in the Staffing Plan and Biographical Sketches. Does the applicant have systems in place to ensure that the most recent HIV/AIDS clinical standards and protocols will be followed?

The strength of the organization's mission, structure, and experience which will support the provision of comprehensive, coordinated HIV medical services as evidenced by medical provider/clinic licensure and organizational chart. Overall, does the applicant demonstrate the organization's ability to implement the proposed project?

The overall extent to which the applicant documents the organization's fiscal and MIS capacity to manage this grant and meet program requirements, including monitoring grant expenditures and providing data reports (e.g., RSR). Does the applicant clearly describe systems to bill, collect, and track for reimbursable health care services? If applicable, does the applicant demonstrate the ability to manage and monitor subcontractor performance and compliance with Part D requirements?

**Criterion 6: Support Requested (10 points)**

*This section corresponds to the overall application, budget documents, and the Attachment sections of the application.*

The appropriateness of the requested funding level for each year of the three-year project period in comparison to the level of effort, number of WICY patients to be served (total and by category), and the number of patients who are uninsured or underinsured for the itemized services. The reasonableness of the average cost of care for each service category. For all applicants, the number of patients, the number of patients with AIDS versus HIV, and the

number of patients with no form of third party reimbursement or funding from Part A, B, or C will be considered. Reviewers will consider the epidemiologic data reported in the Needs section and the objectives in the Work Plan Summary.

The degree to which the budgeted amount of licensed medical provider time is reasonable for the number of patients and whether the supportive (clinical and non-clinical) positions are in reasonable proportion to the provider time requested. The extent to which the budget allocates resources for the provision of HIV and other medical services, after reserving funds for clinical quality management and administration. The extent to which budget allocations for clinical quality management are at a reasonable level. Evidence that the budget adheres to the **10 percent** limit on administrative costs (including any indirect costs claimed). The extent to which the program narrative and budget documents **address the NHAS goal: to increase access to care and optimize health outcomes for people living with HIV.**

The reasonableness of the 424A Section B and program-specific line item budget for the each year of the proposed project period. The clarity and appropriateness of the presented budget justification narrative that fully explains each line item.

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

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applications competing for federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of the committee, e.g., geographic distribution. Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review criteria noted above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

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

HRSA reserves the right to review fundable applicants for compliance with HRSA program requirements through reviews of site visits, audit data, Uniform Data System (UDS) or similar reports, Medicare/Medicaid cost reports, external accreditation or other performance reports, as applicable. The results of this review may impact final funding decisions.

### ***GEOGRAPHIC CONSIDERATION:***

The goal of the HRSA in making this funding announcement is to respond to the changing HIV epidemiology and provide comprehensive HIV health services to WICY populations in areas of greatest need without duplication of effort. Therefore, if more than one application is submitted for a given service area, HRSA will fund the highest ranked application for that service area.

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

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

## **VI. Award Administration Information**

### **1. Award Notices**

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

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

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

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

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes, as applicable, any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at <http://www.hrsa.gov/grants/>. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

### **Trafficking in Persons**

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

### **Smoke-Free Workplace**

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

### **Cultural and Linguistic Competence**

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

### **Healthy People 2020**

Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. The program consists of over 40 topic areas, containing measurable objectives. HRSA has actively participated in the work groups of all the topic areas and is committed to the achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found online at <http://www.healthypeople.gov/>.

### **Health IT**

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

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

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

### **3. Reporting**

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

a. **Audit Requirements**

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

b. **Payment Management Requirements**

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

c. **Status Reports**

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

2) **Progress Report(s).** The awardee must submit a noncompeting progress report to HRSA on an annual basis. *Submission and HRSA approval of your Progress Report(s) triggers the budget period renewal and release of subsequent year funds.* Further information will be provided in the award notice.

3) Submit the annual **Ryan White HIV/AIDS Program Services Report (RSR)**, which consists of grantee, service provider, and client level reports via the HRSA Electronic Handbook.

4) Submit an **Allocation Report**, due 60 days after the start of the budget period, and an **Expenditure Report**, due 90 days after the end of the budget period. These reports account for the allocation and then expenditure of all grant funds according to specific core medical services, support services, clinical quality management, and administration. Data for these reports will be uploaded to a secure HRSA server via the HRSA Electronic Handbook. The forms to report this information for all parts of the Ryan White HIV/AIDS Program were approved by the Office of Management and Budget on May 1, 2008, and extended on March 21, 2011, OMB Number 0915-0318.

5) Submit, every two (2) years, to the lead State agency for Part B, audits consistent with Office of Management and Budget Circular **A-133**, regarding funds expended in accordance with this title and include necessary client level data to complete unmet need calculations and the Statewide Coordinated Statements of Need process.

6) **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>.

**d. Transparency Act Reporting Requirements**

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

## VII. Agency Contacts

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

Joi Grymes  
Grants Management Specialist  
Attn.: Ryan White Part D  
HRSA Division of Grants Management Operations, OFAM  
Parklawn Building, Room 12-07  
5600 Fishers Lane  
Rockville, MD 20857  
Telephone: (301) 443-2632  
Fax: 301-443-9810  
Email: [jgrymes@hrsa.gov](mailto:jgrymes@hrsa.gov)

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

Anna K. Huang, M.D.  
Northeastern Branch Chief  
Division of Community Based Programs  
Attn: Ryan White Part D  
HIV/AIDS Bureau, HRSA  
Parklawn Building, Room 7A-21  
5600 Fishers Lane  
Rockville, MD 20857  
Telephone: (301) 443-3995  
Fax: (301) 443-1839  
Email: [ahuang1@hrsa.gov](mailto:ahuang1@hrsa.gov)

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

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

## **VIII. OTHER INFORMATION**

### **Technical Assistance**

All applicants are encouraged to participate in a technical assistance (TA) WebEx Call for this funding opportunity. The technical assistance WebEx Call information regarding this application announcement is as follows:

Dates:

January 23, 2012 2:00-4:00 p.m. ET. To join the meeting:  
[https://hrsa.connectsolutions.com/ryanwhitepartd\\_2012\\_foa-ta1/event/registration.html](https://hrsa.connectsolutions.com/ryanwhitepartd_2012_foa-ta1/event/registration.html)

January 30, 2012 2:00-4:00 p.m. ET. To join the meeting:  
[https://hrsa.connectsolutions.com/ryanwhitepartd\\_2012\\_foa-ta2/event/registration.html](https://hrsa.connectsolutions.com/ryanwhitepartd_2012_foa-ta2/event/registration.html)

February 2, 2012 2:30-4:30 p.m. ET. To join the meeting:  
[https://hrsa.connectsolutions.com/ryanwhitepartd\\_2012\\_foa-ta3/event/registration.html](https://hrsa.connectsolutions.com/ryanwhitepartd_2012_foa-ta3/event/registration.html)

February 7, 2012 2:00- 4:00 p.m. ET. To join the meeting:  
[https://hrsa.connectsolutions.com/ryanwhitepartd\\_2012\\_foa-ta/event/registration.html](https://hrsa.connectsolutions.com/ryanwhitepartd_2012_foa-ta/event/registration.html)

The calls will be recorded and placed on the Target Center along with the Q & A transcript within 5 business days of the first call.

### **Funding Opportunity Announcement Short Video**

A video for applicants highlighting changes in the Part D Women, Infants, Children and Youth (WICY) program is at <http://www.youtube.com/watch?v=-ckoUK40By8>.

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

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

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

# Appendix A- Part D Agreement and Assurances

## Ryan White HIV/AIDS Treatment Extension Act of 2009, Part D

The authorized representative of the applicant must include a copy of this agreement form with the grant application. This agreement lists the program assurances which must be satisfied in order to qualify for a Part D grant, as required by section 2671.

I, the authorized representative of \_\_\_\_\_ in applying for a grant under Part D of Title XXVI, Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009, P.L. 111-87, 42 U.S.C. 300ff-71, hereby agree that:

As required in section 2671 subsection (c) - Coordination With Other Entities:

- (1) The applicant will coordinate activities under the grant with other providers of health care services under this Act, and under Title V of the Social Security Act, including programs promoting the reduction and elimination of the risk of HIV/AIDS for youth;
- (2) The applicant will participate in the statewide coordinated statement of need under Part B (where it has been initiated by the public health agency responsible for administering grants under part B) and in revisions of such statements;
- (3) The applicant will every 2 years submit to the lead State agency audits regarding funds expended in accordance with this Title and shall include necessary client-level data to complete unmet need calculations and Statewide coordinated statements of need process.

As required in section 2671 subsection (d), the applicant will provide information regarding how the expected grant expenditures are related to Ryan White parts A and B planning processes. The applicant will also submit a specification of the expected expenditures and how those expenditures will improve overall patient outcomes as outlined as part of the State plan.

As required in section 2671 subsection (f), the applicant will not use more than 10 percent of grant award for administrative expenses. The applicant will implement 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 (DHHS) guidelines for the treatment of HIV/AIDS and related opportunistic infection, and 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.

I understand I can obtain a copy of the Title XXVI, PHS Act Part D at (<http://www.thomas.loc.gov>) to gain full knowledge of its contents.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_