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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 – Evaluation and Technical Assistance Center*

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# **I. Funding Opportunity Description**

## **1. Purpose**

This announcement solicits applications for a Special Projects of National Significance (SPNS) Program *Culturally Appropriate Interventions of Outreach, Access and Retention among Latino/a Populations – Evaluation and Technical Assistance Center*, for a new Special Projects of National Significance (SPNS) Program multi-site initiative. Under this funding opportunity announcement (FOA), a cooperative agreement will be issued to support one organization for up to five years to evaluate and provide technical assistance for up to eight demonstration projects funded under a separate FOA, *Culturally Appropriate Interventions of Outreach, Access and Retention among Latino(a) Populations – Demonstration Sites* (HRSA-13-154). Organizations that apply under this FOA are not eligible to also apply under the Demonstration Sites FOA.

The demonstration site projects will design, implement and evaluate culturally appropriate service delivery models focused on improving health outcomes among Latinos/as living with HIV disease. This initiative will take a transnational approach, with demonstration project applicants proposing innovative interventions targeting HIV-affected Latino/a subpopulations living in the U.S. but specific to their country of origin. The initiative will focus on 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. Demonstration project applicants will 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. Latino/a subpopulations of interest include but are not limited to heterosexual men, heterosexual women, gay and bisexual men, bisexual women, transgender women, and/or injecting drug users (IDUs) located in areas with high concentration of Latino/as with high incidence and/or prevalence of HIV/AIDS, especially in urban areas.

The Evaluation and Technical Center (ETAC) will be expected to fulfill three important functions for this SPNS initiative. The ETAC will 1) provide technical assistance to the demonstration projects over the course of the initiative; 2) conduct a rigorous multi-site evaluation of the implementation and outcomes of all interventions and the multi-site cohort as a whole; and 3) lead and coordinate the efforts for publication and dissemination of findings and lessons learned from the initiative. The ETAC will work in close consultation with the SPNS program in all aspects of the initiative, but especially in the implementation of the multi-site evaluation and dissemination.

The successful applicant will demonstrate expertise in engagement and retention in HIV primary care. Applications should include a literature review that demonstrates an in-depth understanding of the Latino/a population and the challenges involved in identifying Latinos/as who are unaware of their HIV status, as well as engaging and retaining those newly diagnosed in HIV primary care. Applicants should discuss the sociocultural and structural barriers, especially stigma, that affect Latino/as' access and retention in HIV primary care. Applicants should also discuss the factors driving HIV incidence and prevalence rates among Latinos/as using the most recent, available data. Finally, applicants should propose a multi-site evaluation plan that will produce findings that enhance knowledge of the disparities in health outcomes affecting Latino populations living in the United States (U.S.).

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.<sup>1</sup> 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 U.S. at the end of 2009, with almost 20 percent unaware of their infection.<sup>2</sup> Although representing 16 percent of the total U.S. 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.<sup>3</sup> By the end of 2009, over 114,000 Latino/as had died from HIV/AIDS since the epidemic began in the U.S.<sup>4</sup>

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.<sup>5</sup> Latino MSM comprised nearly two-thirds of all new infections among Latino/as, and comprise the single largest subgroup of Latino people living with HIV/AIDS.<sup>6</sup> 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.<sup>7</sup> 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.<sup>8,9,10,11,12</sup> The CDC's National HIV Behavioral

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

<sup>2</sup> 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, 2010—United States. Available from: [http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp\\_vol17no3/pdf/hssr\\_vol\\_17\\_no\\_3.pdf#page=22](http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp_vol17no3/pdf/hssr_vol_17_no_3.pdf#page=22)

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

<sup>4</sup> 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](http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010_HIV_Surveillance_Report_vol_22.pdf#Page=44)

<sup>5</sup> 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](http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010_HIV_Surveillance_Report_vol_22.pdf#Page=26)

<sup>6</sup> 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>

<sup>7</sup> CDC. HIV Surveillance Report, Volume 22, Table 3b.

<sup>8</sup> 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.

<sup>9</sup> 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.

<sup>10</sup> 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.

<sup>11</sup> 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.

<sup>12</sup> 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.

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.<sup>13</sup>

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.”<sup>14</sup>

The National HIV/AIDS Strategy (NHAS)<sup>15</sup> has three primary goals: (1) reducing the number of people who become infected with HIV; (2) increasing access to care and optimizing health outcomes for people living with HIV; and (3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for people living with HIV to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against people living with HIV. To the extent possible, program activities should strive to support the three primary goals of the NHAS. As encouraged by the NHAS, programs should seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. Programs providing direct services should comply with federally-approved guidelines for HIV Prevention and Treatment.<sup>16</sup>

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 in, and 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*

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<sup>13</sup> 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>

<sup>14</sup> 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>

<sup>15</sup> 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>

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

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.”<sup>17</sup>

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.<sup>18</sup> Although the Ryan White HIV/AIDS Program served 178,581 Latino/a people living with HIV/AIDS in 2010, and its AIDS Drug Assistance Program (ADAP) program 49, 927 duplicated Latino clients, more work remains to be done to meet these NHAS goals.<sup>19</sup>

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.<sup>20</sup> Those unaware account for over half of new sexually transmitted HIV infections, with transmission rates 3.5 times higher than those who are aware.<sup>21</sup> Additionally, as many as one third of those previously diagnosed and aware of their HIV infection remain out of care,<sup>22</sup> often for years.<sup>23</sup> Timely entry into HIV care post-diagnosis has been found to have a number of benefits, including decreased morbidity, mortality and infectiousness,<sup>24</sup> as well as exposure to effective secondary prevention efforts through cost-effective clinical interventions.<sup>25, 26</sup> There are many reasons why HIV-positive persons may delay entering care upon diagnosis, including structural, financial and personal/cultural barriers arising from racial, ethnic and gender disparities.<sup>27</sup> Continuous retention in care has benefits similar to those of timely entry, and a number of strategies have

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<sup>17</sup> ONAP, NHAS, page 31.

<sup>18</sup> ONAP, NHAS, page 31.

<sup>19</sup> 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).

<sup>20</sup> 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.

<sup>21</sup> 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.

<sup>22</sup> Fleming PL, Byers RH, Sweeney PA, et al. HIV prevalence in the United States, 2000. Presented at the 9th Conference on Retroviruses and Opportunistic Infections, February 24-28, 2002, Seattle, WA.

<sup>23</sup> Samet JH, Freedberg KA, Savetsky JB, et al. Understanding delay to medical care for HIV infection: the long-term non-presenter. *AIDS*, 2001 January, 15 (1): 77-85.

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

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

<sup>26</sup> Marseille E, Shade SB, Myers J, & Morin S. The cost-effectiveness of HIV prevention interventions for HIV-infected patients seen in clinical settings. *Journal of Acquired Immune Deficiency Syndromes*, 2011 March; 56 (3): e87-e94.

<sup>27</sup> Tobias C, Cunningham WE, Cunningham CO, & Pounds MB. Making the Connection: The Importance of Engagement and Retention in HIV Medical Care. *AIDS Patient Care & STDs*, 2007; 21 (Supplement 1): S3-S8.

been developed to promote retention such as intensive case management, patient navigation, peer support groups, and mobile van outreach to find clients who were lost to follow-up.<sup>27, 28</sup>

Viral load suppression has become a key indicator of effective engagement in HIV primary care.<sup>29</sup> 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 six months to a year after diagnosis.<sup>30</sup> 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 three to four months after diagnosis, but only 51 percent of diagnosed persons were retained in medical care.<sup>31</sup> 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.<sup>32</sup>

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* initiative, composed of five demonstration projects and an evaluation center.<sup>33</sup> Only 41 percent of Latino/a participants in this initiative entered HIV primary care in the same year of their diagnosis,<sup>34</sup> and 58 percent of new (treatment-naïve) patients were diagnosed with AIDS at intake.<sup>35</sup> 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.<sup>36</sup>

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

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<sup>28</sup> Gardner L, Marks G, Metsch L, et al. Psychological and Behavioral Correlates of Entering Care for HIV Infection: The Antiretroviral Treatment Access Study (ARTAS) *AIDS Patient Care and STDs*, 2007; 21 (6): 418-425.

<sup>29</sup> 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](http://www.nap.edu/catalog.php?record_id=13225)

<sup>30</sup> 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.

<sup>31</sup> 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>

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

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

<sup>34</sup> 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.

<sup>35</sup> 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.

<sup>36</sup> 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.

heterogeneous cultural orientations, histories and Spanish language dialects specific to those countries of origin that often resist homogenization. A 2011 Pew Hispanic Center survey<sup>37</sup> 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.<sup>38</sup>

The research literature regarding HIV prevention among Latino/as 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,<sup>39,40</sup> especially among Latino Gay and Bisexual men and transgender *Latinas*.<sup>41,42</sup> 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.<sup>43</sup> 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. Alcohol and substance abuse is also high among these subpopulations.<sup>44,45,46</sup>

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.<sup>47</sup> 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 with HIV testing and timely access to treatment

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<sup>37</sup> 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.

<sup>38</sup> Motel S & Patten E. Hispanic Origin Profiles. Pew Hispanic Center, June 27, 2012.

<sup>39</sup> Keesee, Natale, & Curiel, 2012.

<sup>40</sup> 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.

<sup>41</sup> 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.

<sup>42</sup> 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.

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

<sup>44</sup> 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.

<sup>45</sup> 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.

<sup>46</sup> 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.

<sup>47</sup> Keesee, Natale, & Curiel, 2012.

after HIV diagnosis, causing Latinos/as to fare more poorly in relation to health outcomes compared with other racial/ethnic groups.

Although many Latino/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.<sup>48</sup> These differences between Latino/as born in the U.S. and those born in other countries and Puerto Rico can have major impacts on both HIV risk and access to health care.<sup>49</sup> For example, CDC has noted that significant numbers of men born in Puerto Rico have become infected with HIV through injection drug use.<sup>50</sup> 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.<sup>51</sup> The most common place of birth among Latino/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.<sup>52</sup>

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."<sup>53</sup> 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.

Latino/as can be of any race, and this FOA will define Latino/as as those who self-identify as having a Hispanic or Latino ethnicity, a category established by the Office of Management and Budget's Standards for Data on Race and Ethnicity<sup>54</sup> and used by the U.S. Census Bureau. For their interventions, demonstration sites will specify a Latino/a target population specific to

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<sup>48</sup> Motel S & Patten E. The 10 Largest Hispanic Origin Groups: Characteristics, Rankings, Top Counties – Overview. Pew Hispanic Center, updated July 12, 2012.

<sup>49</sup> 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>

<sup>50</sup> CDC. HIV among Latinos Fact Sheet, November 2011.

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

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

<sup>53</sup> 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.

<sup>54</sup> 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](http://www.whitehouse.gov/sites/default/files/omb/assets/information_and_regulatory_affairs/re_app-a-update.pdf)

country of origin that also includes gender (men, women, transgender women, or all of these) and/or HIV transmission category (men who have sex with men, injection drug users or high-risk heterosexuals). *Country of origin* as used in this announcement refers to place of birth and/or country of familial descent and heritage. *Transgender* is used in this announcement to describe persons with gender identities and/or gender expressions not associated with their birth sex. 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.

The successful applicant 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.*<sup>55</sup> 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.*<sup>56</sup> 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:<sup>57</sup>

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

## 2. Background

This 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

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<sup>55</sup> 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=>

<sup>56</sup> See Appendix 2 of the 2013 Ryan White Part B Funding Opportunity Announcement (HRSA-13-158)

<sup>57</sup> Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87), Section 2604, Use of Amounts.

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 cooperative agreement. A cooperative agreement, as opposed to a grant, is an award instrument of financial assistance where substantial involvement is anticipated between HRSA and the recipient during performance of the contemplated project.

In addition to the usual monitoring and technical assistance provided under the cooperative agreement, **HRSA SPNS Program responsibilities under the terms of this cooperative agreement will include the following:**

- Making available the services of experienced HRSA/ HIV/AIDS Bureau (HAB) personnel as participants in the planning and development of all phases of the project;
- Ongoing review of activities, procedures, measures, and tools to be established and implemented for accomplishing the goals of the cooperative agreement;
- Participation in conference calls, meetings and conferences to be conducted during the period of the cooperative agreement;
- Provision of information resources;
- Review and approval of all project information prior to dissemination; and
- Participation in the dissemination of project findings, best practices and lessons learned.

**The cooperative agreement recipient's responsibilities shall include:**

#### **A) Provide Technical Assistance**

The ETAC will provide technical assistance (TA) to the demonstration projects for a range of needs over the course of the entire initiative. ETAC applicants must propose a means of routine assessment of the TA needs of the demonstration projects, to include a formatted regular report to SPNS staff. The ETAC will be expected to provide TA during regular teleconferences; through its website and webinars; during annual site visits; and at the twice-a-year SPNS grantee meetings across the following domains:

*i) Program Development, Implementation and Sustainability.* The ETAC will monitor, assess, and identify areas of need in the development and implementation of demonstration project interventions. When appropriate, the ETAC will provide remedial TA for issues such as counseling and testing; provision of intervention-related outreach, case management, peer education, patient navigation, and other related engagement and retention activities; referral network development, expansion and maintenance; project promotion and participant recruitment; and resources for staff training for interventions that incorporate existing interventions (such as DEBIs- Diffusion of Effective Behavioral Interventions) and/or use of

peer educators, community health outreach workers, *promotores* and/or patient navigators. Although prevention interventions such as the DEBIs<sup>58</sup> may be incorporated into a demonstration site project, the goals of these interventions must focus on the identification, engagement and retention of Latino/a people living with HIV infection in care. The ETAC also will provide resources related to sustaining the interventions beyond the SPNS funding, including third party reimbursement and additional public and private funding streams and opportunities.

*ii) Multi-site and Local Evaluation.* The ETAC will be expected to assist the demonstration projects in implementing its multi-site evaluation plan, to include but not limited to training demonstration project staff in the use of the data collection instruments and web-based data entry portal; regular monitoring of data collection and reporting efforts by the demonstration projects; and remedial action when necessary to assure data collection of the highest quality. Demonstration projects will be expected to conduct local evaluations to assess the effectiveness of their interventions, and the ETAC will serve as a resource for refining the designs and monitoring the implementation of their local evaluation plans to assure their rigor and quality.

*iii) Human Research Subjects Protection.* The requisite collection of client-level data for this SPNS initiative will require diligent efforts to assure the privacy and confidentiality of project participants, their medical records and their health-seeking efforts. The ETAC will be expected to lead these efforts and guide the demonstration projects in their compliance with human subjects research protection set forth in the Code of Federal Regulations.<sup>59</sup> This will include review of the demonstration projects' required plans to safeguard study participants' privacy and confidentiality and their documentation of procedures for electronic and physical protection of project participant information and data, in accordance with HIPAA regulations and human subjects research protections. Any deficits identified must be remedied by demonstration projects with the assistance of the ETAC.

*iv) Institutional Review Boards.* The ETAC is also expected to serve as a resource for demonstration projects regarding the Institutional Review Board (IRB) review, approval and renewals of client-level data collection instruments, informed consents and any other pertinent evaluation documentation for all local evaluations and the multi-site evaluation. Both the ETAC and the demonstration projects will be required to submit documentation to the SPNS program of all IRB approvals and annual renewals. Additionally, demonstration projects will be required to submit their IRB approvals and renewals to the ETAC, which will submit regular tracking reports of this IRB documentation and status to the SPNS program.

With SPNS staff, the ETAC will be expected to conduct an annual site visit with each demonstration project for each year of the initiative. The ETAC will develop a Site Visit Protocol in Year 1 to include all potential TA needs across the domains mentioned above to be assessed and addressed during site visits. TA needs during the early years of the initiative will focus on implementing the interventions, local evaluations and the multi-site evaluations, and obtaining IRB approvals. TA needs in the later years will focus on data collection, reporting and quality issues, as well as sustainability of the interventions. Due to these initiative dynamics, the

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<sup>58</sup> See <http://www.effectiveinterventions.org/>

<sup>59</sup> See Code of Federal Regulations, Title 45, Part 46 Protection of Human Subjects, Revised January 15, 2009 Effective July 14, 2009. Available from: <http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html>

Site Visit Protocol will require revision in each succeeding year of the initiative, with submission to SPNS staff for its approval.

## **B) Conduct a Rigorous Multi-Site Evaluation**

The successful applicant, in collaboration with SPNS staff, will design and implement a comprehensive national multi-site evaluation plan to assess the effectiveness of the demonstration project interventions in improving timely entry, engagement and retention of Latino/a people in quality HIV primary care. The ETAC's proposed staff should have demonstrated knowledge and expertise in conducting health care evaluations among HIV infected populations. As terms of their award, demonstration projects must agree to fully cooperate with the ETAC in the multi-site evaluation, and to include at a minimum, a 0.25 full-time equivalent (FTE) local evaluator or local evaluation team in their project staff. The ETAC will work closely with the local evaluator(s), as well as the Principal Investigator/Project Director and of each demonstration project and SPNS staff, to implement the multi-site evaluation plan.

The multi-site evaluation will collect and report relevant quantitative and qualitative outcome, process and cost measures for the interventions, and also assess the treatment experience of the multi-site participant cohort as a whole. *Outcome measures* in this initiative 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 proposed by the ETAC. A *Process Evaluation* will document any barriers to the effective implementation of strategies employed by the interventions. A *Cost Analysis Study* (or cost effectiveness study, if feasible) will document the labor and programmatic costs incurred by each intervention, to inform its potential future replication. Costs relating to the evaluation of this initiative will not be included in the cost study.

On August 8, 2012, the Department of Health and Human Services (HHS) Secretary, Kathleen Sebelius, released a set of seven common core indicators for monitoring HHS-funded prevention, treatment and care services.<sup>60</sup> To assure expeditious translation of research into practice, both the ETAC and the demonstration sites 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 multi-site evaluation plans.<sup>61</sup>

The successful applicant will describe its detailed multi-site evaluation plan and provide a sound theoretical basis for its proposed multi-site evaluation methodology. The ETAC may also propose additional focused studies regarding related aspects of HIV testing and treatment, and access to substance abuse treatment, mental health services, and routine health care. Examples

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<sup>60</sup> 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>

<sup>61</sup> 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](http://www.nap.edu/catalog.php?record_id=13225)

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.

The successful applicant will be required to submit its proposed multi-site evaluation plan and any other related studies to its IRB for review and approval. The ETAC will be required to submit their IRB's approval and annual renewals for all client-level data collection instruments, informed consents and evaluation materials to the SPNS program. The ETAC also will be responsible for tracking the demonstration projects' required submissions of their IRB approvals and annual renewals for the multi-site evaluation, their local evaluation and any other related studies.

The ETAC will coordinate the efforts of demonstration projects to assure the privacy and confidentiality of study participants' and their health-seeking efforts. The ETAC and the demonstration projects will be expected to conform with regulations for human subjects research protection as set forth in the Code of Federal Regulations.<sup>62</sup> All key ETAC project personnel are expected to have successfully completed Human Subjects Research Protections training, such as the online training offered by the National Institutes of Health (NIH).<sup>63</sup> The ETAC will be expected to review the required plans of demonstration projects to safeguard the privacy and confidentiality of study participants, in accordance with HIPAA regulations and human subjects research protections.

The successful applicant will be expected to construct and maintain a secure website for the initiative to serve as a data portal for the reporting of multi-site evaluation data by the demonstration projects. Applicants must demonstrate they have documented procedures for the electronic and physical protection of participant information and data. The website should serve as a communications nexus for the initiative, and have both public access for promotion of the initiative and private password-protected access for demonstration project, ETAC and SPNS staff. In addition to the secure data entry portal, the website will be expected to support technical assistance resources for the multi-site evaluation; ongoing documentation of presentation, publication and dissemination efforts for the initiative; a calendar of upcoming initiative events and national conferences with abstract submission deadlines; a registration system for the twice-a-year national meetings of the initiative; recent findings of interest from outside the initiative; and links for relevant resources. Demonstration projects will be expected to contribute materials for inclusion on the initiative's website.

### **C) Lead and Coordinate Publication and Dissemination of Findings and Lessons Learned**

The ETAC will be expected to lead the publication and dissemination activities for the initiative, working in collaboration with the demonstration projects and SPNS staff. The ETAC will form a publications and disseminations committee, with SPNS staff and demonstration projects expected to contribute at least one staff member to this committee. The publications and disseminations committee will work collaboratively to formulate its own publication and policy guidelines to cover such issues as governance and function; authorship; multi-site data requests;

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<sup>62</sup> See Code of Federal Regulations, Title 45, Part 46 Protection of Human Subjects, Revised January 15, 2009 Effective July 14, 2009. Available from: <http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html>

<sup>63</sup> See <http://phrp.nihtraining.com/users/login.php>

and other operational issues. The publications and disseminations committee will be expected to generate research questions; topics for presentations and publications; concept sheets and analyses; and an overall dissemination plan for the initiatives products.

The successful applicant will have personnel with the necessary skills and experience to communicate project findings and lessons learned to local communities, state and national conferences, and policymakers, and to lead collaborative efforts in the writing and publishing of findings in peer reviewed journals and in 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 Latino/a people living with HIV infection; their timely entry, engagement and retention in high quality HIV primary care; and lessons learned and best practices that will improve health outcomes among Latino/as living with HIV infection.

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.<sup>64</sup> 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. The ETAC will be expected to work collaboratively with the demonstration projects and SPNS staff to develop an interventions monograph for iHIP that will facilitate future replication of successful interventions. The draft and final versions of the monograph will be due in year five of the initiative, with the ETAC coordinating its production and providing technical assistance to the demonstration projects in its development.

The successful applicant will also be expected to partner with at least one AIDS Education Training Center (AETC) with experience in the provision of education to clinical providers on treatment and care services to Latinos/as. The ETAC will work collaboratively with the AETC(s) to identify and/or co-develop training resources for the demonstration projects. The ETAC will also disseminate its findings, including the Interventions manual, through the AETC(s), in order to reach a wider audience of HIV care providers. The applicant is to obtain a formal agreement (e.g., Subcontract, or Memorandum of Agreement (MOA) or Understanding (MOU)) with the AETC(s) describing the roles and responsibilities of all parties. This formal agreement must be included in the application as either a subcontract listed in the proposed budget or as an attached MOA/MOU.

The successful applicant will be expected to lead and coordinate the logistics for two national meetings in each of the five years of the initiative with the demonstration projects. This activity includes but is not limited to site location and logistics; meeting registration; and the development of meeting agendas and presentation in collaboration with SPNS and demonstration project staff. All SPNS grantee meetings will take place in the Washington, DC metropolitan area, and the ETAC should allocate funds for the Principal Investigator/Project Director, and two other key staff members to attend these two day meetings twice a year.

## **2. Summary of Funding**

This program will provide funding during Federal fiscal years 2013 -2017. Approximately \$550,000 is expected to be available annually to fund one (1) awardee. Applicants may apply for

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<sup>64</sup> See <http://www.careacttarget.org/library/integrating-hiv-innovative-practices-ihip>

a ceiling amount of up to \$550,000 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, awardee 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 private nonprofit entities, including faith-based and community-based organizations, institutions of higher education; and nonprofits having a 501 (c)(3) status with IRS. Applicants must have significant experience in evaluating the effectiveness of demonstration projects and conducting multi-site evaluations. In addition, applicants must have significant experience researching, evaluating and disseminating findings on issues related to the provision of culturally appropriate outreach, access and retention interventions among Latino/a populations.

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

Cost Sharing/Matching is not required for this program.

#### **3. Other**

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

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

NOTE: Multiple applications from an organization are not allowable. Applicants for this FOA may not apply for funding under the Demonstration Site FOA (HRSA-13-154).

### **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](mailto: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 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](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 (EHBs). Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.

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

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

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

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

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

### **Application Format Requirements**

The total size of all uploaded files may not exceed the equivalent of 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
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list.	Not counted in the page limit.
Attachment 1-15	Attachment	Can be uploaded in Other Attachments form 1-15.	Refer to the attachment table provided below for <b>specific</b> sequence. Counted in the page limit.

- 🔔 To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- 🔔 Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- 🔔 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, 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
Attachment 2	Line Item Budgets for Years 1 through 5 Spreadsheet Table
Attachment 3	Staffing Plan
Attachment 4	Position Descriptions
Attachment 5	Biosketches
Attachment 6	Work Plan
Attachment 7	Project organizational chart
Attachment 8	Signed letters of support and memoranda of agreement, and descriptions of proposed and existing contracts
Attachment 9	Cultural and Linguistic Factors Competency Statement
Attachment 10	Healthy People 2020 Statement
Attachments 11-15	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 sub-recipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-character identification number provided by the commercial company, Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found at <http://fedgov.dnb.com/webform> 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 SAM in order to conduct electronic business with the Federal Government. SAM registration must be maintained with current, accurate information at all times during which an entity has an active award or an application or plan under consideration by HRSA. It is extremely important to verify that the applicant organization SAM registration is active and the Marketing Partner ID Number (MPIN) is current. Information about registering with SAM can be found at <https://www.sam.gov>. 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
<b>Amount that may be claimed on the application budget due to the legislative salary limitation:</b> Individual’s base full time salary <i>adjusted</i> to Executive Level II: \$179,700 50% of time will be devoted to the project	
Direct salary	<b>\$89,850</b>
Fringe (25% of salary)	<b>\$22,462.50</b>
Total amount	<b>\$112,312.50</b>

**iv. Budget Justification**

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

“other” category is justified. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

**Budget for Multi-Year Award**

This announcement is inviting applications for project periods up to five (5) years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be 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 the Principal Investigator/Project Director and two other key 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. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops.

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

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

*Contractual:* Applicants are responsible for ensuring that their organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential subrecipients that entities receiving subawards must be registered in 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: <https://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 key staff position in **Attachment 3**. Key staff are defined as those with direct responsibility for ETAC activities, and at a minimum, include the Principal Investigator, Project Director, and a lead clinician. Other staff may include site liaisons responsible for providing technical assistance and capacity building to the demonstration projects; and evaluation, data collection and website development and support. If applicable, the staffing

plan should include consultants; staff within subcontracted organizations; and staff within agencies providing significant in-kind support through memoranda of agreement or letters of support.

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](http://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 roles and activities of the Evaluation and Technical Assistance Center (ETAC). Specifically, how the ETAC will provide leadership in the multi-site evaluation and dissemination of findings, and technical assistance and capacity building to the demonstration projects of the SPNS *Culturally Appropriate Interventions of Outreach, Access and Retention among Latino/a Populations* initiative. Briefly describe the multi-site evaluation, technical assistance and capacity building services that the ETAC will provide. Briefly describe the applicant organization and any collaborating organizations.

- ***NEEDS ASSESSMENT***

Provide a summary of the literature that demonstrates a comprehensive understanding of the issues that interfere with identifying Latinos/as living with HIV infection, and engaging and retaining them in quality HIV primary care. Discuss the factors driving incidence and prevalence rates of HIV infection among Latinos/as, using the most recent, available data. Data sources may include HIV testing data; surveillance and epidemiology reports and profiles of state and local public health departments; needs assessment surveys; risk behavioral surveys; programmatic data and other Latino/a-specific studies. Discuss HIV counseling and testing, substance abuse treatment, mental health, family planning, and primary care services for this population, with a focus on challenges in identifying those 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. Propose strategies that have been or may be employed to overcome these challenges.

Describe the issues that interfere with engaging and retaining Latinos/as living with HIV infection in quality HIV primary care, including those who are newly diagnosed during the project, and what strategies may be used to overcome them. Provide a summary of the policy, financial, structural, cultural and clinical issues related to improving timely entry, access to and retention in quality HIV care for Latinos/as.

- ***METHODOLOGY***

Describe a plan for the provision of technical assistance (TA) to the demonstration projects over the course of the initiative, to include a routine means of TA needs assessment. Describe what kinds of TA needs are anticipated, and by what means they will be addressed, across the following domains: program development, implementation and sustainability; clinical consultation; multi-site and local evaluations; human research subjects protection; Institutional Review Board approval and renewal; and interventions monograph. Describe a plan for review of the demonstration projects' plans to safeguard the privacy and confidentiality of study participants and their documented procedures for the electronic and physical protection of study participant information and data, and a means of addressing deficits. Describe the elements of a site visit protocol for the annual site visits to the demonstration projects.

Describe a plan for a rigorous national multi-site evaluation across demonstration projects that will have maximum impact on practice and policy affecting timely entry, access to and retention in quality HIV primary care for Latinos/as. Discuss anticipated evaluation questions for assessing the effectiveness of demonstration project interventions. Describe the methodology that will be used to conduct the multi-site evaluation and provide the

rationale for its selection. Outline the outcome, process and cost elements of the multi-site evaluation, and propose possible measures for them. Propose any additional focused studies of interest relating to Latinos/as living with HIV, describing their rationale and possible impact.

Describe your approach in leading publication and dissemination efforts for the initiative's findings and lessons learned. Provide a brief discussion of how a publications and dissemination committee would operate. Describe the experience of proposed key project staff (including any consultants and subcontractors) in collaborative writing and publishing study findings in peer reviewed journals. Provide a dissemination plan identifying appropriate venues and target audiences, including but not limited to policy makers and national conferences geared toward HIV primary care and social service providers. The dissemination plan should include lessons learned or best practices and help facilitate the replication of interventions proven effective by the multi-site and local evaluations by HIV primary care and social service organizations serving Latinos/as at risk or living with HIV infection. Describe the experience of proposed key project staff in making presentations to local communities, state and national conferences and to policy makers.

Identify the AIDS Education Training Center(s) with whom you will work collaboratively to identify and/or co-develop training resources for the demonstration projects, and to disseminate findings from this SPNS initiative. Explain your approach and rationale for working with the particular AETC(s) including its experience in the development of its training resources educating providers in the provision of HIV treatment and care to Latinos/as.

- *WORK PLAN*

Provide a work plan that delineates the ETAC's goals for the five-year project period. The work plan should directly relate to your Methodology section and the program requirements of this announcement. Include all aspects of planning and provision of technical assistance and capacity building; design and implementation of the multi-site evaluation; and publication and dissemination activities. 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/or subcontractors; 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. Include the project's work plan as **Attachment 6**.

- *RESOLUTION OF CHALLENGES*

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

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

Describe your expertise in issues relating to engagement and retention in HIV treatment. Describe your capacity to conduct a comprehensive multi-site evaluation to assess the interventions of the demonstration projects and the multi-site participant cohort as a whole. Include evidence of experience, skills, training and knowledge of proposed key project staff (including any consultants and subcontractors) in achieving scientific excellence and

evaluation integrity in conducting a multi-site evaluation of national scope that will have maximum impact on practice and policy affecting timely entry, access to and retention in quality HIV primary care for Latinos/as.

Describe how the proposed key project staff (including any consultants and subcontractors, if applicable) have the necessary knowledge, experience, training and skills in designing and implementing public health program evaluations, specifically quantitative and qualitative outcome and process evaluations and cost studies of innovative HIV access and retention projects. Include any specific experience in the evaluation of programs reaching those who are unaware of their HIV status, as well as engaging and retaining those newly diagnosed in quality HIV primary care. Include any specific experience in the design, implementation and evaluation of programs serving Latinos/as at risk or living with HIV infection. Describe any experience in conducting focused studies related to engagement and retention in HIV treatment, and if applicable, describe any published materials and presentations.

Describe the capacity of the proposed project staff to provide leadership and technical assistance to demonstration sites for the multi-site and local evaluations. Describe the experience of proposed project staff (to include consultants' and subcontractors', if applicable) in providing technical assistance to HIV primary care and social service organizations; and logistical planning, implementation and evaluation of national meetings. Describe your approach to working collaboratively with the demonstration projects in leading data collection and reporting efforts for the multi-site evaluation and additional focused evaluation studies.

State your agreement to submit 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. Describe any training in human subjects research protection by proposed project staff. Describe your plans to safeguard the privacy and confidentiality of study participants, in accordance with HIPAA regulations and human subjects research protections. Describe your plans for the initiative's website, its data portal and your documented procedures for the electronic and physical protection of participant information and data. Describe your system of tracking and reporting to SPNS staff the demonstration projects' IRB approvals and annual renewals for the multi-site evaluation, their local evaluations and any other related studies.

▪ ***ORGANIZATIONAL INFORMATION***

Describe the organization's mission, organizational structure, the quality and availability of facilities and personnel, and the scope of current activities of the organization. Describe how these all contribute to the organization's ability to successfully carry out a project of this magnitude and meet the goals and objectives of the initiative. Describe your organization's capacity to conduct the required multi-site evaluation, technical assistance, and capacity building activities described earlier in this announcement. Describe the capacity of your organization's management information systems to support a comprehensive multi-site evaluation in the collection, reporting and secure storage of client-level data.

Include a one-page project organizational chart depicting the organizational structure of only the project, not the entire organization, and include subcontractors and other significant collaborators, as **Attachment 7**.

Current and proposed collaborating organizations and individuals must demonstrate their commitment to fulfill the goals and objectives of the project through signed and dated letters or memoranda of agreement/understanding. Include either a Memorandum of Agreement/Understanding or a summary of the subcontract with the proposed AETC(s) with which the applicant will work, describing the roles and responsibilities of all parties in **Attachment 8**. If other consultants and/or subcontractors will be used to carry out aspects of the proposed project, describe their roles and responsibilities. Include any other signed and dated MOAs/MOUs or Letters of Support, and descriptions of any existing or proposed contracts relating to the proposed project, also in **Attachment 8**.

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.<sup>65</sup> It includes an understanding of integrated patterns of human behavior, including language, beliefs, norms, and values, as well as socioeconomic and political factors that may have significant impact on psychological well-being and incorporating those variables into assessment and treatment. Include the project's cultural and linguistic competence factors in **Attachment 9**.

**x. Attachments**

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

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

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

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

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*

The Staffing plan should include education and professional qualifications for each key staff position. The staffing plan also should include a justification for the amount of time requested for each staff position.

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<sup>65</sup> 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>

**Attachment 4: *Position Descriptions***

Keep each to one page in length. 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: *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 7: *Project Organizational Chart***

The organization chart should be a one-page figure that depicts the organizational structure of only the project, not the entire organization, and it should include consultants, subcontractors and other significant collaborators.

**Attachment 8: *Signed and Dated Memoranda of Agreement or Understanding, Letters of Support, 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 9: *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.<sup>66</sup>

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 10: *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 11-15: *Other Relevant Documents***

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

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<sup>66</sup> See *National Standards for Culturally and Linguistically Appropriate Services* at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

opportunity 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.

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](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 \$550,000 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](mailto:support@grants.gov) or by phone at 1-800-518-4726. Applicants should ensure that all passwords and registration are current well in advance of the deadline.

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

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

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

## **V. Application Review Information**

### **1. Review Criteria**

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 the problem and associated contributing factors to the problem.

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

#### **i. Introduction**

- Strength and clarity of the applicant's succinct description of the roles and activities of the Evaluation and Technical Assistance Center (ETAC) in achieving the purpose of the initiative to improve timely entry, engagement and retention in quality HIV primary care for Latinos/as at risk or living with HIV/AIDS.
- Strength and clarity of the applicant's brief descriptions of the applicant organization, any collaborating organizations and the multi-site evaluation, technical assistance and capacity building services the ETAC will provide.

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

- Extent to which the summary of the literature demonstrates a comprehensive 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 discussion of factors driving incidence and prevalence rates of HIV infection among Latinos/as, using the most recent, available data.
- Strength and clarity of the discussion of HIV counseling and testing of Latinos/as, including the challenges to identifying those 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; and what strategies have been or may be used to overcome these challenges.
- Strength and clarity of the description of the issues that interfere with engaging and retaining Latinos/as living with HIV infection in quality HIV primary care, including those who are newly diagnosed during the project, and what strategies may be used to overcome them.
  - Strength and clarity of the summary of the policy, financial, structural, and clinical issues related to improving timely entry, access to and retention in quality HIV care for Latinos/as living with HIV infection.

### **Criterion 2: Response (25 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 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.

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

#### **i. Methodology**

- Strength and feasibility of the applicant's proposed plan for the provision of technical assistance (TA) to the demonstration projects over the course of the initiative, including a routine means of TA needs assessment.
- Strength and feasibility of the applicant's description of anticipated TA needs and the means by which they will be addressed.
- Feasibility of the applicant's plan to review the demonstration projects' plans to safeguard the privacy and confidentiality of study participants, and their documented procedures for the electronic and physical protection of study participant information and data, and a means to address deficits.
- Strength and clarity of the description of the elements of a site visit protocol for annual site visits to the demonstration projects.
- Strength of the approach to the provision of culturally and linguistically competent health care and social services to Latinos/as living with HIV infection, with a focus on racial, ethnic, sexual and gender minority disparities faced by this population.
- Evidence of experience of proposed project staff in logistical planning and implementation of national meetings.

#### **ii. Work Plan**

- Strength, clarity and feasibility of the Work Plan and its goals for the 5-year project period (**Attachment 6**).
- Extent to which the goals of the Work Plan address the program requirements the applicant described in the Methodology section of the Narrative.
- Evidence the objectives for Year 1 are complete, specific to each goal, time-framed, and measurable.
- Evidence the Work Plan includes each planning, implementation and evaluation activity, and identifies the staff responsible to accomplish each step.

### **iii. Resolution of Challenges**

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

### **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 feasibility of the proposed plan for a rigorous national multi-site evaluation across demonstration projects that will have maximum impact on practice and policy affecting timely entry, access to and retention in quality HIV primary care for Latinos/as living with HIV infection.
- Strength and clarity of the anticipated evaluation questions for assessing the effectiveness of demonstration project interventions.
- Strength and feasibility of the methodology that will be used to conduct the multi-site evaluation and its rationale for selection.
- Strength and clarity of the outline for the outcome, process and cost elements of the multi-site evaluation, and possible measures for them.
- Strength of the proposed focused studies of interest relating to Latinos/as living with HIV infection, including their rationale and possible impact.

### **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.

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

- Strength of approach in leading publication and dissemination efforts for the initiative's findings and lessons learned.
- Clarity of the discussion of how a publications and disseminations committee would operate.
- Strength of the proposed plan for dissemination of project findings, best practices and lessons learned to target audiences at appropriate venues including national conferences, and policymakers.

### **Criterion 5: Resources/Capabilities (25 Points)**

The extent to which project personnel (including consultants and subcontractors) 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 and Technical Assistance Capacity and Organizational Information sections of the Narrative.

**i. Evaluation and Technical Assistance Capacity**

- Evidence of demonstrated expertise in issues relating to engagement and retention in HIV treatment.
- Evidence of capacity to conduct a comprehensive multi-site evaluation and the multi-site participant cohort as a whole.
- Extent of experience, skills, training and knowledge of proposed key project staff (including any consultants and subcontractors, if applicable) in achieving scientific excellence and evaluation integrity in conducting a multi-site evaluation of national scope that will have maximum impact on practice and policy affecting timely entry, access to and retention in quality HIV primary care for Latinos/as living with HIV infection.
- Strength and clarity of the approach to working collaboratively with demonstration projects in leading data collection and reporting efforts for the multi-site evaluation and additional focused evaluation studies.
- Extent of experience, skills, training and knowledge of proposed key project staff (including any consultants and subcontractors, if applicable) in designing and implementing public health program evaluations, specifically quantitative and qualitative outcome and process evaluations and cost studies of innovative HIV access and retention projects.
- Evidence of any specific experience of proposed key project staff in the evaluation of programs reaching those who are unaware of their HIV status, as well as engaging and retaining those newly diagnosed in quality HIV primary care.
- Evidence of any specific experience of proposed staff in the design, implementation and evaluation of programs serving Latinos/as living with HIV infection at risk or living with HIV infection.
- Evidence of any specific experience of proposed staff in conducting focused studies related to engagement and retention in HIV treatment, and if applicable, any published materials and presentations.
- Strength of applicant's capacity to provide leadership and technical assistance to demonstration sites for the multi-site and local evaluations.
- Extent of experience of the proposed staff (including consultants' and subcontractors', if applicable) in providing technical assistance and capacity building to HIV primary care and social service organizations.
- Extent of experience of proposed key project staff (including any consultants and subcontractors) in collaborative writing and publishing study findings in peer reviewed journals.
- Extent of experience of proposed key project staff (including any consultants and subcontractors) in making presentations to local communities, State and national conferences and to policy makers.
- Extent of experience of proposed key project staff (including any consultants and subcontractors) in logistical planning, implementation and evaluation of national meetings.
- Evidence the applicant agrees to submit proof of IRB approvals and renewals for all client-level data collection instruments, informed consents and evaluation materials to the SPNS program on an annual basis.

- Evidence of any training in human subjects research protection by proposed key project staff of the applicant.
- Strength of the plan to safeguard patients' privacy and confidentiality, and documented procedures for electronically and physically protecting the privacy of patient information and data, in accordance with HIPAA regulations and human subjects research protections.
- Strength of the plans for the initiative's website, its data portal and the documented procedures for the electronic and physical protection of participant information and data.
- Strength of the proposed system or methods to be used for tracking the demonstration projects' IRB approvals and annual renewals for the multi-site evaluation, their local evaluations and any other related studies and reporting them to SPNS Program staff.

## **ii. Organizational Information**

- The extent to which the applicant organization's mission, organizational structure, the quality and availability of facilities and personnel, and the 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 capacity to conduct the required multi-site evaluation, technical assistance and capacity building activities described earlier in this announcement.
- Evidence of the capacity of the applicant's management information system (MIS) to support a comprehensive multi-site evaluation in the collection, reporting and secure storage of client-level data.
- Evidence of a project organizational chart, depicting only the project, not the entire organization, and including subcontractors and other significant collaborators (**Attachment 7**).
- If applicable, extent to which the roles and responsibilities of consultants and/or subcontractors to be used to carry out aspects of the proposed project are appropriate.
- Strength of the applicant's proposed collaborative agreement with at least one AIDS Education Training Center for the development of training resources for the demonstration projects and the dissemination of SPNS products (**Attachment 8**).
- If applicable, the appropriateness of other signed and dated letters or memoranda of agreement or understanding from current and proposed collaborating organizations and individuals to fulfill the goals and objectives of the project (**Attachment 8**).
- Evidence of the applicant organization's cultural competency capabilities (**Attachment 9**).

## **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**

- Appropriateness of the line item budgets for each year of the project period (**Attachment 2**) as they relate to the proposed work plan.
- Appropriateness and clarity of the 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 logistical meeting arrangements and long distance travel expenses associated with the two SPNS grantee meetings in Washington, D.C.

## ii. Staffing Plan

- The extent to which the staffing plan is consistent with the project description and project activities (**Attachment 3**).
- Evidence the staffing plan includes key personnel with the skills, knowledge, education and training required to successfully implement all of the project activities throughout the project as described in the work plan.
- Extent to which the time allocated for key staff is consistent with their expected workload and goals and objectives of the project.
- Strength and appropriateness of the job descriptions for key staff (**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](http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html).

### **Trafficking in Persons**

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

### **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](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 HRSA EHBs. 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 NoA.

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 HRSA EHBs 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 NoA.

**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 opportunity 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 – Evaluation and Technical Assistance Center* (# HRSA-13-151)  
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](mailto:ACajina@hrsa.gov)

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

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

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

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

## **VIII. 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>.