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Health Resources and Services Administration**

HIV/AIDS Bureau
Special Projects of National Significance Program

***Culturally Appropriate Interventions of Outreach, Access and Retention among
Latino/a Populations – Demonstration Sites***

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Adan Cajina
Branch Chief, Demonstration and Evaluation Branch
Email: ACajina@hrsa.gov
Telephone (301) 443-3180
Fax: (301) 594-2511

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Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87)

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I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for a Special Projects of National Significance (SPNS) Program multi-site initiative entitled *Culturally Appropriate Interventions of Outreach, Access and Retention among Latino(a) Populations – Demonstration Sites*. This initiative is expected to provide funding during Federal fiscal years 2013-2017 to support organizations that will design, implement and evaluate culturally appropriate service delivery models focused on improving health outcomes among Latinos/as living with HIV disease. The initiative will focus on Latinos/as who are who are at high risk of HIV infection or are infected with HIV but are unaware of their HIV status; are aware of their HIV infection but have never been engaged in care; are aware but have refused referral to care; or have dropped out of care. Applicants must propose innovative interventions that identify Latinos/as at high risk or living with HIV, and improve their access, timely entry and retention in quality HIV primary care. Applicants must have the clinical capacity to implement and sustain their interventions, and propose evaluation plans for these interventions that will enhance knowledge of the disparities in health outcomes affecting Latino populations living in the United States.

This initiative will take a transnational approach, and applicants must propose innovative interventions targeting HIV-affected Latino/a subpopulations living in the US but specific to their country of origin. Proposed interventions must address sociocultural and structural barriers, especially stigma, that affect Latino/as' access and retention in HIV primary care. Latino/a subpopulations of interest include but are not limited to heterosexual men, heterosexual women, gay and bisexual men, bisexual women, transgender women, and injecting drug users (IDUs). Awards will be limited to organizations located in areas with high concentration of Latino/as with high incidence and/or prevalence of HIV/AIDS, especially in urban areas. Consortia of multiple outpatient clinics serving the same identified target population are encouraged to apply.

Up to eight awards are anticipated, at up to \$300,000 per year over a five year project period. Awardees will be required to participate in a comprehensive multi-site evaluation throughout the five year project period led by an Evaluation and Technical Assistance Center (ETAC) to identify and document successful models for purposes of dissemination and replication at the national level. Funding for the ETAC is being made available under a separate announcement (HRSA-13-151) and organizations that apply under this funding announcement may not also apply under the ETAC announcement. Funds awarded under this announcement may not be used for direct HIV care services or for duplication of existing services, but rather to fund activities designed to identify, engage and retain HIV-positive Latino/a in quality HIV care. Direct HIV care is funded by other sources, such as Ryan White HIV/AIDS Program Parts A, B, C, and D.

According to the 2010 Census, there are 50.5 million people of Hispanic or Latino origin (hereafter cited as *Latino/as*) living in the U.S.¹ After African-Americans, Latino/as are the most disproportionately impacted racial/ethnic group by the HIV/AIDS epidemic in the U.S. According to the Centers for Disease Control and Prevention (CDC), an estimated 220,000 Latino/as were living with HIV infection in the US at the end of 2009, with almost 20 percent

¹ U.S. Census. The Hispanic Population: 2010. 2010 Census Brief, May 2011. Available from: <http://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf>

unaware of their infection.² Although representing 16 percent of the total US population, Latino/as comprised 22 percent of those newly diagnosed with HIV in 2010, with an infection rate almost three times as high as that of whites.³ By the end of 2009, over 114,000 Latino/as had died from HIV/AIDS since the epidemic began in the U.S.⁴

Among Latino/as, men comprised 83 percent of new HIV infections in 2010, with 76 percent of those infections among Men who have Sex with Men (MSM), 11 percent from heterosexual contact and 9 percent from injection drug use.⁵ Latino MSM comprised nearly two-thirds of all new infections among Latino/as and are the single largest subgroup of Latino people living with HIV/AIDS.⁶ Latina women accounted for 21 percent of new infections among Latino/as, with 77 percent of those infections attributed to heterosexual contact and 21 percent to injection drug use.⁷ Although CDC does not yet report HIV surveillance data for transgender women who are classified as MSM, HIV prevalence among transgender Latinas has been found to range from 14 to 50 percent in 5 studies.^{8,9,10,11,12} The CDC's National HIV Behavioral Surveillance System study of over 10,000 injecting drug users in 20 cities found that Latino/a IDUs had the highest HIV prevalence (12 percent) among all ethnicities.¹³

² CDC. HIV Surveillance Supplemental Report, Volume 17, Number 3 (Part A), Table 5a. Estimated numbers and rates of persons aged 13 years and older living with HIV infection (prevalence), and numbers and percentages whose HIV infection was undiagnosed, by selected characteristics, 2009—United States. Available from: http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp_vol17no3/pdf/hssr_vol_17_no_3.pdf#page=22

³ CDC. HIV Surveillance Supplemental Report, Volume 17, Number 3 (Part A), Table 5a.

⁴ CDC. HIV Surveillance Report, Volume 22, Table 12b. Deaths of persons with an AIDS diagnosis, by year of death and selected characteristics, 2007-2009 and cumulative - United States and 6 U.S. dependent areas. Available from: http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010_HIV_Surveillance_Report_vol_22.pdf#Page=44

⁵ CDC. HIV Surveillance Report, Volume 22, Table 3b. Diagnoses of HIV infection, by race/ethnicity and selected characteristics – 46 states and 5 U.S. dependent areas with confidential name-based HIV infection reporting. Available from: http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010_HIV_Surveillance_Report_vol_22.pdf#Page=26

⁶ CDC. Subpopulation estimates from the HIV incidence surveillance system – United States, 2006. Morbidity and Mortality Weekly Report 57(36): 985-989, September 12, 2008. Available from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5736a1.htm>

⁷ CDC. HIV Surveillance Report, Volume 22, Table 3b.

⁸ Simon P, Reback C, & Bemis C. HIV prevalence and incidence among male-to-female transsexuals receiving HIV prevention services in Los Angeles County. *AIDS*, December 22, 2000; 14 (18): 2953-2955. No abstract available.

⁹ Clements-Nolle K, Marx R, Guzman R, et al. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health*, 2001 June; 91(6): 915-921. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/11392934>

¹⁰ Nemoto T, Operario D, Keatley J, et al. HIV risk behaviors among male-to-female transgender persons of color in San Francisco. *American Journal of Public Health*, 2004 July; 94(7): 1193-1199. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/15226142>

¹¹ Rodríguez-Madera S, Toro-Alfonso J. Gender as an obstacle in HIV/AIDS prevention: Considerations for the development of HIV/AIDS prevention efforts for male-to-female transgenders. *International Journal of Transgenderism*, 2005; 8(2/3):113-122. No abstract available.

¹² Nuttbrock L, Hwahng S, Bockting W, et al. Lifetime risk factors for HIV/sexually transmitted infections among male-to-female transgender persons. *Journal of Acquired Immune Deficiency Syndromes*, 2009 November; 52(3): 417-21. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/19550351>

¹³ CDC. HIV Infection and HIV-Associated Behaviors Among Injecting Drug Users - 20 Cities, United States, 2009. Morbidity and Mortality Weekly Report, 61(8): 133-138, March 2, 2012. Available from: <http://www.cdc.gov/mmwr/pdf/wk/mm6108.pdf>

In an analysis of regional differences among Latinos/as diagnosed with HIV in 2010, CDC found that Latinos/as living in the northeastern U.S. had an incidence rate that was twice that of other regions, and that the northeast stood out for higher percentages of new infections among those born in Puerto Rico and among IDUs. The majority (86 percent) of new diagnoses among Latinos/as in 2010 were among those living in cities. Compared with Latinos/as in the 46 States used in this analysis, newly diagnosed Puerto Ricans had higher percentages of infections attributable to heterosexual contact (40.7 percent versus 22 percent) and injection drug use (20.4 percent versus 8.6 percent), and a lower percentage due to MSM (36.1 percent versus 66.5 percent). Based on these findings, CDC recommended that “HIV interventions should be tailored to the characteristics and needs of the Hispanic or Latino population in different geographical areas.”¹⁴

The National HIV/AIDS Strategy (NHAS¹⁵) released in July 2010 by the White House Office of National AIDS Policy has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed and recognizes the importance of getting people with HIV into care early after infection. Therefore, to the extent possible, Ryan White program activities should strive to support the three primary goals of the National HIV/AIDS Strategy. 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.¹⁶

Although this SPNS initiative will address all three goals of the NHAS, its primary focus is the third primary goal of reducing HIV-related health disparities amongst Latino/as. The NHAS identifies Latino/as, African-Americans, gay and bisexual men as the principal groups facing HIV/AIDS-related disparities states that

“The transmission of HIV has long been concentrated in groups that have been marginalized or underserved. For persons living with HIV, this issue often transcends discrete measures such as incidence, morbidity and mortality rates, but speaks to a confluence of factors that lead to poorer health overall. In some communities, a major challenge is overcoming a sense of fatalism where people believe that they are destined to become infected with HIV.”¹⁷

The NHAS sets a goal of increasing “the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent by 2015.” To accomplish this goal, the NHAS includes actionable steps of reducing HIV-related mortality in communities at high risk for HIV infection; the adoption of community-level approaches to reduce HIV infection in high-risk communities; and the reduction of stigma and discrimination against people living with HIV.¹⁸ Although the Ryan

¹⁴ CDC. Geographic Differences in HIV Infection Among Hispanics or Latinos — 46 States and Puerto Rico, 2010. Morbidity and Mortality Weekly Report, 61 (40): 805-810, October 12, 2012. Available from: <http://www.cdc.gov/mmwr/pdf/wk/mm6140.pdf>

¹⁵ Office of National AIDS Policy (2010) National HIV/AIDS Strategy for the United States. ONAP, The White House. Available from: <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>

¹⁶ See <http://www.aidsinfo.nih.gov/Guidelines/Default.aspx> as a reliable source for current guidelines

¹⁷ ONAP, NHAS, page 31.

¹⁸ ONAP, NHAS, page 31.

White HIV/AIDS Program served 178,581 duplicated Latino/a people living with HIV/AIDS in 2010, and its ADAP program 49, 927 duplicated Latino clients, more work remains to be done to meet these NHAS goals.¹⁹

In 2010, CDC estimated that 21 percent of the 1,106,400 adults and adolescents living with HIV in the U.S. at the end of 2006 were unaware of their infection.²⁰ Those unaware account for over half of new sexually transmitted HIV infections, with transmission rates 3.5 times higher than those who are aware.²¹ Additionally, as many as one third of those previously diagnosed and aware of their HIV infection remain out of care,²² often for years.²³ Timely entry into HIV care post-diagnosis has been found to have a number of benefits, including decreased morbidity, mortality and infectiousness,²⁴ as well as exposure to effective secondary prevention efforts through cost-effective clinical interventions.^{25, 26} There are many reasons why HIV-positive persons may delay entering care upon diagnosis, including structural, financial and personal/cultural barriers arising from racial, ethnic and gender disparities.²⁷ Continuous retention in care has benefits similar to those of timely entry, and a number of strategies have been developed to promote retention such as intensive case management, patient navigation, peer support groups, and mobile van outreach to find clients who were lost to follow-up.^{27, 28}

¹⁹ Health Resources and Services Administration. *2010 State Profiles, Ryan White HIV/AIDS Program*. HIV AIDS Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. Available from: <http://hab.hrsa.gov/stateprofiles/2010/states/us/Client-Characteristics.htm>. Note: These totals represent duplicated counts of clients served based on the 2010 Ryan White Data Report (RDR).

²⁰ Campsmith ML, Rhodes PH, Hall HI, & Green TA. Undiagnosed HIV Prevalence Among Adults and Adolescents in the United States at the End of 2006. *Journal of Acquired Immune Deficiency Syndromes*, 2010 April; 53 (5): 619-624. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/19838124>

²¹ Marks G, Crepaz N, & Janssen RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS*, 2006 June; 20 (10): 1447-50140. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/16791020>

²² Fleming PL, Byers RH, Sweeney PA, et al. HIV prevalence in the United States, 2000. Presented at the 9th Conference on Retroviruses and Opportunistic Infections, February 24-28, 2002, Seattle, WA. Accessed 10/11/12 from <http://www.retroconference.org/2002/abstract/13996.htm>

²³ Samet JH, Freedberg KA, Savetsky JB, et al. Understanding delay to medical care for HIV infection: the long-term non-presenter. *AIDS*, 2001 January, 15 (1): 77-85. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/11192871>

²⁴ Department of Health and Human Services, Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents, pages E1 to E19. Department of Health and Human Services. March 27, 2012. Available from: <http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>

²⁵ Myers JJ, Shade SB, Rose CD, et al. Interventions Delivered in Clinical Settings are Effective in Reducing Risk of HIV Transmission Among People Living with HIV: Results from the Health Resources and Services Administration (HRSA)'s Special Projects of National Significance Initiative. *AIDS and Behavior*, 2010 June; 14 (3): 483-492. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/20229132>

²⁶ Marseille E, Shade SB, Myers J, & Morin S. The cost-effectiveness of HIV prevention interventions for HIV-infected patients seen in clinical settings. *Journal of Acquired Immune Deficiency Syndromes*, 2011 March; 56 (3): e87-e94. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/21317579>

²⁷ Tobias C, Cunningham WE, Cunningham CO, & Pounds MB. Making the Connection: The Importance of Engagement and Retention in HIV Medical Care. *AIDS Patient Care & STDs*, 2007; 21 (Supplement 1): S3-S8. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/17563287>

²⁸ Gardner L, Marks G, Metsch L, et al. Psychological and Behavioral Correlates of Entering Care for HIV Infection: The Antiretroviral Treatment Access Study (ARTAS) *AIDS Patient Care and STDs*, 2007; 21 (6): 418-425. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/17594251>

Viral load suppression has become a key indicator of effective engagement in HIV primary care.²⁹ In a 2011 review of the spectrum of engagement in care for people living with HIV infection in the U.S., Gardner, et al, estimated that only 19 percent had undetectable viral loads. Their review also estimated that 75 percent of those newly diagnosed with HIV were successfully linked to care within 6 months to a year after diagnosis.³⁰ Using more recent data, CDC estimated later in 2011 that 28 percent of people living with HIV/AIDS were virally suppressed. CDC also estimated that 77 percent of HIV-infected adults were linked to care within 3 to 4 months after diagnosis, but only 51 percent of diagnosed persons were retained in medical care.³¹ Another CDC analysis of 2009 prevalence data released in July 2012 estimated that 80 percent of Latinos/as living with HIV had been diagnosed, and 67 percent were linked to care. However, only 37 percent were retained in care, 33 percent were prescribed anti-retroviral therapy (ART) and just 26 percent were virally suppressed.³²

From 2001 to 2005 the Ryan White HIV/AIDS Program's Special Projects of National Significance conducted the *Demonstration and Evaluation Models that Advance HIV Service Innovation Along the U.S./Mexico Border*. This initiative was composed of five demonstration projects and an evaluation center.³³ Only 41 percent of Latino/a participants in this initiative entered HIV primary care in the same year of their diagnosis,³⁴ and 58 percent of new (treatment-naïve) patients were diagnosed with AIDS at intake.³⁵ An analysis of 470 treatment-naïve participants of this SPNS initiative found that 73 percent lacked insurance, and the most significant reasons reported for their delayed entry into HIV care were a lack of knowledge of the requirements to qualify for HIV medical care; its perceived cost; and that HIV medications would not be available to them.³⁶

Although Latino/as are commonly conflated as a single population, they comprise people from twenty countries, most with multiple racial groups and indigenous peoples. As such, they have heterogeneous cultural orientations, histories and Spanish language dialects specific to those

²⁹ Institute of Medicine. *Monitoring HIV Care in the United States - Indicators and Data Systems*. March 15, 2012. Washington, DC: The National Academies Press. Available from:

http://www.nap.edu/catalog.php?record_id=13225

³⁰ Gardner E, McLees M, Steiner J et al. The spectrum of engagement in HIV care and its relevance to Test-and-Treat strategies for prevention of HIV Infection. *Clinical Infectious Diseases*, 2011; 52: 793-800. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/21367734>

³¹ CDC. Vital Signs: HIV Prevention Through Care and Treatment – United States. Morbidity and Mortality Weekly Report, Early Release, Volume 60, November 29, 2011. Available from: <http://www.cdc.gov/mmwr/pdf/wk/mm60e1129.pdf?source=govdelivery>

³² CDC. HIV in the United States: the Stages of Care. Fact Sheet, July 2012. Available from: <http://www.cdc.gov/nchstp/newsroom/docs/2012/Stages-of-CareFactSheet-508.pdf>

³³ See <http://hab.hrsa.gov/about/hab/special/usmexicoborder.html#b>

³⁴ Keesee MS, Shinault KA, Carabin H, et al. Socio-Demographic Characteristics of HIV/AIDS Individuals Living and Receiving Care Along the U.S.-Mexico Border Through Five SPNS Demonstration Projects. *Journal of HIV/AIDS & Social Services*, 2006; 5 (2): 15-35.

³⁵ Carabin H, Keesee MS, Machado LJ, et al. Estimation of the prevalence of AIDS, opportunistic infections, and standard of care among patients with HIV/AIDS receiving care along the U.S.-Mexico border through the Special Projects of National Significance: a cross-sectional study. *AIDS Patient Care and STDs*, 2008; 22 (11): 887-95. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/19025483>

³⁶ Keesee MS, Natale AP, & Curiel HF. HIV Positive Hispanic/Latinos Who Delay HIV Care: Analysis of Multilevel Care Engagement Barriers. *Social Work in Health Care*, 2012; 51(5): 457-478. <http://www.ncbi.nlm.nih.gov/pubmed/202258303>

countries of origin that often resist homogenization. A 2011 Pew Hispanic Center survey³⁷ found that only 24 percent of Latino/as prefer to identify themselves as Hispanic or Latino. The majority (51 percent) reported their preference for national identity, specific to their country of origin. According to a Pew Hispanic Center analysis of the 2010 American Community Survey conducted by the U.S. Census Bureau, the top ten countries of origin for Latino/as living in the U.S. are (in order of population size) Mexico, Puerto Rico (a U.S. Territory), Cuba, El Salvador, Dominican Republic, Guatemala, Columbia, Honduras, Ecuador, and Peru, with almost two-thirds from Mexico.³⁸

The research literature regarding HIV prevention among Latino/as living in the U.S. identifies many commonly shared factors that place them at increased risk for HIV infection. These include stigma; racial/ethnic and socioeconomic discrimination; domestic violence; and rigid gender roles and expectations. Stigma has proven to be a very powerful factor influencing Latinos/as,^{39,40} especially among Latino Gay and Bisexual men and transgender Latinas.^{41,42} There are also uniquely Latino/a sociocultural factors such as *machismo*, *marianismo*, *fatalismo*, *familismo*, *personalismo*, *simpatía*, and the importance of religion. Latino/a men and women, especially Puerto Ricans, have become infected with HIV through injection drug use.⁴³ Latino gay men, bisexual men and women, and transgender women also deal with homophobia, biphobia and transphobia that manifests as discrimination and bias-related violence, and alcohol and substance abuse is high among these subpopulations.^{44,45,46} Additionally, Latinos/as have faced other barriers to access to health care, including poverty; lack of insurance; language and level of acculturation; and immigration status. In many impoverished migrant communities, Latinos/as living with HIV may be unaware of how to access HIV primary care or how to pay for it.⁴⁷ Care services may be unavailable and/or located at great distances from those who need it, and there is a lack of community organizations to support those who are seeking such care. Together, all these factors not only increase risk of HIV infection but also are likely to interfere

³⁷ Taylor P, Lopez MH, Martínez JH, Velasco G. When Labels Don't Fit: Hispanics and Their Views of Identity. Pew Hispanic Center, April 4, 2012. Available from: <http://www.pewhispanic.org/2012/04/04/when-labels-dont-fit-hispanics-and-their-views-of-identity/>

³⁸ Motel S & Patten E. Hispanic Origin Profiles. Pew Hispanic Center, June 27, 2012. Available from: <http://www.pewhispanic.org/2012/06/27/country-of-origin-profiles/>

³⁹ Keesee, Natale, & Curiel, 2012.

⁴⁰ Varas-Díaz N, Toro-Alfonso J, & Serrano-García I. AIDS-Related Stigma and Social Interaction: Puerto Ricans Living With HIV/AIDS. *Qualitative Health Research*, February 2005; 15(2): 169-187. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/15611202>

⁴¹ Bruce D, Ramirez-Valles J, & Campbell RT. Stigmatization, Substance Use, and Sexual Risk Behavior Among Latino Gay and Bisexual Men and Transgender Persons. *Journal of Drug Issues*, 2008; 35: 235-260.

⁴² Ramirez-Valles J, Kuhns LM, Campbell RT, & Diaz RM. Social integration and health: community involvement, stigmatized identities, and sexual risk in Latino sexual minorities. *Journal of Health and Social Behavior*, March 2010; 51(1): 30-47. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/20420293>

⁴³ CDC. HIV Infection and HIV-Associated Behaviors Among Injecting Drug Users - 20 Cities, United States, 2009.

⁴⁴ Diaz RH, Ayala G, Bein E, et al. The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: findings from 3 US cities. *American Journal of Public Health*, June 2001; 91(6): 927-932. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/11392936>

⁴⁵ Diaz RH, Ayala G, and Bein E. Sexual Risk as an Outcome of Social Oppression: Data From a Probability Sample of Latino Gay Men in Three U.S. Cities. *Cultural Diversity and Ethnic Minority Psychology*, 2004; 10(3): 255-267. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/15311978>

⁴⁶ Ramirez-Valles J, Garcia D, Campbell RT, et al. HIV Infection, Sexual Risk Behavior, and Substance Use Among Latino Gay and Bisexual Men and Transgender Persons. *American Journal of Public Health*, June 2008, 98(6): 1036-1042. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/18445807>

⁴⁷ Keesee, Natale, & Curiel, 2012.

with HIV testing and timely access to treatment after HIV diagnosis, causing Latinos/as to fare more poorly in health outcomes compared with other racial/ethnic groups.

Although many Latinos/as share these general characteristics with regard to HIV risk and health care barriers, foreign-born Latino/as experience additional difficulties, including lack of acculturation; language barriers; isolation from family and country of origin; and social marginalization. According to another Pew Hispanic Center's analysis of 2010 American Community Survey data, 37 percent of Latino/as in the U.S. in 2010 were foreign born.⁴⁸ These differences between Latino/as born in the continental U.S. and those born in other countries and Puerto Rico can have major impacts on both HIV risk and access to health care.⁴⁹ For example, CDC has noted that significant numbers of men born in Puerto Rico have become infected with HIV through injection drug use.⁵⁰ Overall, 31 percent of Latino/as in the U.S. lack health insurance, with those of Central American origin (Honduras, Guatemala and El Salvador) least likely to be insured.⁵¹ The most common place of birth among Latinos/as born outside the U.S. mainland and diagnosed with HIV in 2010 was Puerto Rico in the northeastern U.S., and Mexico in the other regions.⁵²

This SPNS initiative will take a transnational approach to improving access to and retention in HIV primary care by Latino/as living with HIV infection in the U.S. This approach recognizes that Latino/as and particularly foreign-born migrants “maintain strong, affective, social, cultural, economic and political ties with their places of origin, even many years after relocation...(that are) increasingly facilitated by the availability of fast communication technologies.”⁵³ Moreover, these bonds endure long after Latino/as become established in the U.S. through stable employment, permanent residency and citizenship. Therefore this approach requires assessing the culture of their homelands, their lived experience in their countries of origin, and the ways these factors interact with their lives in the U.S. Rather than just relying on static, traditional conceptualizations of Latino/a sexual mores, healthcare seeking and information sharing, this approach recognizes the importance of the dynamic interactions and tensions between the cultures of countries of origin and that of the U.S.

Program Requirements

Latino/as can be of any race, and this funding opportunity announcement will define Latino/as as those who self-identify as having a Hispanic or Latino ethnicity, a category established by the

⁴⁸ Motel S & Patten E. The 10 Largest Hispanic Origin Groups: Characteristics, Rankings, Top Counties – Overview. Pew Hispanic Center, updated July 12, 2012. Available from: <http://www.pewhispanic.org/2012/06/27/the-10-largest-hispanic-origin-groups-characteristics-rankings-top-counties/>

⁴⁹ Although the ethnicity of Puerto Ricans is Hispanic/Latino/a, Puerto Rico is a U.S. Territory, and the U.S. Census does not consider Puerto Ricans living elsewhere in the U.S. to be foreign born. See U.S. Census, The Foreign Born From Latin America and the Caribbean: 2010 American Community Survey Brief, available from: <http://www.census.gov/prod/2011pubs/acsbr10-15.pdf>

⁵⁰ CDC. HIV among Latinos Fact Sheet, November 2011.

⁵¹ Motel S & Patten E. The 10 Largest Hispanic Origin Groups: Characteristics, Rankings, Top Counties – Economics and Health Insurance.

⁵² CDC. Geographic Differences in HIV Infection Among Hispanics or Latinos - 46 States and Puerto Rico, 2010.

⁵³ Carrillo H. Sexual Culture, Structure and Change – a Transnational Framework for Studies of Latino/a Migration and HIV,” in Organista K. (ed.) *HIV Prevention With Latinos – Theory, Research and Practice*. New York: Oxford University Press, 2012.

Office of Management and Budget's Standards for Data on Race and Ethnicity⁵⁴ and used by the U.S. Census Bureau. Although Latino/a people living with HIV infection are the primary target population for the multi-site evaluation of this initiative, this definition does not preclude the provision of services under this initiative to persons of any race, ethnicity, sex, sexual orientation, or gender identity.

Applicants must identify a Latino/a target population specific to country of origin that also includes gender (men, women, transgender women; some or all of these) and/or HIV transmission category (men who have sex with men, injection drug users or high-risk heterosexuals). At a minimum, each applicant will be expected to recruit at least 100 participants in its intervention. *Country of origin* as used in this announcement refers to place of birth and/or country of familial descent and heritage. *Transgender women* is used in this announcement to describe persons with female gender identities and/or gender expressions not associated with their male birth sex.

Successful applicants will demonstrate their familiarity with their local Latino/a target population, and be able to show high incidence and/or prevalence rates of HIV infection among Latinos/as within their jurisdictions, using the most recent, available data. Data sources may include but are not limited to HIV testing data; surveillance and epidemiology reports and profiles of state and local public health departments; needs assessment surveys; risk behavioral surveys and other Latino/a-specific studies. Applications should include a literature review that demonstrates an in-depth understanding of the issues that interfere with identifying, engaging and retaining Latino/a people living with HIV infection in HIV primary care. If applicable, applicants should review and cite successful HIV interventions conducted in their target population's country of origin, which may inform their proposed intervention.

Successful applicants will demonstrate their ability to connect with their target population through traditional and non-traditional outreach, to include churches, homes, schools and community groups. Applicants also must propose strategies to identify HIV positive Latino/as, with an emphasis on those who are unaware of their HIV infection. In 2006, CDC released its Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings⁵⁵ which seeks to increase HIV screening of patients, improve earlier detection of HIV infection and to connect those previously unaware of their infection into treatment and prevention services. To accomplish these objectives, these recommendations called for the expansion of HIV testing beyond traditional HIV providers to include hospital emergency rooms, urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, community clinics, correctional health-care facilities, and other primary care settings. Therefore applicants will be expected to effectively leverage their own existing HIV counseling and testing resources, as well as those within their service communities, to test and identify HIV-positive Latinos/as. Because the primary focus of this SPNS initiative is engagement and retention in HIV primary care, the SPNS program is limiting funding for HIV testing to a maximum of five (5) percent of total annual awards – **refer to budget section.**

⁵⁴ Office of Management and Budget. Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity – Appendix A (Excerpt from *Federal Register*, October 30, 1997). Available from: http://www.whitehouse.gov/sites/default/files/omb/assets/information_and_regulatory_affairs/re_app-a-update.pdf

⁵⁵ See CDC (2006) Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. *Morbidity and Mortality Weekly Report*, 55 (RR14): 1-17, available from: <http://www.cdc.gov/mmwr/pdf/rr/rr5514.pdf>.

Successful applications will demonstrate a thorough understanding of the issues specific to their service areas that interfere with identifying Latino/as who are unaware of their HIV status, as well as engaging and retaining those newly diagnosed in quality HIV primary care. Ryan White Parts A, B and C –funded organizations are already required to describe their strategies, plans and data for the Early Identification of Individuals with HIV/AIDS (EIIHA), which is defined as *the identifying, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to medical care.*⁵⁶ This initiative will use the 2013 EIIHA definition of those who are unaware of their HIV status as *any individual who has not been tested for HIV in the past 12 months, or any individual who has not been informed of their HIV test result (HIV positive or HIV negative), or any HIV positive individual who has not been informed of their confirmatory HIV test result.*⁵⁷

For the purposes of this funding opportunity announcement, HIV primary care is defined as the receipt of one or more of the thirteen core medical services specified by the Ryan White HIV/AIDS Program:⁵⁸

1. Outpatient and ambulatory health services
2. AIDS Drug Assistance Program (ADAP) treatments
3. AIDS pharmaceutical assistance (local)
4. Oral health care
5. Early intervention services
6. Health insurance premium and cost sharing assistance for low-income individuals
7. Home health care
8. Medical nutrition therapy
9. Hospice services
10. Home and community-based health services
11. Mental health services
12. Substance abuse outpatient care
13. Medical case management, including treatment adherence services

Successful applicants will propose interventions that address the structural, financial, personal and cultural barriers to access to care encountered by Latino/as living with HIV infection. *Structural barriers* may include but are not limited to the lack of community-based infrastructure to support timely entry and engagement in care; the availability of services; lack of housing and limited or no transportation. *Financial barriers* may include but are not limited to poverty; socioeconomic discrimination; lack of insurance, and lack of information on how to obtain or pay for HIV care services and medications. *Personal barriers* may include but are not limited to racial/ethnic discrimination; immigration status; language; acculturation level; interpersonal and bias-related violence; homophobia, biphobia and transphobia; injection drug use and other kinds of substance abuse. *Cultural barriers* may include but are not limited to stigma; Latino/a sociocultural factors such as *machismo, marianismo, fatalismo, familismo, personalismo,*

⁵⁶ See page 22 of the 2013 Ryan White Part B Funding Opportunity Announcement (HRSA-13-158) available from: <https://grants.hrsa.gov/webExternal/FundingOppDetails.asp?FundingCycleId=F4082369-0092-4E30-8C03-30904781F209&ViewMode=EU&GoBack=&PrintMode=&OnlineAvailabilityFlag=&pageNumber=&version=&NC=&Popup=>

⁵⁷ See Appendix 2 of the 2013 Ryan White Part B Funding Opportunity Announcement (HRSA-13-158)

⁵⁸ Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87), Section 2604, Use of Amounts.

simpatía; and the importance of religion. Applicants must include a stigma reduction plan in their proposed intervention to lessen its impact on their target population. Interventions may also address provider-patient communications and provider cultural competence; secondary prevention of HIV transmission; and patient education needs.

Applicants must include a description of the theoretical basis for their proposed intervention. Interventions may be based upon proven outreach and engagement models; and/or adaptations of proven models; and /or novel models of outreach and engagement in care. Although existing prevention interventions such as the DEBIs (Diffusion of Effective Behavioral Interventions)⁵⁹ may be adapted and incorporated into a demonstration site project, the goals of the interventions must focus on the identification, engagement and retention of Latino/a people living with HIV infection in care. Interventions that plan on utilizing HIV-positive peers as *promotores* or community health outreach workers to engage Latino/a PLWHA in care should refer to the resources of the Peer Education and Evaluation Resource Center, which includes a toolkit for training HIV-positive peers to engage PLWHA in care available in both English and Spanish.⁶⁰

Successful applicants will also be required to work collaboratively with the Evaluation and Technical Assistance Center (ETAC) funded under a separate announcement. The ETAC will fulfill three important roles for this SPNS initiative. With the collaboration of the SPNS Program, the ETAC will design and implement a comprehensive national multi-site evaluation to assess the interventions of the demonstration sites and the multi-site participant cohort as a whole. The ETAC also will provide technical assistance to the demonstration sites during regular teleconferences; through its website and webinars; during annual site visits; and at the twice-a-year national meetings of the initiative. Finally, the ETAC will lead publication and dissemination activities, in collaboration with the demonstration sites and SPNS Program staff. Applicants should carefully read the requirements for the ETAC under Announcement Number HRSA-13-151 to better understand the importance of the national, multi-site evaluation requirements.

Demonstration sites must agree to fully participate in the multi-site evaluation of this SPNS initiative led by the ETAC. Demonstration sites will be expected to collect and report relevant quantitative and qualitative outcome, process and cost measures for their interventions to the ETAC. These data may include but are not limited to client characteristics; biomedical and behavioral health indicators; barriers to access and factors facilitating the utilization of core HIV medical and support services; medication adherence; and other outcome measures as defined by the ETAC. A process evaluation will document any barriers to the effective implementation of strategies employed by the interventions. A cost analysis or effectiveness study will collect labor and programmatic costs incurred by the intervention, and applicants must have access to data from their most recent Ryan White Services Report (RSR) to establish baseline measures.

Applicants should note that clinical client level data will be collected and reported in this initiative to assess treatment efficacy and other outcome measures. If the applicant organization is not a direct provider of HIV primary medical care, it therefore must identify a medical provider organization with which to work collaboratively. The collaborating medical provider organization must state in a formal Memorandum of Agreement (to be included as an attachment in the application) its willingness and ability to collect and report such clinical data to the ETAC;

⁵⁹ See <http://www.effectiveinterventions.org/>

⁶⁰ See <http://peer.hdwg.org/>

its intentions to obtain Institutional Review Board (IRB) approval and annual renewals to do so; and its willingness to submit these IRB approvals and renewals to the ETAC and SPNS Program staff.

The ETAC may also conduct focused studies in addition to the multi-site evaluation regarding related aspects of HIV testing and treatment, and access to routine health care, mental health and substance abuse treatment services. Demonstration sites are also expected to participate in these focused studies, with specific topics generated by the ETAC in collaboration with the demonstration sites and the SPNS Program. Examples of these focused studies include but are not limited to case studies; provider-patient communications and provider cultural competencies; secondary prevention of HIV transmission; social support and patient education needs. These focused studies will be developed in collaboration with the demonstration projects and the SPNS program.

Demonstration sites also will be expected to conduct their own local evaluations to assess the effectiveness of their interventions in improving timely entry, engagement and retention of Latinos/as in quality HIV primary care. Successful applicants will describe a detailed plan for conducting a rigorous local evaluation of their interventions, including proposed evaluation questions to be explored and quantitative and/or qualitative methodology to be used to assess the effectiveness of their intervention. Proposed staffing plans must include at a minimum, a 25 percent full-time equivalent (.25 FTE) local evaluator or local evaluation team, to design and oversee the implementation of the local evaluation and coordinate the multi-site evaluation activities led by the ETAC. Proposed evaluation staff should have demonstrated knowledge and expertise in conducting health care evaluations.

On August 8, 2012, the Department of Health and Human Services Secretary, Kathleen Sebelius, released a set of seven common core indicators for monitoring HHS-funded prevention, treatment and care services.⁶¹ To assure expeditious translation of research into practice, both the demonstration sites and the ETAC will be required to incorporate these core indicators if the relevant services are being provided in planning their multi-site and local evaluations for this SPNS initiative. Applicants should also refer to the Institute of Medicine's report, *Monitoring HIV Care in the United States - Indicators and Data Systems*, when developing their proposed local evaluation plans.⁶²

Successful applicants will be required to submit their proposed local evaluation plan, the multi-site evaluation plan and any other related studies to their respective IRBs for review and approval. Demonstration sites will be required to submit to the ETAC and the SPNS Program on an annual basis proof of IRB approvals and renewals for all client-level data collection instruments, informed consents and evaluation materials. Demonstration sites also must cooperate with the ETAC and the SPNS Program regarding the privacy and confidentiality of study participants and their health-seeking efforts. Demonstration sites will be expected to conform to regulations for human subjects research protection as set forth in the Code of Federal

⁶¹ Department of Health and Human Services. Secretary Sebelius Approves Indicators for Monitoring HHS-Funded HIV Services. August 8, 2012. Available from: <http://blog.aids.gov/2012/08/secretary-sebelius-approves-indicators-for-monitoring-hhs-funded-hiv-services.html>

⁶² Institute of Medicine (2012) *Monitoring HIV Care in the United States - Indicators and Data Systems*. March 15, 2012. Washington, DC: The National Academies Press. Available from: http://www.nap.edu/catalog.php?record_id=13225

Regulations.⁶³ Therefore, the principal investigator, project director and other key project personnel should have received training in human subjects research protections, such as the National Institutes of Health (NIH) online course.⁶⁴ Applicants must have a written plan in place to safeguard study participants' privacy and confidentiality, in accordance with HIPAA regulations and human subjects research protections. Applicants also must demonstrate they have documented procedures for the electronic and physical protection of study participant information and data. If awarded, both the plan to safeguard study participants' privacy and confidentiality and the documented procedures for the electronic and physical protection of participant data will undergo review by the ETAC for its thoroughness, and any deficits must be remedied. All client-level data to be collected by demonstration sites in the multi-state evaluation must be electronically maintained and electronically transferable to the ETAC's web-based data collection system.

Successful applicants must agree to participate in publication and dissemination of program findings and lessons learned in collaboration with the ETAC and SPNS Program staff. Each demonstration site will be expected to contribute at least one project staff member to represent them on the initiative's publications and disseminations committee. Successful applicants will have personnel with the necessary skills to communicate project findings and lessons learned to local communities, state and national conferences, and policymakers, and to work collaboratively in writing and publishing findings in peer reviewed journals and making presentations at conferences. Project findings to be disseminated include, but are not limited to, innovative strategies and novel approaches to improve the identification of Latinos/as living with HIV infection; their timely entry, engagement and retention in high quality HIV primary care; lessons learned and best practices. Demonstration sites will be expected to contribute materials for inclusion on the initiative's website, which will be maintained by the ETAC.

In 2011 the SPNS Program began its iHiP (Integrating HIV Innovative Practices) web-based project for improved dissemination and enhanced replication of proven interventions from its previous initiatives.⁶⁵ iHiP includes resources and SPNS products such as training manuals, curricula and webinars, and will include intervention monographs documenting the methodology, implementation, outcomes and programmatic costs of proven interventions developed by SPNS demonstration projects. Demonstration sites will be expected to work collaboratively with the ETAC and SPNS staff to develop an intervention monograph for iHiP that will facilitate future replication of successful interventions. The draft and final versions of the monograph will be due in Year 5 of the initiative, with the ETAC coordinating its production and providing technical assistance to the demonstration projects in its development. In addition, the ETAC will partner with at their regional AIDS Education Training Center (AETC) to identify and develop training resources for the demonstration sites, and also to assist in the dissemination of findings from this initiative, including the Interventions Manual.

Demonstration sites will be expected to attend two national meetings with the ETAC, SPNS Program staff and the other demonstration sites in each year of this SPNS initiative. All SPNS Program grantee meetings will take place in the Washington, DC metropolitan area, and the grantee should allocate funds for the Principal Investigator or Project Director, Evaluator, and

⁶³ See Code of Federal Regulations, Title 45, Part 46 Protection of Human Subjects, Revised January 15, 2009 Effective July 14, 2009. Available from: <http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html>

⁶⁴ See <http://phrp.nihtraining.com/users/login.php>

⁶⁵ See <http://www.careactarget.org/library/integrating-hiv-innovative-practices-ihip>

one other key staff person to attend these 2 day meetings. Finally, successful applicants will be expected to address how their interventions, if proven successful, will be sustained within their service communities beyond the five year term of the SPNS Program initiative.

2. Background

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

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 2013 -2017. Approximately \$2,400, 000 is expected to be available annually to fund eight (8) grantees. Applicants may apply for a ceiling amount of up to \$300,000 per year. The project period is five (5) years. Funding beyond the first year is dependent on the availability of appropriated funds for the SPNS Program in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal government.

III. Eligibility Information

1. Eligible Applicants

Eligible applicants include public and nonprofit entities funded under Ryan White HIV Program Parts A, B, C and D. These include, but are not limited to state and local governments; academic institutions; local health departments; hospitals and outpatient clinics; community health centers receiving support under Section 330 of the PHS Act; Federally Qualified Health Centers as described in Title XIX, Section 1905 of the Social Security Act; faith-based and community-based organizations; and Indian Tribes or tribal organizations with or without Federal recognition. Consortia of multiple outpatient clinics serving the same identified target population are encouraged to apply.

2. Cost Sharing/Matching

Cost Sharing/Matching is not required for this program.

3. Other

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

SPNS funding may not be used to supplant or supplement Ryan White activities or services already funded under concurrent Parts A, B, C, D, or F grants.

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

NOTE: Multiple applications from a single organization are not allowable. Applicants for this funding opportunity announcement may not apply for funding under the Evaluation and Technical Assistance Center announcement (HRSA-13-151).

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials and Required Electronic Submission Information

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

IMPORTANT NOTICE: CCR moved to the System for Award Management (SAM) Effective July 30, 2012

The Central Contractor Registration (CCR) transitioned to the System for Award Management (SAM) on July 30, 2012.

For any registrations in process during the transition period, data submitted to CCR will be migrated to SAM.

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

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

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

Items to consider are:

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

To learn more about SAM, please visit <https://www.sam.gov>.

Note: SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). Grants.gov will reject submissions from applicants with expired registrations. Do not wait until the last minute to register in SAM. According to the SAM Quick Guide for Grantees (https://www.sam.gov/sam/transcript/SAM_Quick_Guide_Grants_Registrations-v1.6.pdf), an entity's registration will become active after 3-5 days. Therefore, ***check for active registration well before the application deadline.***

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

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

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

Applicants must submit proposals according to the instructions in the Guide and in this funding opportunity announcement in conjunction with Application Form SF-424. The forms contain

additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained by:

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

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

2. Content and Form of Application Submission

Application Format Requirements

The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. The total file size may not exceed 10 MB. The 80-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit. **HRSA strongly urges applicants to print their 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 the application can be printed efficiently and consistently for review.
-  Failure to follow the instructions may make the application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.
-  For electronic submissions, applicants only have to number the electronic attachment pages sequentially, resetting the numbering for each attachment, i.e., start at page 1 for each attachment. Do not attempt to number standard OMB approved form pages.
-  For electronic submissions, no Table of Contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.

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

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Grants.gov Lobbying Form	Form	Supports structured data for lobbying activities.	Optional, as applicable. Not counted in the page limit.
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list.	Not counted in the page limit.
Attachment 1-15	Attachment	Can be uploaded in Other Attachments form 1-15.	Refer to the attachment table provided below for specific 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 a table of contents cover page is included specific to the attachment. The Table of Contents page will not be counted in the page limit.
- 🔔 Please use only the following characters when naming your attachments: A-Z, 0-9, underscore (_), hyphen (-), space, period, and limit the file name to 50 or fewer characters. Attachments that do not follow this rule may cause the entire application to be rejected or cause issues during processing.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Copy of SF-424A Section B for Fifth Year Budget (not counted in the page limit)
Attachment 2	Line Item Budgets for Years 1 through 5 Spreadsheet Table
Attachment 3	Staffing Plan and Project Organizational Chart
Attachment 4	Position Descriptions
Attachment 5	Biographical Sketches of Key Personnel
Attachment 6	Statement of Consistency with Statewide Coordinated Statement of Need
Attachment 7	Logic Model
Attachment 8	Work Plan
Attachment 9	Signed letters of agreement, and descriptions of proposed and existing contracts
Attachment 10	Cultural and Linguistic Factors Competency Statement
Attachment 11	Statement of Consistency with Healthy People 2020
Attachments 12-15	Other Relevant Documents, as necessary

Application Format

i. Application Face Page

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

DUNS Number

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

Additionally, the applicant organization (and any subrecipient of HRSA award funds) is required to register annually with the System for Award Management (SAM) in order to conduct electronic business with the Federal Government. SAM registration must be maintained with current, accurate information at all times during which an entity has an active award or an application or plan under consideration by HRSA. It is extremely important to verify that the applicant organization SAM registration is active and the Marketing Partner ID Number (MPIN) is current. Information about registering with the SAM can be found at <https://www.sam.gov>. Please see Section IV of this funding opportunity announcement for SAM registration requirements.

ii. Table of Contents

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

iii. Budget

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

Sections A and B of the SF-424A as **Attachment 1**.

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

Salary Limitation:

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

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

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

iv. Budget Justification

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant **must** submit one-year budgets for each of the subsequent budget periods within the requested project period at the time of application. Line item information must be provided to explain the costs entered in the SF-424A. Be very careful about showing how each item in the

“other” category is justified. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative. Please note that the primary focus of this SPNS Program initiative is access to and retention in HIV primary care, and funding for HIV testing supplies or related testing programmatic costs will be limited to five (5) percent of total annual awards.

Budget for Multi-Year Award

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

Include the following in the Budget Justification narrative:

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

Sample:

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

*Actual annual salary = \$350,000

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

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. Long distance travel for three staff members to attend the two SPNS grantee meetings held each project year in Washington, DC should be broken down by airfare/train fare, ground transportation, lodging and meals and incidental expenses. Additionally, the budget should include travel costs for 2 staff members to attend the Ryan White All Grantees Meeting held in Washington, DC during Years 1

(2014) 3 (2016) and 5 (2016) of the project. The budget should also reflect the travel expenses associated with proposed trainings or workshops for project staff and participation in meetings to present SPNS findings in Years 4 and 5 of the project.

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; testing supplies are test kits, 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 SAM and provide the recipient with their DUNS number.

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

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

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

v. *Staffing Plan and Personnel Requirements*

Applicants must present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. The proposed staffing plan must include, at a minimum, a 25 percent

full time equivalent (0.25 FTE) local evaluator or local evaluation team to design and oversee the implementation of its local evaluation, and to work closely with the Evaluation and Technical Assistance Center (ETAC) to collect, report and analyze multi-site evaluation data. Applicants must also provide a project organizational chart in the form of a one-page figure that depicts the organizational structure of only the project, not the entire organization, and including subcontractors and other significant collaborators. Include the staffing plan and project organizational chart as **Attachment 3**.

Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff must be included as **Attachment 4**. Biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included as **Attachment 5**. When applicable, biographical sketches should include training, language fluency and experience working with the cultural and linguistically diverse populations that are served by their programs.

vi. Assurances

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

If research involving human subjects is anticipated, applicants must meet the requirements of the HHS regulations to protect human subjects from research risks as specified in the Code of Federal Regulations, Title 45 – Public Welfare, Part 46 – Protection of Human Subjects (45 CFR 46), available online at www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html.

vii. Certifications

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

viii. Project Abstract

Provide a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, and the population group(s) to be served.

Please place the following at the top of the abstract:

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

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

ix. Project Narrative

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

Use the following section headers for the Narrative:

▪ **INTRODUCTION**

Provide a clear and succinct description of the proposed project to implement an intervention model designed to improve timely entry, engagement and retention in quality HIV primary care for Latinos/as living with HIV infection. Briefly describe the proposed strategies to identify Latinos/as who are at high risk of HIV infection or are infected with HIV but are unaware of their HIV status; are aware of their HIV infection but have never been engaged in care; are aware but have refused referral to care; or have dropped out of care in your service area. Briefly describe the proposed innovative strategies that will facilitate the identification, engagement and retention in care of Latinos/as living with HIV in your service area. Briefly describe how the intervention model will address the principal structural, financial, personal and cultural barriers to access and retention in care encountered by Latinos/as living with HIV in your service area.

▪ **NEEDS ASSESSMENT**

Provide a succinct summary of the literature that demonstrates a comprehensive understanding of the issues that interfere with identifying, engaging and retaining Latinos/as living with HIV in quality HIV primary care. Describe the Latino/a population in your service area, to include its countries of origin; other demographic information; and HIV incidence and/or prevalence rates, using the most recent, available data. Sources for HIV data may include HIV testing data; surveillance and epidemiology reports and profiles of state and local public health departments; needs assessment surveys; risk behavioral surveys and other Latino/a-specific studies. Describe existing HIV counseling and testing, substance abuse treatment, mental health, family planning, and primary care services for this population, with a focus on specific issues unique to your service area that interfere with identifying Latinos/as who are at high risk of HIV infection or are infected with HIV but are unaware of their HIV status; are aware of their HIV infection but have never been engaged to care; are aware but have refused referral to care; or have dropped out of care.

Authorizing legislation indicates that the Secretary may not make a grant unless the applicant demonstrates the proposed program is consistent with the Statewide Coordinated Statement of Need (SCSN), and that the applicant agrees to participate in the ongoing revision process of the SCSN. Provide a statement indicating how the proposed project is consistent with your state's SCSN,⁶⁶ and include as **Attachment 6**.

▪ **METHODOLOGY**

Identify your specific Latino/a target population by its country of origin, and include its gender composition (men; women; transgender women; some or all of these) and/or HIV transmission category (heterosexuals, injection drug users, or men who have sex with men). Provide an estimate of the numbers of participants you expect to recruit for your

⁶⁶ If applicable, please note that in regard to this requirement, transgender women may be counted as Men who have Sex with Men (MSM) or contained within the MSM classification category in the SCSN.

intervention, with a minimum of 100 participants. Describe your familiarity and ability to connect with the target population through traditional and non-traditional outreach, to include churches, schools, homes, and community groups.

Describe all necessary components of your innovative intervention model and its specific strategies that will facilitate timely entry, engagement and retention in quality HIV primary care for your target population. Provide the theoretical basis for these strategies and the rationale for their use, including the transnational approach as specified earlier. If applicable, identify any successful HIV interventions conducted in your target population's country of origin, which inform your proposed intervention.

Describe your strategies to identify HIV positive Latino/as, with an emphasis on those who are unaware of their HIV infection. Describe how these strategies address key factors identified in the literature and those specific to your service area that interfere with identifying Latinos/as who are unaware of their HIV status. Describe any plans for HIV testing of Latinos/as by your organization and other organizations in your service community, and how these plans will address any anticipated challenges in the provision of counseling and testing to Latinos/as.

Describe your strategies to engage and retain in care Latinos/as who are newly diagnosed, or identified as HIV positive and out of care, during the project, and what challenges you anticipate to their engagement and retention in HIV primary care. Describe how your proposed intervention addresses key factors identified in the literature and those specific to your service area that interfere with engaging and retaining Latinos/as in quality HIV primary care. Describe a plan to reduce the impact of stigma in access to and retention in HIV primary care by the target population.

Describe a plan for creating a new or improving an existing referral network that will link Latinos/as to HIV medical care and support services to ensure a continuum of community-based care. The plan may include linkage and retention strategies such as collaborative arrangements between medical, mental health and substance abuse treatment providers; transportation, legal and vocational rehabilitation assistance; coordinated treatment and case management; and patient navigation and peer support.

Provide a logic model⁶⁷ that illustrates the inputs, activities, outputs, and the short-term, intermediate and long term outcomes of the proposed project. Illustrate the logical flow at client, provider and structural levels, and include inputs and resources utilized to implement the components of the intervention, and anticipated outcomes as outputs. Include the proposed project's Logic Model as **Attachment 7**.

Provide a detailed proposal for a rigorous local evaluation plan to evaluate the effectiveness of your intervention in improving timely entry, engagement and retention of Latinos/as in quality HIV primary care. Discuss proposed evaluation questions to be explored and the quantitative and/or qualitative methodology to be used to assess the effectiveness of your intervention.

⁶⁷ Additional information on developing logic models can be found at:
http://www.cdc.gov/nccdphp/dnpao/hwi/programdesign/logic_model.htm

State explicitly your willingness to fully cooperate and work collaboratively with the ETAC throughout the initiative. This collaboration includes but is not limited to data collection and reporting of outcome, process and cost data for the multi-site evaluation and additional focused evaluation studies; development an interventions monograph for iHIP; and publication and dissemination efforts of the initiative's findings and lessons learned at the national, State and local levels. Describe your familiarity with and ability to access the data from your most recent Ryan White Services Report (RSR) submitted to the HIV-AIDS Bureau of HRSA.

Identify the Institutional Review Board (IRB) which will review your local evaluation plan and the multi-site evaluation plan. State your agreement to submit to the ETAC and to the SPNS program on an annual basis proof of IRB approvals and renewals for all client-level data collection instruments, informed consents and evaluation materials. State your agreement to cooperate with the ETAC and SPNS Program staff regarding the privacy and confidentiality of study participant medical records.

Discuss how the intervention, if proven successful, might be sustained within your service community beyond the five year project period the SPNS initiative.

- *WORK PLAN*

Provide a work plan that delineates all steps and activities that will be used to achieve the goals and objectives of your proposed project. The work plan should directly relate to your Methodology section and the program requirements of this announcement. Include all aspects of planning, implementation, and evaluation, listing the role of everyone involved in each activity. The work plan should include clearly written (1) goals; (2) objectives that are specific, time-framed, and measurable; (3) action steps; (4) staff responsible for each action step; and (5) anticipated dates of completion. Please note that goals for the work plan are to be written for the entire proposed five year project period, but objectives and action steps are required only for the goals set for Year 1. Clearly indicate the anticipated start date of the intervention, and provide numbers for targeted outcomes where applicable, not just percentages. Include the project's work plan in **Attachment 8**.

- *RESOLUTION OF CHALLENGES*

Discuss the challenges that are likely to be encountered in planning and implementing the project's activities described in the work plan, and describe realistic and appropriate approaches to be used to resolve these challenges.

- *EVALUATION CAPACITY*

Describe your capacity to conduct a comprehensive local evaluation of the proposed project. Describe how the proposed key project personnel (including any consultants and subcontractors) have the necessary knowledge, experience, training and skills in designing and implementing public health program evaluations, specifically evaluations of innovative access to and retention in HIV primary care projects. Include any specific experience in the evaluation of programs reaching those who are unaware of their HIV status or those aware but out of care, or programs serving Latinos/as at risk or living with HIV infection.

Describe any training in human subjects research protection by proposed key project staff. Describe your plan to safeguard the privacy and confidentiality of study participants, and your documented procedures for the electronic and physical protection of study participant information and data, in accordance with HIPAA regulations and human subjects research protections. State your willingness to have both the plan and procedures reviewed by ETAC staff for its thoroughness, and to remedy any deficits identified with the assistance of the ETAC.

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

- ***ORGANIZATIONAL INFORMATION***

Describe your organization's mission and experience in implementing and managing HIV programs serving Latinos/as. Provide information on your organization's current structure and scope of current activities. Describe how these all contribute to the ability of your organization to conduct the proposed project and meet the expectations of the program requirements. Describe the current HIV counseling and testing capacity of your organization, and any existing collaborative arrangements with other organizations within your service area that provide HIV counseling and testing services. Describe the capacity of your organization's management information system (MIS) to support a comprehensive local evaluation in the collection, reporting and secure storage of study participant data.

If applicable, describe the roles and responsibilities of any consultants and/or subcontractors will be used to carry out aspects of the proposed project. If applicable, identify any collaborating organizations that will assist the applicant through HIV testing to identify Latinos/as living with HIV infection. If applicant is not a direct provider of HIV primary medical care, identify at least one medical provider organization with which to work collaboratively. The collaborating medical provider organization must state in a formal Memorandum of Agreement: 1) its willingness and ability to collect and report such clinical data to the ETAC; 2) its intentions to obtain Institutional Review Board approval and annual renewals to collect and report this data; and 3) its willingness to submit these IRB approvals and renewals to the ETAC and SPNS Program staff.

Any current and/or proposed collaborating organizations, consultants and/or subcontractors must demonstrate their commitment to fulfill the goals and objectives of the project through signed and dated letters of support or memoranda of agreement or understanding. Include any such letters or memoranda, and descriptions of any existing or proposed contracts relating to the proposed project, as **Attachment 9**.

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

Describe your cultural competency capabilities. *Cultural competence* means having a set of congruent behaviors, attitudes, and policies that come together in a system or organization or among professionals that enables effective work in cross-cultural situations.⁶⁸ It includes an understanding of integrated patterns of human behavior, including language, beliefs, norms, and values, as well as socioeconomic and political factors that may have significant impact on psychological well-being and incorporating those variables into assessment and treatment. Include the project's cultural and linguistic competence factors in **Attachment 10**.

x. **Attachments**

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

Attachment 1: Copy of SF-424A Sections A and B for Year 5 Budget

For the proposed year 5 budget, complete and submit a copy of Sections A and B of the SF-424A. Not counted in the page limit.

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

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

Attachment 3: Staffing Plan and Project Organizational Chart

The staffing plan should include education and professional qualifications for each staff position. The staffing plan should also include a justification for the amount of time requested for each staff position. The organization chart should be a one-page figure that depicts the organizational structure of only the project, not the entire organization, and it should include consultants, subcontractors and other significant collaborators.

Attachment 4: Position Descriptions

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

Attachment 5: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in Attachment 3 not to exceed two pages in length. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch.

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

Authorizing legislation indicates that the Secretary may not make a grant unless the applicant demonstrates the proposed program is consistent with the statewide coordinated

⁶⁸ See Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services*. OMH, DHHS, 2007 Available from: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

statement of need (SCSN), and agrees to participate in the ongoing revision process of such statement of need. Please describe how the program is consistent with your State's or Territory's SCSN.

Attachment 7: Logic Model

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

Attachment 8: Work Plan

The work plan should include clearly written (1) goals; (2) objectives that are specific, time-framed, and measurable; (3) action steps; (4) staff responsible for each action step (including consultants); and (5) anticipated dates of completion. Please note that goals for the work plan are to be written for the entire proposed five year project period, but objectives and action steps are required only for the goals set for Year 1.

Attachment 9: Signed and Dated Letters of Support, Memoranda of Agreement or Understanding, and Descriptions of Proposed and Existing Contracts

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

Attachment 10: Cultural and Linguistic Factors Competency Statement

The Health Resources and Services Administration (HRSA) envisions optimal health for all, supported by a health care system that assures access to comprehensive, culturally competent, quality care. HRSA defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, organization, or among professionals and enable that system, organization, or those professionals to work effectively in cross-cultural and linguistically diverse situations. Healthcare providers funded through HRSA grants need to be alert to the importance of cross-cultural and language-appropriate communications, as well as general health literacy issues. HRSA supports and promotes a unified health communication perspective that addresses cultural competency, limited English proficiency, and health literacy in an integrated approach in order to develop the skills and abilities needed by HRSA-funded providers and staff to deliver the best quality health care effectively to the diverse populations they serve.

HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, and materials delivered by competent providers in a manner that factor 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 published by the U.S. Department of Health and Human Services.⁶⁹

Describe the program's or institution's strategic plan, policies, and initiatives that demonstrate a commitment to providing culturally and linguistically competent health care and developing culturally and linguistically competent health care providers, faculty, staff, and program participants. This includes participation in, and support of programs that focus on cross-cultural health communication approaches as strategies to educate health care providers serving diverse patients, families, and communities.

Describe the organization's programs that work to (1) improve medication compliance of patients, and (2) improve patient understanding regarding health conditions and (3) improve the ability of the patient to manage their condition. Wherever appropriate, describe a plan to recruit and retain key staff with demonstrated experience serving the specific target population and familiarity with the culture and language of the particular communities served.

Describe the program or institution's strategic plan, policies, and initiatives that demonstrate a commitment to serving the specific target population and familiarity with the culture and literacy level of the particular target group. Present a summary of specific training, and /or learning experiences to develop knowledge and appreciation of how culture and language influences health literacy improvement and the delivery of high quality, effective and predictably safe healthcare services.

Attachment 11: Statement of Consistency with Healthy People 2020

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

Attachment 12 -15: Other Relevant Documents, as Necessary

Include here any other documents that are relevant to the application and or referenced in the application. If you are submitting an Indirect Cost Rate agreement, please attach it here. Indirect Cost Rate Agreements will not count toward the page limit.

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement is March 18, 2013 at 11:59 P.M. Eastern Time. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically to the correct funding opportunity announcement number, by the organization's Authorized Organization Representative (AOR) through Grants.gov and validated by Grants.gov on or before the deadline date and time.

Receipt acknowledgement: Upon receipt of an application, Grants.gov will send a series of email messages to document the progress of an application through the system.

⁶⁹ See *National Standards for Culturally and Linguistically Appropriate Services at:* <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

1. The first will confirm receipt in the system;
2. The second will indicate whether the application has been successfully validated or has been rejected due to errors;
3. The third will be sent when the application has been successfully downloaded at HRSA; and
4. The fourth will notify the applicant of the Agency Tracking Number assigned to the application.

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

Late applications:

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

4. Intergovernmental Review

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

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

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

- 1) To directly provide health care or testing services that are billable to third party payers (e.g., private health insurance, prepaid health plans, Medicaid, Medicare, other Ryan White Program funding including ADAP);

- 2) To directly provide health care services that duplicate existing services;
- 3) Purchase, construction of new facilities or capital improvements to existing facilities;
- 4) Purchase or improvement to land;
- 5) Purchase vehicles;
- 6) Fundraising expenses;
- 7) Lobbying activities and expenses;
- 8) Reimbursement of pre-award costs;
- 9) International travel; and/or
- 10) Cash payments to intended service recipients, as opposed to various non-cash incentives to encourage participation in evaluation activities.

SPNS funding may not be used to supplant or supplement concurrent Ryan White activities or services already funded under any other Part grants. Funds awarded under this grant may not be used for direct services, including HIV care and counseling and testing, that are billable to third party payers.

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

Per Division F, Title V, Section 503 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011 (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself. (b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government. (c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

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

6. Other Submission Requirements

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

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

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

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

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

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

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

Tracking an application: It is incumbent on the applicant to track their application by using the Grants.gov tracking number (GRANTXXXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking an application can be found at

<https://apply07.grants.gov/apply/checkApplStatus.faces>. Be sure the application is validated by Grants.gov prior to the application deadline.

V. Application Review Information

1. Review Criteria

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

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

Criterion 1: NEED (10 Points)

The extent to which the application demonstrates an understanding of and associated contributing factors to the problem. Strength, clarity and quality of applicants introduction and needs assessment as it relates to timely entry, engaging and Latinos/as in care and services.

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

i. Introduction

- Strength and clarity of the applicant's succinct description of the proposed project and its intervention model designed to improve timely entry, engagement and retention in quality HIV primary care for Latinos/as.
- Strength and clarity of the brief description of the proposed strategies for identifying Latinos/as who are at high risk of HIV infection or are infected with HIV but are unaware of their HIV status; are aware of their HIV infection but have never been engaged in care; are aware but have refused referral to care; or have dropped out of care in its service area.
- Strength and clarity of the brief description of proposed innovative strategies that will facilitate the engagement and retention in care of Latinos/as living with HIV in the applicant's service area.
- Strength and clarity of the brief description of how the intervention model addresses the principal structural, financial, personal and cultural barriers to access and retention in care encountered by Latinos/as living with HIV in the applicant's service area.

ii. Needs Assessment

- Strength and clarity of the applicant's succinct summary of the literature demonstrating its understanding of the issues that interfere with identifying, engaging and retaining Latinos/as living with HIV infection in quality HIV primary care.

- Strength and clarity of the applicant’s description of the Latino/a population in its service area, including its countries of origin; other demographic information; and HIV incidence and/or prevalence rates, using the most recent, available data.
- Strength and clarity of the applicant’s description of the specific issues unique to its service area that interfere with identifying Latinos/as who are at high risk of HIV infection or are infected with HIV but are unaware of their HIV status; that are aware of their HIV infection but have never been engaged to care; are aware but have refused referral to care; or have dropped out of care.
- Strength and clarity of the applicant’s statement of consistency with the Statewide Coordinated Statement of Need⁷⁰ (**Attachment 6**).

Criterion 2: RESPONSE (35 Points)

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

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

i. Methodology

- Strength and clarity of the applicant’s description of the specific target population of its project by country of origin, gender and/or transmission category.
- Evidence the applicant has provided an estimate of the numbers of participants it expects to recruit for the intervention (with a minimum of 100 participants).
- Strength of the applicant’s description of its familiarity and ability to connect with its target population through traditional and non-traditional outreach, including churches, homes, schools and community groups.
- Strength and feasibility of the applicant’s proposed strategies to identify HIV positive Latino/as, with an emphasis on those who are unaware of their HIV infection.
- Extent to which the proposed identification strategies address key factors identified in the literature and specific to the applicant’s service area that interfere with identifying Latinos/as who are unaware of their HIV status.
- Strength and feasibility of applicant’s plans for HIV testing of Latinos/as in their service community, and how well these plans address any anticipated challenges in the provision of counseling and testing to Latinos/as.
- Strength and feasibility of the applicant’s proposed strategies to engage and retain in care those Latinos/as who are newly diagnosed, or identified as HIV positive and out of care, during the project.
- Extent to which the proposed engagement and retention strategies address key factors identified in the literature and specific to the applicant’s service area that interfere with engaging and retaining Latinos/as in quality HIV primary care.
- Strength and feasibility of the applicant’s proposed stigma reduction plan.

⁷⁰ If applicable, please note that in regard to this requirement, transgender Latinas may be counted as Men who have Sex with Men (MSM) or contained within the MSM of color classification category in the SCSN.

- Strength and feasibility of the linkage and retention strategies proposed in the applicant's plan to create a new or improve an existing referral network that will link Latinos/as to HIV medical care and support services to ensure a continuum of community-based care.
- Strength and clarity of the theoretical basis and rationale for the use of the interventions proposed strategies, including the transnational approach.
- If applicable, the appropriateness of any successful HIV interventions conducted in your target population's country of origin, which inform your proposed intervention.
- Strength of the applicant's logic model that illustrates the inputs, activities, outputs, and the short-term, intermediate and long term outcomes of the proposed project (**Attachment 7**).

ii. Work Plan

- Strength, clarity and feasibility of the applicant's Work Plan and its goals for the 5-year project period (**Attachment 8**).
- Extent to which the applicant's Work Plan addresses the program requirements the applicant described in the Methodology section of the Narrative.
- Evidence the applicant's objectives for Year 1 are specific to each goal, time-framed, and measurable.
- Evidence the applicant's Work Plan includes each planning, implementation and evaluation activity; the staff responsible to accomplish each step; and anticipated dates of completion.
- Evidence the applicant clearly identifies the project's anticipated start date of the intervention, and provides numbers for targeted outcomes where applicable, not just percentages.

iii. Resolution of Challenges

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

Criterion 3: EVALUATIVE MEASURES (20 points)

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

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

- Strength and clarity of the applicant's plan for a rigorous local evaluation plan to evaluate the effectiveness of the intervention in improving timely entry, engagement and retention of Latinos/as in quality HIV primary care.
- Strength and clarity of the applicant's discussion of the proposed evaluation questions to be explored and quantitative and/or qualitative methodology to be used to assess the effectiveness of the intervention.

- Evidence of the applicant's agreement to fully cooperate and work collaboratively with the ETAC, including data collection and reporting for the multi-site evaluation; additional focused studies; development of an interventions monograph for iHIP; and publication and dissemination efforts of the initiative's findings and lessons learned.
- Extent to which the applicant is familiar with and able to access the data from its most recent Ryan White Services Report (RSR) submitted to the HIV-AIDS Bureau of HRSA.
- Evidence of the applicant's identification of the Institutional Review Board (IRB) which will review and approve its local evaluation plan and the multi-site evaluation plan.
- Evidence of the applicant's agreement to submit proof of IRB approvals and renewals for all client-level data collection instruments, informed consents and evaluation materials to the ETAC and to the SPNS program on an annual basis.
- Evidence of the applicant's agreement to cooperate with the ETAC and SPNS Program staff regarding the privacy and confidentiality of study participant medical records.

Criterion 4: IMPACT (10 Points)

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

This corresponds to the Methodology section of the Narrative.

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

Criterion 5: RESOURCES/CAPABILITIES (15 Points)

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

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

- Strength of the applicant's capacity to conduct a comprehensive local evaluation of the proposed project.
- Extent to which the proposed key project personnel (including any consultants and subcontractors) possess the necessary knowledge, experience, training and skills in designing and implementing public health program evaluations, specifically evaluations of innovative access to and retention in HIV primary care projects.
- Evidence of any specific experience of proposed key staff in the evaluation of programs reaching those who are unaware of their HIV status or those aware but out of care, or programs serving Latinos/as at risk or living with HIV infection.
- Evidence of any training in human subjects research protection by proposed key project staff of the applicant.

- Strength of the applicant's description of its plan to safeguard the privacy and confidentiality of study participants, and documented procedures for the electronic and physical protection of study participant information and data, in accordance with HIPAA regulations and human subjects research protections.
- Evidence of the applicant's willingness to have both its plan to safeguard study participants' privacy and confidentiality and its documented procedures for the protection of participant data reviewed by ETAC staff, and to remedy any identified deficits with the ETAC's assistance.
- Extent to which proposed key project personnel (including any consultants and subcontractors) have experience in participating in a multi-site evaluation of national scope.
- Extent to which proposed key project personnel (including any consultants and subcontractors) have experience in writing and publishing study findings in peer reviewed journals and in disseminating findings to local communities, national conferences and to policy makers.
- The extent to which the applicant's mission and experience has been focused in implementing and managing HIV programs serving Latinos/as.
- The extent to which the applicant's organizational current structure and scope of current activities contribute to its ability to conduct the proposed project and meet the expectations of the program requirements.
- Strength of the applicant's current HIV counseling and testing capacity, and any existing collaborative arrangements with other organizations that provide HIV counseling and testing services within its service area.
- Strength of the capacity of the applicant's management information system (MIS) to support a comprehensive local evaluation in the collection, reporting and secure storage of study participant data.
- If applicable, clarity of description and appropriateness of the roles and responsibilities of consultants and/or subcontractors to be used to carry out aspects of the project.
- If applicable, evidence of applicant's identification of collaborating organizations that will assist the applicant through HIV testing to identify Latinos/as living with HIV infection.
- If applicable (when applicant is not a direct provider of HIV primary medical care): evidence the applicant has identified a medical provider organization with which to work collaboratively. This must include a signed and dated formal Memorandum of Agreement in which a medical provider organization states: 1) its willingness and ability to collect and report such clinical data to the ETAC; 2) its intentions to obtain Institutional Review Board approval and annual renewals to collect and report this data; and 3) its willingness to submit these IRB approvals and renewals to the ETAC and SPNS Program staff (**Attachment 9**).
- If applicable, the strength and appropriateness of signed and dated letters or memoranda of agreement or understanding from current and proposed collaborating organizations, consultants and subcontractors to fulfill the goals and objectives of the project (**Attachment 9**).
- If applicable, clarity of the description of anticipated needs for technical assistance in the design, implementation and evaluation of the applicant's project, as well as any anticipated staff training needs.
- Strength of the applicant's cultural competency capabilities (**Attachment 10**).

Criterion 6: SUPPORT REQUESTED (10 Points)

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

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

i. Budget and Budget Justification

- Strength of the applicant's line item budgets for each year of the project period (**Attachment 2**) and their appropriateness to the proposed work plan.
- Strength and clarity of the application's budget justification narrative's support for each line item.
- Evidence the line item budgets specify allocations for staffing in percentages of full-time equivalents (FTEs) that are adequate for the proposed activities for each year of the project.
- If applicable, the extent to which contracts for proposed subcontractors and consultants are clearly described in terms of contract purposes; how costs are derived; and that payment mechanisms and deliverables are reasonable and appropriate.
- Evidence the budgets allocate sufficient support to meet the long distance travel expenses associated with the two SPNS Program grantee meetings held each project year in Washington, DC; and any travel relating to proposed staff training.
- Evidence the budget allocates no more than 5 percent of its total to support HIV testing activities.

ii. Staffing Plan

- The extent to which the staffing plan and project organizational chart (**Attachment 3**) are consistent with the project description and project activities.
- Evidence the staffing plan includes sufficient personnel to successfully implement all of the project activities throughout the project as described in the work plan.
- Extent to which the time allocated for staff is consistent with their anticipated workload and the goals and objectives of the project.
- Evidence the staffing plan includes a qualified evaluator or evaluation staff at a minimum a 25 percent full-time equivalent (.25 FTE) level.
- Strength and appropriateness of the job descriptions for key staff (**Attachment 4**).
- Strength and appropriateness of the biographical sketches (**Attachment 5**)

2. Review and Selection Process

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

criteria noted above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

Applications that pass the initial HRSA eligibility screening will be reviewed and rated by a panel based on the program elements and review criteria presented in Section V. 1. Review Criteria of this funding opportunity announcement. The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

3. Anticipated Announcement and Award Dates

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

VI. Award Administration Information

1. Award Notices

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's 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 NoA sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-Federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative, and reflects the only authorizing document. It will be sent prior to the start date of September 1, 2013.

2. Administrative and National Policy Requirements

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

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

Non-Discrimination Requirements

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

Human Subjects Protection

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

Trafficking in Persons

Awards issued under this funding opportunity announcement are subject to the requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to <http://www.hrsa.gov/grants/trafficking.html>.

Smoke-Free Workplace

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

Cultural and Linguistic Competence

HRSA programs serve culturally and linguistically diverse communities and multiple cultures. Although race and ethnicity are often thought to be dominant elements of culture, HRSA-funded programs embrace a broader definition to incorporate diversity within specific cultural groups including but not limited to cultural uniqueness within Native American populations, Native Hawaiian, Pacific Islanders, and other ethnic groups, language, gender, socio-economic status, sexual orientation and gender identity, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA-supported entities respect and respond to the cultural diversity of communities, clients and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations

served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) published by HHS and available online at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>. Additional cultural competency and health literacy tools, resources and definitions are available online at <http://www.hrsa.gov/culturalcompetence> and <http://www.hrsa.gov/healthliteracy>.

Healthy People 2020

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

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.

b. Payment Management Requirements

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

c. Status Reports

1) **Federal Financial Report.** The Federal Financial Report (SF-425) is required according to the following schedule:
<http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrschedule.pdf>. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the NoA.

2) **Progress Report(s).** The awardee must submit a progress report to HRSA on a semi-annual basis. Submission and HRSA approval of grantee Progress Report(s) triggers the budget period renewal and release of subsequent year funds. Further information regarding the semi-annual progress reports will be provided in the Notice of Grant Award.

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

4) **Tangible Personal Property Report.** If applicable, the awardee must submit the Tangible Personal Property Report (SF-428) and any related forms. The report must be submitted within 90 days after the project period ends. Awardees are required to report all federally-owned property and acquired equipment with an acquisition cost of \$5,000 or more per unit. Tangible personal property means property of any kind, except real property, that has physical existence. It includes equipment and supplies. Property may be provided by HRSA or acquired by the recipient with award funds. Federally-owned property consists of items that were furnished by the Federal Government. Tangible personal property reports must be submitted electronically through EHB. More specific information will be included in the Notice of Grant Award.

d. Transparency Act Reporting Requirements

New awards (“Type 1”) issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier 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 NoA.

VII. Agency Contacts

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

Beverly Smith
Attn.: HRSA Division of Grants Management Operations, OFAM

Parklawn Building, Room 15-19
5600 Fishers Lane
Rockville, MD 20857 Telephone: (301) 443-7065
Fax: (301) 443-6343
Email: BSmith@HRSA.gov

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

Adan Cajina
Demonstration and Evaluation Branch
Attn: *Culturally Appropriate Interventions of Outreach, Access and Retention among Latino(a) Populations – Demonstration Sites* (# HRSA-13-154)
HIV/AIDS Bureau, HRSA
Parklawn Building, Room 7-74
5600 Fishers Lane
Rockville, MD 20857
Telephone: 301-443-3180
Fax: (301) 594-2511
Email: ACajina@hrsa.gov

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

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

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

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

VIII. Tips for Writing a Strong Application

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

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