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

HIV/AIDS Bureau
Division of Service Systems

HIV Emergency Relief Grant Program
Part A:
Announcement Type: Competing Continuation
Announcement Number: HRSA-11-062

Catalog of Federal Domestic Assistance (CFDA) No. 93.914

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2011

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

EXECUTIVE SUMMARY

The new National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV.

To ensure success, the NHAS requires the Federal government and State, tribal and local governments to increase collaboration, efficiency, and innovation. Therefore, to the extent possible, Ryan White program activities should strive to support the three primary goals of the National HIV/AIDS Strategy.

The Ryan White Part A Application Guidance is provided to assist applicants in preparing their fiscal year (FY) 2011 single-grant application for funds under Part A of Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87), which includes Minority AIDS Initiative (MAI) funds (hereafter referred to as the Ryan White HIV/AIDS Program). Applicants should include MAI funds in their planning activities. The legislation can be obtained at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ087.111.pdf.

Part A funding is based on living cases of HIV and AIDS reported to and confirmed by the Centers for Disease Control and Prevention (CDC), and Code Based Data submitted to Health Resources and Services Administration. This Guidance requires applicants to report on the numbers of persons living with HIV and AIDS in their jurisdictions

As a Condition of Award for Fiscal Year 2011, Ryan White Part A grantees will be required to meet specific requirements regarding the monitoring of both the grantee and their providers/sub-recipients. To help our grantees meet this challenge, HRSA through the Division of Service Systems (DSS) is in the process of developing guidelines outlining the responsibilities of both HRSA staff and grantee staff.

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

The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) recognizes that Part A Eligible Metropolitan Areas (EMA) and Transitional Grant Areas (TGA) must use grant funds to support and further develop and/or expand systems of care to meet the

needs of Persons Living with HIV/AIDS (PLWH/A) within the EMA/TGA and strengthen strategies to reach minority populations.

Both the Centers for Disease Control and Prevention (CDC) and HRSA have ongoing initiatives that may identify significant new numbers of PLWH/A that will be seeking services. This requires careful reassessment of how the EMA/TGA will assure access to primary care and medications as well as ensure the provision of critical support services necessary to maintain individuals in systems of care. The ongoing CDC initiatives as well as HAB efforts with grantees to estimate and address unmet need of those aware of their HIV status and the new requirement to identify and bring into care those persons in their jurisdictions that are unaware of their positive HIV status, should result in many more PLWH entering into the EMA/TGA care system. The EMA/TGA planning process must ensure that essential core medical services have been adequately funded to meet the needs of both those already in care and those being linked to care as a result of increased efforts to bring both the aware and previously unaware into care. A list of CDC initiatives can be found at http://www.cdc.gov/hiv/topics/prev_prog/index.htm.

CDC estimates that of the 1.1 million adults and adolescents at the end of 2006 living with HIV, 21% of infected persons do not know their HIV status. The ultimate US Public Health goal is to inform all HIV+ persons of their status and bring them into care in order to improve their health status, prolong their lives and slow the spread of the epidemic in the United States through enhanced prevention efforts. A new legislative requirement focuses on specific requirements and expectations for identifying the unaware and bringing them into care. This application requires the grantee to provide a strategy and plan for reaching this goal within their jurisdiction. The importance of this new requirement is reflected in the legislative requirement that this section of the application be apportioned no less than one-third of the points.

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

- Applicants must include a description of the Strategy, Plan, and Data associated with the Early Identification of Individuals who are Unaware of their HIV/AIDS Status

- Part A funds are subject to Section 2604(c) of the Public Health Service Act, which requires that not less than 75 percent of the funds be used to provide core medical services that are needed in the EMA/TGA for individuals with HIV/AIDS who are identified and eligible under the Ryan White HIV/AIDS Program.

- Core Medical Services and Support Services are limited to services that are needed for individuals with HIV/AIDS to achieve their medical outcomes as defined by the Ryan White HIV/AIDS Program. The most recent service definitions can be found at the following link: http://datasupport.hab.hrsa.gov/2008docs/2008RDRinstructions.pdf (see page 16).

- Applicants seeking a waiver to the core medical services requirement must submit a waiver request with this grant application in accordance with the information and criteria published by HRSA in the Federal Register Notice, Vol. 73, No. 113, dated Wednesday June 11, 2008, and may be found at http://edocket.access.gpo.gov/2008/E8-13102.htm. This waiver request process has been approved by the Office of Management and Budget (OMB) under the paperwork Reduction Act of 1995 (OMB number 0915-0307). In addition, Grantees are advised that a FY 2011 Part A waiver request must include funds awarded under the

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

- The Baton Rouge, LA and Charlotte NC TGA grantees will continue to provide narrative responses to the community planning processes in a separate section.

- EMA/TGA Agreements and Compliance Assurances are included (**Appendix A**) with this guidance and require the signature of the CEO, or of his or her designee. This document should be included as **Attachment 2**.

- The Ryan White Services Report (RSR) captures information necessary to demonstrate program performance and accountability. All Ryan White core service and support service providers are required to submit client-level data for Calendar Year 2011. Please refer to the HIV/AIDS Program Client Level Data website at http://hab.hrsa.gov/manage/CLD.htm for additional information.

- Quality Management: HIV/AIDS Bureau has developed the HIV/AIDS Clinical Performance Measures for Adults and Adolescents and companion guide to assist grantees in the use and implementation of the core clinical performance measures. Information on Performance Measures can be found at http://hab.hrsa.gov/special/habmeasures.htm

- Program Income: Ryan White HIV/AIDS Program legislation requires grantees to collect and report program income. The program income is to be returned to the respective Ryan White HIV/AIDS Program and used to provide eligible services to eligible clients. "Program income is gross income—earned by a recipient, sub-recipient, or a contractor under a grant—directly generated by the grant-supported activity or earned as a result of the award. Program income includes, but is not limited to, income from fees for services performed (e.g., direct payment, or reimbursements received from Medicaid, Medicare and third-party insurance); …and income a recipient or sub-recipient earns as the result of a benefit made possible by receipt of a grant or grant funds, e.g., income as a result of drug sales when a recipient is eligible to buy the drugs because it has received a Federal grant." Please refer to the HHS Grants Policy Statement at http://www.hhs.gov/grantsnet/docs/HHSGPS_107.doc. Direct payments include charges imposed by recipients and sub-recipients for Part A services as required under Section 2605(e) of Program legislation, such as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges. As specified on the Part A notice of grant award (NGA), program income must be "Added to funds committed to the project or program and used to further eligible project or program objectives." Grantees are responsible for ensuring that sub-recipients have systems in place to account for program income, and for monitoring to ensure that sub-recipients are tracking and using program income consistent with grant requirements. See the HHS Grants Policy Statement at ftp://ftp.hrsa.gov/grants/hhsgrantspolicystatement.pdf, the Part A NGA, and 45 CFR 92.25.

- Third Party Reimbursement: HRSA expects grantees to screen and document financial eligibility and proof of HIV status within each program year, and stipulate this in the contracts with sub-recipients. The Ryan White legislation requires all non-Ryan White fiscal resources to be used first before utilizing, committing, or obligating Ryan White grant funds, including the clients own resources.

- Healthcare providers funded via HRSA grants need to be alert to the importance of cross-cultural and language appropriate communications and general health literacy issues. HRSA

supports and promotes a unified health communication perspective that addresses cultural competency, limited English proficiency, and health literacy in an integrated approach in order to develop the skills and abilities needed by HRSA-funded providers and staff to deliver the best quality healthcare effectively to the diverse populations they serve. EMA/TGA can find national standards for cultural and linguistically appropriate services in healthcare are available online at http://www.omhrc.gov/clas. Cultural competence resources for healthcare providers are available at: http://www.hrsa.gov/culturalcompetence.

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

Table of Contents

I. Funding Opportunity Description

1. Purpose

The Part A program is authorized by Title XXVI of the Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009. Part A funds provide direct financial assistance to an Eligible Metropolitan Area (EMA)/Transitional Grant Area (TGA) that has been severely affected by the HIV epidemic. Formula and supplemental grants assist eligible program areas in developing or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV. A comprehensive continuum of care includes the 13 core medical services specified in law, and appropriate support services that assist PLWH/A in accessing treatment for HIV/AIDS infection that is consistent with the Department of Health and Human Service (DHHS) Treatment Guidelines. (See http://www.aidsinfo.nih.gov). Comprehensive HIV/AIDS care beyond these core services may include supportive services that meet the criteria of enabling individuals and families living with HIV/AIDS to access and remain in primary medical care and improve their medical outcomes.

This Funding Opportunity Announcement contains instructions for completing a comprehensive application response for funds under Part A of the Ryan White HIV/AIDS Program. It provides information on completing the application form, preparing the budget, and developing the narrative sections of the application. Applicants must use the Application Forms SF-424 to prepare the application. The application may be downloaded from the following website: www.grants.gov.

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding for Federal fiscal year 2011. Approximately $671,075,000 is expected to be available to fund (52) grantees. The period of support and budget period is one year.

Formula funding for Part A will be determined by the number of living cases of HIV/AIDS in the eligible area reported to and confirmed by the Director of CDC, as of December 31 for the most recent calendar year for which data is available. The current legislation permits code-based reporting to HRSA through FY 2012. Data as of December 31, 2009 will be used to calculate the 2011 awards.

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

a) contains a report concerning the dissemination of the Part A formula funds and the plan for utilization of such funds;

b) demonstrates the need in such area, on an objective and quantified basis for supplemental financial assistance to combat the HIV epidemic;

c) demonstrates the existing commitment of local resources of the area, both financial and in-kind, to combating the HIV epidemic;

d) demonstrates the ability of the area to utilize such supplemental financial resources in a manner that is immediately responsive and cost effective;

e) demonstrates that resources will be allocated in accordance with the local demographic incidence of AIDS including appropriate allocations for services for infants, children, youth, women, and families with HIV/AIDS;

f) demonstrates the inclusiveness of affected communities and individuals living with HIV/AIDS;

g) demonstrates the manner in which the proposed services are consistent with the local needs assessment and the statewide coordinated statement of need;

h) demonstrates the ability of the applicant to expend funds efficiently by not having had, for the most recent Part A formula grant year for which data is available, more than 5 percent of grant funds unobligated at the end of the year, even if a request for carryover was granted.

i) demonstrates success in identifying individuals with HIV and AIDS, who are unaware of their HIV/AIDS status, and provides a description of the Strategy, Plan, and Data associated with the early identification of these individuals.

III. Eligibility Information

1. Eligible Applicants

Grantees that were classified as an EMA or as a TGA in FY 2007 and continue to meet the statutory requirements are eligible to apply for these funds. For an EMA, this is more than 2,000 living cases of AIDS, and for a TGA, this is at least 1,000, but fewer than 2,000 living cases of AIDS. Additionally, they must not have fallen below, for three consecutive years, the required incidence levels already specified AND required prevalence levels (cumulative total of living cases of AIDS reported to and confirmed by the Director of the Centers for Disease Control and Prevention as of December 31 of the most recent calendar year for which such data are available). For an EMA, this is 3,000 living cases of AIDS, and for a TGA, this is 1,500 living cases of AIDS.

2. Cost Sharing/Matching

Cost sharing and matching are not a requirement of this grant.

3. Other

Maintenance of Effort (MOE)

The Ryan White legislation requires Part A grantees to maintain, as a Condition of Award, EMA/TGA political subdivision expenditures for HIV-related Core Medical Services and Support Services at a level equal to the 1-year period preceding the fiscal year (FY) for which the grantee is applying to receive a Part A grant. After enactment of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, section 2604 (b) (1) of the enacting legislation states: "In general-The chief elected official of an eligible area shall use amounts from a grant under section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services." Core medical services and support services are defined in section 2604(c)(3) and 2604(d) of the legislation and the HIV/AIDS Bureau service definitions distributed to all grantees. Part-A grantees must document that they have met the MOE requirement.

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

(a) A table that identifies the MOE budget elements and the amount of expenditures related to core medical services and support services: from FY 2008 and FY 2009;
(b) A description of the process used to determine the amount of expenditures reported in the table.

This requirement is included as part of the Budget and MOE submission, see page 37.

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.

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. All applicants ***must*** submit in this manner unless they obtain a written exemption from this requirement in advance by the Director of HRSA's Division of Grants Policy. Applicants must request an exemption in writing from DGPWaivers@hrsa.gov, and provide details as to why they are technologically unable to submit electronically though the Grants.gov portal. Your email must include the HRSA announcement number for which you are seeking relief, the name, address, and telephone number of the organization and the name and telephone number of the Project Director as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to your submission along with a copy of the "Rejected with Errors" notification you received from Grants.gov. **HRSA and its Grants Application Center (GAC)**

will only accept paper applications from applicants that received prior written approval. However, the application must still be submitted under the deadline.
Refer to HRSA's *Electronic Submission User Guide*, available online at http://www.hrsa.gov/grants/userguide.htm, for detailed application and submission instructions. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.
Applicants must submit proposals according to the instructions in the Guide and in this funding opportunity announcement in conjunction with Application Forms 424. These forms contain additional general information and instructions for applications, proposal narratives, and budgets. These forms may be obtained from the following sites by:

a) Downloading from www.grants.gov, or

b) Contacting the HRSA Grants Application Center at:
910 Clopper Road
Suite 155 South
Gaithersburg, MD 20878
Telephone: 877-477-2123
HRSAGAC@hrsa.gov

Specific instructions for preparing portions of the application that must accompany Application Form SF-424 appear in the "Application Format" section below.

2. Content and Form of Application Submission

Application Format Requirements

The total size of all uploaded files may not exceed the equivalent of 90 pages when printed by HRSA, or a total file size of 10 MB. This 90-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit.

Applications that exceed the specified limits (approximately 10 MB, or 90 pages when printed by HRSA) will be deemed non-compliant. Non-compliant applications will not be considered under this funding announcement.

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

SF 424 Non Construction Table of Contents

- It is mandatory to follow the instructions provided in this section to ensure that your application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-compliant. Non-compliant 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.
- When providing any electronic attachment with several pages, add a Table of Contents page specific to the attachment. Such pages will not be counted towards the page limit.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Application for Federal Assistance (SF-424)	Form	Pages 1, 2 & 3 of the SF-424 face page.	Not counted in the page limit
Project Summary/Abstract	Attachment	Can be uploaded on page 2 of SF-424 - Box 15	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
Additional Congressional District	Attachment	Can be uploaded on page 3 of SF-424 - Box 16	As applicable to HRSA; not counted in the page limit.
Application Checklist Form HHS-5161-1	Form	Pages 1 & 2 of the HHS checklist.	Not counted in the page limit.
Project Narrative Attachment Form	Form	Supports the upload of Project Narrative document	Not counted in the page limit.
Project Narrative	Attachment	Can be uploaded in Project Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions. Provide table of contents specific to this document only as the first page.
SF-424A Budget Information - Non-Construction Programs	Form	Page 1 & 2 to supports structured budget for the request of Non-construction related funds.	Not counted in the page limit.
SF-424B Assurances - Non-Construction Programs	Form	Supports assurances for non-construction programs.	Not counted in the page limit.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Project/Performance Site Location(s)	Form	Supports primary and 29 additional sites in structured form. See http://apply07.grants.gov/apply/forms/sample/PerformanceSite_1_4-V1.4.pdf for a copy of the forms.	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). See http://apply07.grants.gov/apply/forms/sample/PerformanceSite_1_4-V1.4.pdf for a copy of the forms	Not counted in the page limit.
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
Other Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list.	Not counted in the page limit.
Attachment 1-15	Attachment	Can be uploaded in Other Attachments form 1-15.	Refer to the attachment table provided below for **specific** sequence. Counted in the page limit.

- To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
- Merge similar documents into a single document. Where several pages are expected in the attachment, ensure that you place a table of contents cover page specific to the attachment. The Table of Contents page will not be counted in the page limit.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Organizational Chart, Job Descriptions, Bio-sketches, Staffing Plan
Attachment 2	Letters of Agreement, Memorandum of Understanding (MOU), Intergovernmental Agreements (IGAs), FY 2011 Agreements and Compliance Assurances
Attachment 3	HIV/AIDS Epidemiology Table
Attachment 4	Co-morbidities, Cost and Complexity Table
Attachment 5	Report on the Availability of Other Public Funding
Attachment 6	Unmet Need Framework
Attachment 7	FY 2011 Implementation Plan

Attachment Number	Attachment Description (Program Guidelines)
Attachment 8	Planned Services Table, Core Medical Services Waiver Request (if applicable)
Attachment 9	EIIHA Matrix

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. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93. 914.

DUNS Number
All applicant organizations are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant 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://www.hrsa.gov/grants/dunsccr.htm or call 1-866-705-5711. Please include the DUNS number in Application Form 5161-1 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.

Additionally, the applicant organization is required to register annually with the Federal Government's Central Contractor Registry (CCR) in order to do electronic business with the Federal Government. It is extremely important to verify that your CCR registration is active. Information about registering with the CCR can be found at http://www.ccr.gov.

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. *Application Checklist*
Complete the HHS Application Checklist Form PHS 5161-1 provided with the application package.

iv. *Budget*
Complete Application Form SF 424A Budget Information – Non-Construction Programs provided with the application package. Please complete Sections A, B, E, and F, and then provide a line item budget for each year of the project period using Section B Budget Categories of the SF-424A.

Under Section B, budget categories, there should be at least four columns: "Administrative," "Clinical Quality Management," "MAI," and "HIV Services." Personnel and fringe benefits for program staff assigned to these budget categories should be placed on the appropriate line. On the Contractual Services line-item list the amounts allocated for personnel or services contracted to outside providers for all HIV services. Show the amount allocated to any activities that are not conducted "in-house" on the contractual line.

Grantee Administration, and Planning Council (PC) Support, are all now considered within the Grantee Administration budget and together are capped at 10%. Grantees must determine the amounts necessary to cover all administrative and former program support activities. The

grantee must also ensure adequate funding for Planning Council mandated functions within the administrative line item. "Planning council support should cover *reasonable and necessary costs* associated with carrying out legislatively mandated functions."

v. *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. Line item information must be provided to explain the costs entered in appropriate form, Application Form SF 424. **The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/goals.** Be careful to show how each item in the "other" category is justified. The budget justification MUST be concise. DO NOT use the justification to expand the project narrative.

Caps on expenses: Part A Grantee Administrative Costs cannot exceed 10% of the grant award. Administrative expenditures for first-line entities or subcontractors may not exceed 10% of the aggregate amount allocated for services. Grantees are allowed to allocate up to 5% of the total grant award or $3,000,000 (whichever is less) for clinical quality management activities.

Include the following in the Budget Justification narrative:

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from grant funds, name (if possible), position title, percent full time equivalency, and annual salary.

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops.

Equipment: A detailed justification that includes the status of current equipment must be provided when requesting funds for the purchase of computers and other equipment (equipment is defined as having a unit cost of $5,000 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 and 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.

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, grantee rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

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 a HHS negotiated indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: http://rates.psc.gov/ to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them

vi. ***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 the rationale for the amount of time being requested for each staff position. Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff must be included in **Attachment 1**. Copies of biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included in **Attachment 1**.

vii. ***Assurances***

Complete Application Form SF 424B Assurances – Non-Construction Programs.

viii. ***Certifications***

Use the Certifications and Disclosure of Lobbying Activities Application Form provided with the application package. Include the Part A FY 2011 Agreements and Compliance as **Attachment 2 (see Appendix A of this funding opportunity announcement)**.

ix. ***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 grant 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 Name
- HRSA Grant Number
- Address

- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable

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

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

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

Note: *As a result of different legislative requirements for the five TGA grantees that received Part A funding for the first time in FY 2007, there are different narrative section responses that are applicable to two of the five TGA grantees that elected to utilize a community planning process. Those two TGA grantees are Baton Rouge, LA, and Charlotte, NC. The three TGA grantees that elected to seat a Planning Council will answer the narrative section responses applicable to Part A grantees with a Planning Council.*

1) Demonstrated Need

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

Supplemental awards are to be directed principally to those eligible areas with the greatest demonstrated need based on documented factors that are comparable across the EMA/TGAs. In order to target funding to these areas, demonstrated need is given greater weight in the scoring process. The FY 2011 plan, budget, and allocations table should be consistent with the discussion of demonstrated need.

Factors to be considered in assessing demonstrated need for the FY 2011 application include:

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

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

1) a. HIV/AIDS Epidemiology

As described above, supplemental funds will be targeted to those eligible areas where epidemiologic data demonstrate that HIV disease prevalence rates are increasing, where there is documented unmet need, and where there is a demonstrated disproportionate impact on vulnerable populations. Grantees are strongly encouraged to use the HRSA/CDC Integrated Guidelines as a tool for developing and reporting their epidemiological profile data. The document can be found at http://www.cdc.gov/hiv/epi_guidelines.htm

(1) Use a table to describe the EMA/TGA living cases of HIV disease through December 31, 2009; AIDS Prevalence and HIV (non AIDS) Prevalence data by demographic group and exposure category. Place the table in **Attachment 3** of the application and ***clearly label the data sources***.

(2) Provide a narrative description of the current HIV/AIDS prevalence in the EMA/TGA, including all of the following elements:

(a) HIV/AIDS cases by demographic characteristics and exposure category in the EMA/TGA including: 1) people living with HIV, 2) the number of people living with

AIDS, and 3) the number of new AIDS cases reported within the past two years (2008, 2009);

(b) Disproportionate impact of HIV/AIDS on certain populations in comparison to the impact on the general population, including disproportionately impacted minority communities, homeless and formerly-incarcerated individuals living with HIV/AIDS;

(c) Populations of PLWH/A in the EMA/TGA that are underrepresented in the Ryan White HIV/AIDS Program funded system of HIV/AIDS primary medical care; and

(d) Estimated level of service gaps among PLWH/A in the EMA/TGA.

1) b. Impact of Co-morbidities on the Cost and Complexity of Providing Care

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

(1) Describe how both service costs and the complexity of providing care to PLWH/A in the EMA/TGA are affected by co-morbidities and co-factors such as poverty and lack of insurance by comparing their rates in the general EMA/TGA population with their rates among PLWH/A in the EMA/TGA. Applicants must provide quantitative evidence (in table format in **Attachment 4**) and document data sources. **These descriptions must include:**

(a) STI rates;

(b) Prevalence of homelessness;

(c) The number and percent of persons without insurance coverage (including those without Medicaid and Medicare); and

(d) The number and percent of persons living at or below 300 percent of the 2010 Federal Poverty Level.

(e) Identify trends in services and fiscal resources as a result of municipal and state budget cuts in HIV related and funded clinical and non-clinical services.

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

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

1) c. Impact of Part A Funding: Funding Mechanisms and the Impact of the Decline in Ryan White Formula Funding

The purpose of this section is to describe the impact of Part A funding, including the decline in Ryan White Part A formula funding, and how service and funding mechanisms are coordinated in the EMA/TGA.

(1) Report on the Availability of Other Public Funding

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

(a) Report on the availability of public funding for HIV/AIDS-related care services within the EMA/TGA from Federal, State and local sources. The report should reflect the funds anticipated for support of HIV/AIDS-related services during the FY 2011 budget period. This information should be reported in a table format and included in **Attachment 5**. The table should include both the actual dollar amounts and the percentage of the total available funds from each source, using the following seven categories:

i) Ambulatory/Outpatient Medical Care;
ii) State AIDS Drug Assistance Programs;
iii) Home and Community Based Support Services;
iv) Other Outpatient/ Community Based Primary Medical Care Services;
v) Oral Healthcare;
vi) Substance Abuse/Mental Health
vii) Minority AIDS Initiative; and
viii) HIV Counseling and Testing Services

(2) Coordination of Services and Funding Streams

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

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

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

vii) Services for Women and Children (i.e., Special Supplemental Food Program for Women, Infants, and Children (WIC) Program and Substance Abuse Treatment Programs for Pregnant Women);
viii) Other State and Local Social Service Programs (i.e., General Assistance, Vocational Rehabilitation);
ix) Local, State, and Federal Public Health programs;
x) Local and Federal funds for substance abuse/mental health treatment services and;
xi) Other Ryan White HIV/AIDS Program funding (Parts B, C, D and F).

1) d. Assessment of Emerging Populations with Special Needs

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

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

> ***Note:*** *The narrative discussion of the assessment of emerging populations should be consistent with the FY 2011 Plan, allocations table, and the EMA/TGA most recent Comprehensive Plan.*

1) e. Unique Service Delivery Challenges

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

1) f. Impact of Decline in Ryan White Formula Funding

(1) Did the EMA/TGA experience a decline in Ryan White Formula funding? If so, provide a narrative that addresses:
- ***(a)*** The impact of the decline in formula funding including the number of services reduced or eliminated, what services were reduced or eliminated, waiting lists implemented, etc.

(b) The response of the Planning Council or community planning process regarding this reduction in formula funding, and any transitional planning for clients receiving services that were either eliminated or reduced.

1) g. Unmet Need

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

(1) Provide an updated estimate of unmet need in your jurisdiction, using the HRSA/HAB Unmet Need Framework and Calendar Year 2009 data. Include a copy of the framework in **Attachment 6** of this application.

(2) Provide a Table showing the Percent of Unmet Need for PLWA and PLWH for CY 2007, 2008, and 2009. Based on this Table, describe the trends in your Unmet Need percentages. Describe to what you attribute these changes (i.e. increased outreach, increased linkages to care, increased number of low income PLWH/A, etc.).

(3) Describe how these Unmet Need trends are reflected in planning and decision making.

(4) Provide a narrative description of the following:

- ***(a)*** Determination of the demographics and location of people who know their HIV/AIDS status and are not in care;
- ***(b)*** Assessment of service needs, gaps, and barriers to care for people not in care;
- ***(c)*** Efforts to identify individuals not in care and assist them in accessing primary care;
- ***(d)*** Describe how the results of the Unmet Need Framework as reflected in planning and decision making process about priorities, resource allocations, and the system of care. Examples include: (1) outreach activities, (2) system of care and, (3) collaborations with Ryan White and non-Ryan White funded providers;
- ***(e)*** New data sources used in the framework; and
- ***(f)*** Populations determined to be disproportionately out of care.

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

*The purpose of this section is to the describe the **strategy**, **plan**, and **data** associated with ensuring that individuals who are unaware of their HIV positive status are identified, informed of their status, referred into care, and linked to care. The purpose of this initiative is to **increase the number of individuals who are aware** of their HIV status, as well as **increase the number of HIV positive individuals who are in care**.*

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

Associated EIIHA Definitions:

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

Note: *The **12-month** time period is intended to be utilized as a **means to establish a threshold** for the purpose of assisting in the identification of individuals unaware of their HIV status, and is exclusive to Early Identification of Individuals with HIV/AIDS (EIIHA).*
*The **12-month** time period is **NOT** intended to be utilized as a recommended testing frequency, or for the purpose of assessing risk to HIV. For recommended HIV testing frequencies and risk assessments please refer to CDC guidelines.*
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

- **Identification of Individuals Unaware of Their HIV Status:** The ***categorical breakdown*** of the overall unaware population into subgroups, which allow for the overall EIIHA strategy to be ***customized based on the needs of each subgroup***, for the purposes of identifying, counseling, testing, informing, referring, and linking these individuals into care. ***See example EIIHA Matrix 1.1 below:***

Example EIIHA Matrix 1.1

1A. **All Individuals Unaware of their HIV Status** *(HIV positive & HIV negative)*									
2A. **Tested**			2B. **Untested**						
3A. **Individuals Not Post-Test Counseled** *(HIV positive & HIV negative)*		3B. **Received Preliminary HIV Positive Result Only – No Confirmatory Test**	3C. **High Risk Individuals**				3D. **Moderate & Low Risk Individuals**		
4A. **Tested Confidentially**	4B. **Tested Anonymously**		4C. **IVDU**	4D. **MSM**	4E. **Infants Of Infected Mothers**	4F. **Partners of HIV+ Individuals**	4G. **Not Tested in Past 24 Month**	4H. **Not Tested in Past 48 Month**	

- **Informing individuals of their HIV status:** Informing an HIV negative individual, post-test, of their appropriate HIV screening result. Informing an HIV positive individual, post-test, of their ***confirmatory*** HIV result.
- **Referral to care/services:** The provision of timely, appropriate, and pre-established guidance to an individual that is designed to refer him/her to a specific care/service

provider for the purpose of accessing care/services after the individual has been informed of their HIV status (positive or negative).

- **Linkage to care:** The post-referral verification that care/services were accessed by an HIV positive individual being referred into care. *(i.e., Confirmation first scheduled care appointment occurred.)*

2)a. **Strategy** *(Blueprint for implementation)*

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

(a) Describe the specific goals this strategy is intended to achieve.

i. Describe how each goal is consistent with making individuals who are unaware of their HIV status aware of their status.

(b) Describe how this strategy will coordinate with your RW Part B counterpart with regard to the following:

i. Identifying HIV positive unaware individuals.
ii. Informing HIV positive unaware individuals of their status.
iii. Referring HIV positive unaware individuals to care.
iv. Linking HIV positive unaware individuals to care.
v. EIIHA Data Collection and Sharing.

(c) Describe how this strategy will coordinate with prevention and disease control/intervention programs-*without supplanting funds*-with regard to the following:

i. Identifying HIV positive individuals unaware of their status.
ii. Informing HIV positive unaware individuals of their status.
iii. Referring HIV positive unaware individuals to care.
iv. Linking HIV positive unaware individuals to care.
v. EIIHA Data Collection and Sharing.

(d) Describe how this strategy will coordinate with other programs/facilities and community efforts. *(i.e., correctional facilities, CBO's, hospitals, etc.)*

(e) Describe how EIIHA activities and strategies will be incorporated into the program's Requests for Proposals (RFP's).

(f) Describe how ADAP and other medication resources will be considered in order to accommodate the needs of new positives.

(g) Describe the role of Part A funded Early Intervention Services in implementing this strategy.

(h) Describe how this strategy addresses disparities in access and services among affected subpopulations and historically underserved communities.

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

Note: *All Ryan White funded EIIHA activities should be* ***reported under the EIS service category****. If the activities and/or services needed to implement an EIIHA strategy/plan are funded by a* ***source other than Ryan White****, then* ***list the funding source*** *associated with each activity.*

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

(1) **Identifying Individuals Unaware of Their HIV Status**

(a) Within the overall unaware population that encompasses any individual who is unaware of their HIV status, ***develop a matrix listing the sub-groups***, which will allow the applicant's overall strategy to be customized to meet the needs of each subgroup *(For an example, please refer to "EIIHA Matrix 1.1" listed above)*. The EIIHA Matrix should include ***all sub-groups*** that the applicant's EIIHA Strategy, Plan, and Data intend to address. Submit the EIIHA Matrix as **Attachment 9**.

(b) For each subgroup in the EIIHA Matrix, describe how the strategy will be customized to address their respective needs specific to identifying HIV positive individuals unaware of their status.

i) ***Example: Reference EIIHA Matrix 1.1 - Block 3D. (Moderate & Low Risk Individuals):*** *"…promote universal testing which entails routine HIV testing in everyday medical practice, both public and private…"*

(c) For each subgroup in the EIIHA Matrix, describe the respective challenges (including any local legislation or policies) associated with ***identifying*** individuals who are unaware of their HIV status.

(d) For each subgroup in the EIIHA Matrix, describe the respective activities essential for ***identifying*** HIV positive individuals who are unaware of their status.

i) Describe which essential activities are able to be implemented immediately.

ii) Describe which essential activities are proposed but ***NOT*** able to be implemented immediately.

a. Describe the timeline associated with when each essential activity will be implemented.

b. Describe the parties responsible for ensuring each of these essential activities are implemented according to the timeline described.

(2) **Informing Individuals of Their HIV Status**

(a) For each subgroup in the EIIHA Matrix, describe how the overall strategy will be customized to address their respective needs in terms of ***informing*** unaware individuals of their HIV status.

i) ***Example: Reference EIIHA Matrix 1.1 - Block 3D. (Moderate & Low Risk Individuals):*** *"…educate providers regarding resources available whenever a client does not return for their HIV results…"*

(b) For each subgroup in the EIIHA Matrix, describe the respective challenges (including any local legislation or policies) associated with ***informing*** unaware individuals of their HIV status.

(c) For each subgroup in the EIIHA Matrix, describe the respective activities essential to ***informing*** unaware individuals of their HIV status.

i) Describe which essential activities are able to be implemented immediately.
ii) Describe which essential activities are proposed but ***NOT*** able to be implemented immediately.
   a. Describe the timeline associated with when each essential activity will be implemented.
   b. Describe the parties responsible for ensuring each of these essential activities are implemented according to the timeline described.

(3) Referral to Care

(a) For each subgroup in the EIIHA Matrix, describe how the strategy will be customized to address their respective needs specific to ***referring*** individuals recently informed of their HIV status into care.

i) ***Example: Reference EIIHA Matrix 1.1 - Block 3D. (Moderate & Low Risk Individuals):*** *"…educate providers regarding the EMA/TGA's/State's pre-established referral process to ensure…"*

(b) For each subgroup in the EIIHA Matrix, describe the respective challenges (including any local legislation or policies) associated with ***referring*** individuals recently informed of their HIV status into care.

(c) For each subgroup in the EIIHA Matrix, describe the respective activities essential to ***referring*** individuals recently informed of their HIV status into care.

i) Describe which essential activities are able to be implemented immediately.
ii) Describe which essential activities are proposed but ***NOT*** able to be implemented immediately.
   a. Describe the timeline associated with when each essential activity will be implemented.
   b. Describe the parties responsible for ensuring each of these essential activities are implemented according to the timeline described.

(4) Linkage to Care

(a) Describe the activities essential to ensuring access to care regardless of where any newly identified HIV positive individual enters into the continuum of care.

i) Describe which essential activities are able to be implemented immediately.
ii) Describe which essential activities are proposed but ***NOT*** able to be implemented immediately.
   a. Describe the timeline associated with when each essential activity will be implemented.
   b. Describe the parties responsible for ensuring each of these essential activities are implemented according to the timeline described.

(b) For any newly identified HIV positive individual referred into a ***Ryan White funded program***, describe the activities undertaken post-referral to verify that care/services were accessed.

i) Describe which essential activities are able to be implemented immediately.
ii) Describe which essential activities are proposed but ***NOT*** able to be implemented immediately.

a. Describe the timeline associated with when each essential activity will be implemented.
b. Describe the parties responsible for ensuring each of these essential activities are implemented according to the timeline described.

(c) Describe the activities undertaken to form and maintain relationships with private HIV care providers for the purpose of verifying that individuals referred into private care have accessed care post-referral.

i) Describe which essential activities are able to be implemented immediately.

ii) Describe which essential activities are proposed but ***NOT*** able to be implemented immediately.

a. Describe the timeline associated with when each essential activity will be implemented.

b. Describe the parties responsible for ensuring each of these essential activities are implemented according to the timeline described.

(d) Describe the efforts to address legal barriers, including local and state laws and regulations, to routine testing.

2) c. Data

Application of CDC National Estimates (National Proportion Undiagnosed) to Jurisdictional Data: *To obtain a local estimate of undiagnosed persons living with HIV at the end of **2008**, areas should apply the national percentage using the formula below. The number of persons living with diagnosed HIV infection at the end of **2008** should be obtained from data reported to the local health department as of **June 2010.** This allows for18 months for cases and deaths to be reported.*

(1) Report the estimated number of living HIV positive individuals who were unaware of their status as of December 31st, **2008**.

(a) Estimated Back Calculation (EBC) Methodology:

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

i) ***Formula:***

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

*Number of individuals diagnosed with HIV and living as of December 31, **2008** =**N***

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

ii) ***Example:***

*National Proportion Undiagnosed **= 21%***

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

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

(2) Report the ***total number*** of HIV tests conducted using ***local, state & federal funds*** as of December 31st **2009**.

(a) Of the total number tested, report the number of individuals informed of their HIV status (regardless of positive or negative HIV result), also list as percentage.

i) *Of the number* ***informed*** *of their HIV status, report the number of* ***HIV positive*** *individuals, also list as percentage.*

a. *Of the number* ***informed*** *of their HIV positive status,* report the number of individuals ***referred*** into care, also list as percentage.

Note: *Linkage to care numbers will be requested in subsequent years.*

(b) Of the total number tested, report the number of individuals NOT informed of their HIV status (regardless of positive or negative HIV result), also list as percentage.

i) *Of the number* ***NOT*** ***informed*** *of their HIV status,* report the number of ***HIV positive*** individuals, also list as percentage.

(3) Describe how the data in (***3)(b)i-ii*** will impact your Quality Management Plan.

Note: *At this time, the estimated number of living HIV positive individuals who were unaware of their status at the end of* ***2008*** *should* ***NOT*** *be compared to, or correlated with, any data regarding the number of HIV tests conducted using local, state & federal funds at the end of* ***2009****.*

EIIHA Scoring: Important Notes

- *Scoring will be based on the comprehensiveness, strength, and feasibility of the strategy, plan, and data provided by the applicant.*
- *Scoring will* ***NOT*** *be affected by the amount of RW funds committed to EIIHA efforts as long as the strategy, plan, and data can be effectively carried out via collaborative efforts.*
- *Scoring will* ***NOT*** *be affected by the estimated number of individuals unaware of their HIV positive status.*
- *Scoring will* ***NOT*** *be affected by the number of unaware HIV positive individuals indentified, informed, referred, and linked to care.*
- *Scoring will* ***NOT*** *be affected by the number of activities that are able to be implemented immediately VS. the number of activities that are* ***NOT*** *able to be implemented immediately.*

3) Access to HIV/AIDS Care and the Plan for FY 2011

The purpose of this section is to provide a narrative summary describing the EMA/TGA continuum of care during FY 2011, including access to care for those who know their status but are not presently in the system of HIV/AIDS primary medical care and access to primary medical care for emerging population. It should also describe how Part A funded services are integrated and coordinated with other available programs and services at the local level to enhance the continuum of HIV care. Additionally, this section also presents the FY 2011 HIV/AIDS service plan, with specific attention to ensuring access to a continuum of HIV/AIDS outcome disparities among populations with specific needs, including emerging populations identified in the Demonstrated Need section. The plan must address the needs of those

persons in care as well as those who know their HIV status but are not in HIV/AIDS primary medical care. In addition, include strategies for access to care for persons who are unaware of their HIV status.

3) a. The EMA/TGA Established Continuum of HIV/AIDS Care and Access to Care

The Ryan White HIV/AIDS Program requires EMA/TGA to develop a comprehensive continuum of HIV/AIDS care accessible to eligible PLWH/A in the EMA/TGA. The system of care should address the service needs of newly affected and underserved populations — including disproportionately impacted communities of color, emerging populations and those who know their HIV and AIDS status but are not presently in the system of HIV/AIDS primary medical care. The EMA/TGA system of HIV/AIDS care should be consistent with HRSA's goals of increasing access to services and decreasing HIV/AIDS health disparities among affected subpopulations and historically underserved communities.

(1) Describe the EMA/TGA continuum of care for FY 2011, including how integration and coordination of other available services or programs with Part A funded services contributes to the EMA/TGA continuum of care. The description should include: mechanisms within the EMA/TGA that enable newly infected, underserved, hard-to-reach individuals, emerging populations and/or disproportionately impacted communities of color to access and remain in primary medical care.

3) b. Table: FY 2011 Implementation Plan

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

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

(1) List the EMA/TGA four core medical service categories and two support service categories which comprise the largest amounts of Part A funding allocated for FY 2011

on the Implementation Plan. For each of the four core medical services and the two support services listed, develop one or more service goals with time limited and measurable program objectives. For the MAI funds, list two service categories which comprise the largest amounts of the MAI funding allocated for FY 2011 using the implementation plan format as the Part A funding.

(a) For each objective, define the service unit, the number of persons to be served, the units of service to be delivered, timeframe, and the estimated cost of meeting the objective.

(b) These service goals and objectives will comprise the major elements of the FY 2011 Implementation Plan.

(c) The Implementation Plan should be placed in **Attachment 7** of the application.

3) c. Narrative

(1) Based upon the FY 2011 Implementation Plan, provide a narrative that describes the following:

(a) How the EMA/TGA links its latest needs assessment (including results of the HRSA/HAB Unmet Need Framework), Comprehensive Plan, service priorities, and the FY 2011 Implementation Plan;

(b) Identify any prioritized Core Medical Services which will not be funded with Ryan White Program funds and how these services will be delivered in the EMA/TGA;

(c) How the activities described in the plan will provide increased access to the HIV continuum of care for minority communities;

(d) How the activities described in the plan will address the needs of emerging populations, as discussed in the demonstrated needs section;

(e) How the activities described in the plan will encourage PLWH/A to remain engaged in HIV/AIDS primary medical care and adhere to HIV treatments;

(f) How the activities described in the plan will promote parity of HIV services throughout the EMA. Parity of services should be addressed in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness;

(g) How the activities are assuring the services delivered by subcontractors are culturally and linguistically specific to the population served within the EMA/TGA.

(h) How the services and their goals and objectives relate to the goals of the Healthy People 2010 initiative (Chapter 13). Refer to http://www.health.gov/healthypeople/document/.

(i) How the EMA/TGA will ensure that resource allocations for services to women, infants, children, and youth (WICY) are in proportion to the percentage of EMA/TGA AIDS cases represented by each population;

(j) How the EMA/TGA Planning Council or community planning process is using Minority AIDS Initiative (MAI) funding to further enhance the quality of care and

health outcomes in communities of color disproportionately impacted by the HIV epidemic, and how those activities are integral to the overall 2011 plan.

(k) How the EMA/TGA will use the Minority AIDS Initiative (MAI) funding to improve the quality of care and client-level health outcomes in communities of color disproportionately impacted by the HIV epidemic

(l) How the EMA/TGA will use the Minority AIDS Initiative (MAI) funding to reduce disparities in access to care as part of the overall FY 2011 plan. Additionally, how MAI clients will be linked to the Part A funded continuum of care, and be supported in accessing treatment and remaining in care to improve health outcomes.

4) Grantee Administration

The purpose of this section is to demonstrate the extent to which the Chief Elected Official or designee in the EMA/TGA has met the legislative requirements to disburse funds quickly, closely monitor their use and ensure that the Ryan White HIV/AIDS Program is the payer of last resort. The Ryan White HIV/AIDS Program stresses the importance of timely obligation of Ryan White funds. Timely obligation of Ryan White funds ensures that services can be provided as rapidly as possible and decreases the possibility that unobligated funds will remain at the end of the program year. Please refer to Section 2603(c) (1), (2) and (3) of the Public Health Service Act. Unobligated balances do not apply to MAI funds.

Note: *Unobligated formula grant funds up to 5 percent of the award do not incur penalties. There are three penalties if the unobligated formula grant funds exceed the 5 percent threshold.*

- *future year award is offset by the amount of UOB less the amount of approved carry over;*
- *future year award is reduced by the amount of UOB less the amount of approved carry over; and*
- *the grantee will be ineligible to receive competitive supplemental grant funds for a future year.*
- ***Note:*** *Grantees may request use of unobligated supplemental funds in a future year, but the same amount of the unobligated supplemental funds will be reduced from that same future year award.*
- *Please refer to HRSA HAB Policy Notice 10-01—The Unobligated Balances Provision*

4) a. Program Organization

(1) Provide a description of how Part A (including MAI) funds are administered within the EMA/TGA with reference to the staff positions described in the budget narrative and the organizational chart provided in **Attachment 1**. The narrative should describe: the local agency responsible for the grant and identify the entity responsible for administering the Part A program, including the department, unit, staffing levels (including any vacancies, FTEs), fiscal agents, planning/evaluation bodies, and in-kind support staff. Describe the approaches to fill vacant staff positions that are essential for delivery, oversight, and monitoring of the Ryan White core services and MAI activities.

4) b. Grantee Accountability

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

(1) Provide a narrative that describes the following:

- ***(a)*** The process used to separately track formula, supplemental, MAI, and carry over funds, including information on the data systems utilized;
- ***(b)*** The process used to ensure timely monitoring and redistribution of unexpended funds;
- ***(c)*** The process used in fiscal and program monitoring, including frequency of reports;
- ***(d)*** The frequency of fiscal and of programmatic monitoring site visits during a program year;
- ***(e)*** The process and timeline for corrective actions when a fiscal or programmatic-related concern is identified;
- ***(f)*** The total number of contractors funded in FY 2010; and the number and percentage of contractors that received a fiscal and/or programmatic monitoring site visit during the FY 2010 grant year;
- ***(g)*** Any improper charges or other findings in FY 2010 and a summary of the corrective actions planned or taken to address these findings;
- ***(h)*** The number of contractors that received technical assistance (TA) for FY 2010 (types of TA, scope, and timeline);
- ***(i)*** The number and percentage of contractors compliant with the audit requirement in OMB Circular A-133;
- ***(j)*** If there were findings in any subcontractors' A-133 audit reports, describe what the grantee has done to ensure that subcontractors have taken appropriate corrective action. Corrective actions may include but are not limited to HRSA/HAB sponsored TA and training requests from the grantee of record; and
- ***(k)*** The process of receiving vouchers or invoices from contractors/subcontractors; and
- ***(l)*** The process of payment made to contractors/subcontractors, from receipt of voucher/invoice to reimbursement.

(2) Fiscal Staff Accountability

- ***(a)*** Provide a narrative that describes the following:
  - i. The role and responsibilities of program and fiscal staff in ensuring adequate reporting, reconciliation, and tracking of program expenditures;
  - ii. The process and coordination of program and fiscal staff in ensuring adequate reporting, reconciliation, and tracking of program expenditures. For example, the program and fiscal staff's meeting schedule and how fiscal staff share information

with program staff regarding contractor expenditures, formula and supplemental unobligated balances, and program income;

iii. The applicant should include an organizational chart for fiscal staff in **Attachment 1**, only if fiscal staff is not within the program staff personnel.

4) c. Third Party Reimbursement

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

(1) Provide a narrative that describes the following:

(a) The process used by grantees to ensure that contractors are monitoring third party reimbursement. Also describe the contract language or other mechanism to ensure that this takes place;

(b) How subcontractors document that clients have been screened for and enrolled in eligible programs (i.e., Medicare, Medicaid, private health insurance or other programs) to coordinate benefits and to ensure that Ryan White HIV/AIDS Program funds are the payer of last resort; and

(c) How the grantee monitors the appropriate tracking and use of any program income and rebates.

******The next section (5d.1a-c) should be completed by **all applicants <u>except</u> Baton Rouge TGA & Charlotte TGA** ******

4) d. Administrative Assessment

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

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

(a) Activities such as timely payments to contractors or data collection; and

(b) Corrective action or suggested methods of improvement that were recommended.

(c) If any deficiencies were noted, what were the deficiencies, what was the grantee's response to those deficiencies, and what is the current status of the grantee's response?

The next section (5d.2, 3a-c) should be completed by **Baton Rouge TGA & Charlotte TGA ONLY**

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

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

(a) Activities such as timely payments to contractors or data collection;

(b) Corrective action or suggested methods of improvement that were recommended;

(c) If any deficiencies were noted, what were the deficiencies? What was the grantee's response and what is the current status of the grantee's response to these deficiencies?

5) Planning and Resource Allocation

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

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

***The next section (6a.1a-e, 6b. 1-11) should be completed by **all applicants <u>except</u> Baton Rouge TGA and Charlotte TGA** ***

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

(1) Applicants must provide a letter of assurance signed by the Planning Council Chair(s). The letter must address the following:

(a) The FY 2010 Formula, Supplemental , and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the Planning Council;

(b) That all FY 2010 Conditions of Award relative to the Planning Council have been addressed;

(c) The FY 2011 priorities were determined by the Planning Council, and the approved process for establishing those priorities was used by the Planning Council;

(d) Planning Council annual membership training took place; and

(e) The Planning Council is representative and reflective of the epidemic in the EMA/TGA. If there are any vacancies or deficiencies on the Council, provide a plan and timeline for addressing each vacancy or deficiency. Note variations between the demographics of the non-aligned consumers and the HIV disease prevalence of the EMA/TGA.

5) b. Describe how the priority setting and allocation process was conducted, including a description of:

(1) How the needs of those persons not in care were considered;

(2) How the needs of those persons unaware of their HIV status were considered;

(3) How the needs of historically underserved populations were considered;

(4) How PLWH/A were involved in the priority setting and allocation process and how their priorities are considered in the process;

(5) How data were used in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the EMA/TGA;

(6) How changes and trends in HIV/AIDS epidemiology data were used in the priority setting and allocation process;

(7) How cost data were used by the Planning Council in making funding allocation decisions;

(8) How unmet need data were used by the Planning Council in making priority and allocation decisions;

(9) How the Planning Council's process will prospectively address any funding increases or decreases in the Part A award;

(10) How MAI funding was considered during the planning process to enhance services to minority populations; and

(11) How was data related to Persons Unaware of HIV Status Data used in the Priority and Allocations decision making process?

*********The next section (6c.1, 2a-h) should be completed by **Baton Rouge TGA & Charlotte TGA ONLY*****

Note: *A TGA that received Part A funding for the first time in FY 2007 is not required to establish a Planning Council. However, each TGA is required to provide documentation*

that details the process used to obtain community input for formulating the overall plan for priority setting and allocating funds.

5) c. Description of the Community Input Process

(1) Describe the process used by your TGA to obtain community and consumer input for the priority setting and allocations process.

(2) Describe how the planning and allocation processes were conducted, including how the needs of those not in care, those unaware of their HIV status, and those from historically underserved populations were considered in the process. The narrative should include a description of:

- ***(a)*** How PLWH/A were involved in the planning and allocation processes and how their priorities were considered in the process;
- ***(b)*** How data were used in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the TGA;
- ***(c)*** How changes and trends in HIV/AIDS epidemiology data were used in the planning and allocation process;
- ***(d)*** How cost data was used in making funding allocation decisions;
- ***(e)*** How unmet need data was used in making priority and allocation decisions;
- ***(f)*** How the process will prospectively address funding increases or decreases in the Part A award;
- ***(g)*** How MAI funding was considered during the planning process to enhance services to minority populations; and
- ***(h)*** How was EIIHA (unaware of HIV status) Data used in the Priority and Allocations decision making process?

******The next section (6d.1) should be completed by **ALL applicants** ******

5) d. Funding for Core Medical Services

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

(1) All applicants are required to submit a Table that lists planned services for FY 2011 that meet the 75 percent core medical services allocation requirement, regardless of whether the applicant has received or intends to apply for a Core Medical Services Waiver. The table must also be submitted regardless of the results of the Planning Council's or community planning process' priority setting and allocations process. In addition, applicants must provide a table that is reflective of the results of the priority setting and resource allocation process, if those results are different from the table

reflecting compliance with the 75 percent core medical services allocation requirement. (The Planned Services Table and the core medical services waiver request should be included as **Attachment 8**.)

6) Budget and Maintenance of Effort (MOE)

6) a. Budget

(*1*) Follow instructions provided under Section IV. "Application and Submission Information."

6) b. Maintenance of Effort

The Ryan White legislation requires Part A grantees to maintain, as a Condition of Award, EMA/TGA political subdivision expenditures for HIV-related Core Medical Services and Support Services at a level equal to the 1-year period preceding the fiscal year (FY) for which the grantee is applying to receive a Part A grant. After enactment of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, section 2604 (b) (1) of the enacting legislation states: "In general-The chief elected official of an eligible area shall use amounts from a grant under section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services." Core medical services and support services are defined in section 2604(c)(3) and 2604(d) of the legislation and the HIV/AIDS Bureau service definitions distributed to all grantees. Part-A grantees must document that they have met the MOE requirement.

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

- ***(a)*** A table that identifies the MOE budget elements and the amount of expenditures related to core medical services for FY 2008 and FY 2009;
- ***(b)*** A description of the process used to determine the amount of expenditures reported in the table.

7) Clinical Quality Management

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

HAB has established the following minimum expectations of Ryan White HIV/AIDS Program grantees regarding clinical quality management. At a minimum, grantees must have:

(1) Established and implemented a clinical quality management plan;

(2) Established processes for ensuring that Primary Medical Care services are provided in accordance with the Department of Health and Human Services (DHHS) treatment guidelines and standards of care; and

(3) Incorporated quality-related expectations into Requests for Proposals (RFP) and EMA/TGA contracts.

> ***Note****: HRSA's expectations of Ryan White HIV/AIDS Program grantees with respect to improving the quality of care and establishing clinical quality management programs may be found online at: http://hab.hrsa.gov/special/qualitycare.htm. HRSA technical assistance in selecting appropriate service- and client-level outcomes is also available online at: http://hab.hrsa.gov/tools.htm or http://careacttarget.org.*
>
> *The HAB HIV/AIDS Core Clinical Performance Measures for Adults & Adolescents are offered as a set of indicators for use in monitoring the quality of care provided. The measures can be modified by the grantee to meet specific needs of the EMA/TGA. Grantees should select measures that are most important to their programs and the populations they serve, as they relate to their overall goals for improving clinical health outcomes.*

7) a. Description of Clinical Quality Management Program

(1) Provide a narrative that describes the EMA/TGA's overall clinical quality management program, which describes the following:

(a) CQM structure, vision/mission and goals:

- ***i.*** Overall purpose and goals of the clinical quality management program;
- ***ii.*** Roles of staff members or committees/quality management team responsible for overseeing and managing the quality management activities, including allocated resources; and
- ***iii.*** Number of staff FTE's assigned to Quality Management.

(b) Established Quality Management program:

- ***i.*** Internal quality processes that assess the administrative agency's clinical quality management program;
- ***ii.*** Specific activities that have been implemented to assess the quality of services provided by providers/subcontractors;
- ***iii.*** Specific indicators that are being monitored by service category for outpatient and ambulatory health services and medical case management, including how these indicators are measured;
- ***iv.*** Describe the process to implement, monitor, and evaluate the quality management program;
- ***v.*** Describe how MAI outcome data is being used to meet the Quality Management Program objectives to improve clinical care;

vi. Describe any ongoing activities or plans to use data to show how Part A funded services, including support services, are improving HIV-related clinical health outcomes of PLWH/A in the EMA/TGA.

7) b. Description of Data Collection and Results

(1) Describe the grantee's current client level data capabilities (RDR and RSR), including the percentage of providers that are able to report client level data;

(2) Describe the Management Information System (MIS) used for data operations;

(3) Since January 1, 2009, describe the process that is used to collect and report to HRSA client level data (RSR) from all core and support service providers;

(4) Describe what QM data have been collected to date, and provide a summary of results;

(5) Describe how this data was reviewed and validated by the grantee and Planning Council to determine processes to improve clinical outcomes; and

(6) Describe how the QM data have been used to improve or change service delivery in the EMA/TGA.

xi. 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. Be sure each attachment is clearly labeled.

Attachment 1	Organizational Chart, Staffing Plan, Biographical Sketches
Attachment 2	Letters of Agreement, Memorandum of Understanding (MOU), Intergovernmental Agreements (IGAs), FY 2011 Agreements and Compliance Assurances, Certifications
Attachment 3	HIV/AIDS Epidemiology
Attachment 4	Co-morbidities, Cost and Complexity Table
Attachment 5	Report on the Availability of Other Public Funding
Attachment 6	Unmet Need Framework
Attachment 7	FY 2011 Implementation Plan
Attachment 8	Planned Services Table, Core Medical Services Waiver Request (if applicable.)
Attachment 9	EIIHA Matrix

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

3. Submission Dates and Times

Application Due Date

The due date for applications under this grant announcement is October 18*, 2010 at 8:00 P.M. ET*. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by your organization's Authorized Organization Representative (AOR) through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

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

Late applications:

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

4. Intergovernmental Review

The Part A HIV Emergency Relief Grant Program is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. Executive Order 12372 allows States the option of setting up a system for reviewing applications from within their States for assistance under certain Federal programs. Application packages made available under this guidance 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 Officer listed in the Agency Contact(s) section, as well as from the following Web site: http://www.whitehouse.gov/omb/grants/spoc.html.

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

Letters from the State Single Point of Contact (SPOC) in response to Executive Order 12372 are due sixty days after the application due date.

5. Funding Restrictions

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

- Construction is not allowable. Minor alterations and renovations to an existing facility, to make if more suitable for the purpose of the grant program are allowable with prior HRSA approval;
- Entertainment costs are not allowable. This includes the cost of amusements, social activities and related incidental costs;
- Fundraising expenses are not allowable;
- Lobbying expenses are not allowable;
- International travel is not allowable.

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

Caps on expenses: Part A Grantee Administrative Costs cannot exceed 10% of the grant award. Administrative expenditures for first-line entities or subcontractors may not exceed 10% of the aggregate amount allocated for services. Grantees are allowed to allocate up to 5% of the total grant award or $3,000,000 (whichever is less) for clinical quality management activities.

6. Other Submission Requirements

As stated in Section IV.1, except in rare cases HRSA will no longer accept applications for grant opportunities 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 http://www.Grants.gov apply site. When using Grants.gov you will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

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

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

- Obtain an organizational Data Universal Number System (DUNS) number
- Register the organization with Central Contractor Registry (CCR)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's CCR "Marketing Partner ID Number (M-PIN)" password
- Register 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 www.grants.gov. Assistance is also available 24 hours a day, 7 days a week (excluding Federal holidays) from the Grants.gov help desk at support@grants.gov or by phone at 1-800-518-4726.

Formal submission of the electronic application: Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by your organization's AOR through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

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

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 electronic submission prior to the application due date as the final and only acceptable submission of any competing application submitted to Grants.gov.

Tracking your application: It is incumbent on the applicant to track application status by using the Grants.gov tracking number provided in the confirmation email from Grants.gov. For more information about tracking your application can be found at http://www07.grants.gov/applicants/resources.jsp.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of grant applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion

and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Review Criteria are used to review and rank applications.

Note: *As a result of different legislative requirements for the five TGA grantees that received Part A funding for the first time in FY 2007, there are some different narrative section responses that are applicable to two of the TGA grantees that elected to utilize a community planning process. Those two TGA grantees are Baton Rouge, LA, and Charlotte, NC. The three TGA grantees that elected to seat a Planning Council will answer the narrative section responses applicable to Part A grantees with a Planning Council.*

The **HIV Emergency Relief Grant Program** has 7 review criteria:

Criterion 1: NEED (total of 34 points)

Demonstrated Need

a. The applicant provides a table that is complete and consistent with the information in the narrative. The sources for all data should be clearly indicated.

b. The applicant provides a narrative description of current HIV disease prevalence in the EMA, which includes all of the following elements:

1) HIV/AIDS cases by demographic characteristics and exposure category in the EMA including (1) the estimated number of people living with HIV, (2) the number of people living with AIDS and (3) the number of new AIDS cases reported within the past two years (2008, 2009);
2) Disproportionate impact of HIV/AIDS on certain populations in comparison to the impact on the general population, including disproportionately impacted minority communities;
3) Populations of PLWH/A in the EMA/TGA that are underrepresented in the Ryan White-funded system of HIV/AIDS primary medical care; and
4) Estimated level of service gaps among PLWH/A in the EMA/TGA.

c. The applicant provides quantitative evidence in a table format on the impact of co-morbidities and co-factors on the cost and complexity of providing care to PLWH/A. The data on co-morbidities should compare:

1) Numbers for the general population and the population of PLWH/A in the EMA/TGA;
2) STI rates;
3) Estimated number of homeless persons;
4) The number and percent of persons without insurance coverage (including those without Medicaid and Medicare); and
5) The number and percent of person living at or below 300 percent of the 2010 Federal Poverty Level.

d. The applicant provides a narrative description of the impact of co-morbidities and co-factors on the cost and complexity of care in the EMA/TGA that is consistent with the above mentioned table.

e. The applicant provides a narrative that clearly describes the impact on the service delivery system in the EMA/TGA of individuals who were released from Federal, state or local prisons during the preceding three years, and had HIV/AIDS on the date of their release.

f. The applicant includes a table that fully describes the availability of other public funding in the EMA. It includes both the actual dollar amount(s) and the percentage of the total available funds in each of the following categories:

1) Ambulatory/Outpatient Medical Care;
2) State AIDS Drug Assistance Programs;
3) Home and Community Based Support Services;
4) Other Outpatient/Community Based Primary Medical Care Services;
5) Oral Healthcare;
6) Substance Abuse/Mental Health;
7) Minority AIDS Initiative (MAI); and
8) HIV Counseling and Testing Services

g. The applicant discusses ways in which services funded by Federal and local sources (including other Ryan White programs) are taken into consideration in planning for the continuum of HIV care during the priority setting and allocation processes.

h. The applicant fully documents the needs of ***no more than 6*** emerging populations, including:

1) Unique challenges that each population presents to the services delivery system;
2) Service gaps for each population; and
3) Estimated costs associated with delivering services to each population.

i. The applicant provides a clear and compelling narrative description of the need for HIV/AIDS emergency grant funds in the EMA/TGA based on factors not already discussed. The narrative describes the unique service delivery challenges in terms of service cost and complexity, as a result of those challenges.

j. The applicant provides a description of the impact of the decline in funding (state, local, and municipal) including the number of services reduced or eliminated and what services were reduced or eliminated.

k. The applicant describes the EMA/TGA response to the reduction in formula funding, if applicable.

l. The applicant includes the Unmet Need estimates using the specified framework and includes ***data sources*** and calculations (i.e., separate estimates of the total number and percent) of:

1) Population estimates;
2) Estimates of people in care; and
3) Estimates of unmet need.

m. The applicant provides a narrative description of the framework including methods used, revisions or updates from the FY 2010 estimate, any limitations of the data sources and a description of any cross-Parts collaboration that occurred.

n. The applicant provides a clear description of progress and plans for assessing Unmet Need. This includes concrete plans or completed activities to learn who is out of care, assess their service needs and gaps, identify their barriers to care, and get them into primary care.

o. The applicant describes how the results of the Unmet Need Framework are reflected in planning and decision making about priorities, resource allocations, and the system of care. This could include outreach activities, and collaborations with Ryan White and non-Ryan White funded providers.

Criterion 2: Early Identification of Individuals with HIV/AIDS (EIIHA)(total of 33 points) Status Unaware

This Criterion includes the distribution of the total 33 points allowed for this Section. We are providing this Guidance on the Point Values for this Section because it is a new legislative requirement.

Strategy: 8 Points

a. The applicant describes a feasible EIIHA **strategy to identify** individuals who are unaware of their HIV status that includes the following:

1) Describes the specific goals this strategy is intended to achieve
    a) Describes how each goal is consistent with making individuals who are unaware of their HIV status aware of their status
2) Describes how this strategy coordinates with your RW Part B counterpart with regard to the following:
    a) Identifying HIV positive unaware individuals
    b) Informing HIV positive unaware individuals of their status
    c) Referring HIV positive unaware individuals to care
    d) Linking HIV positive unaware individuals to care
    e) EIIHA Data Collection and Sharing
3) Describes how this strategy will coordinate with prevention and disease control/intervention programs with regard to the following:
    a) Identifying HIV positive individuals unaware of their status
    b) Informing HIV positive unaware individuals of their status
    c) Referring HIV positive unaware individuals to care

d) Linking HIV positive unaware individuals to care
e) EIIHA Data Collection and Sharing

4) Describes how this strategy coordinates with other programs/facilities and community efforts
5) Describes how EIIHA activities and strategies will be incorporated into the program's Requests for Proposals (RFP's)
6) Describes how ADAP resources will be considered in order to accommodate the needs of new positives
7) Describes the role of Early Intervention Services in this strategy
8) Describes how this strategy addresses disparities in access and services among affected subpopulations and historically underserved communities.

Identify: 5 Points

b. The applicant describes a feasible **plan to identify** individuals who are unaware of their HIV status that includes the following:

1) Provides a matrix which lists the sub-groups that will allow for the overall strategy to be customized based on the needs of each subgroup
2) The Matrix includes all sub-groups that the EIIHA Strategy, Plan, and Data intend to address
3) For each subgroup, describes how the overall strategy will be customized to address their respective needs specific to identifying HIV positive individuals unaware of their status
4) For each subgroup, describes the respective challenges associated with identifying individuals who are unaware of their HIV status
5) For each subgroup, describes the respective activities essential for identifying HIV positive individuals who are unaware of their status
   a) Describes which essential activities are able to be implemented immediately
   b) Describes which essential activities are proposed but NOT able to be implemented immediately
      i. Describes the timeline associated with when each essential activity will be implemented
      ii. Describes the parties responsible for ensuring each of these essential activities are implemented according to the timeline described

Inform: 5 Points

c. The applicant describes a feasible **plan to inform** unaware individuals of their HIV status that includes the following:

1) For each subgroup, describes how the overall strategy will be customized to address their respective needs specific to informing unaware individuals of their HIV status
2) For each subgroup, describes the respective challenges (including any local legislation or policies) associated with informing unaware individuals of their HIV status
3) For each subgroup, describes the respective activities essential to informing unaware individuals of their HIV status

a. Describes which essential activities are able to be implemented immediately
b. Describes which essential activities are proposed but NOT able to be implemented immediately
    i. Describes the timeline associated with when each essential activity will be implemented
    ii. Describes the parties responsible for ensuring each of these essential activities are implemented according to the timeline described

Refer: 5 Points

d. The applicant describes a feasible **plan to refer** unaware individuals into care that includes the following:

1) For each subgroup, describes how the overall strategy will be customized to address their respective needs specific to referring unaware individuals into care
2) For each subgroup, describes the respective challenges (including any local legislation or policies) associated with referring unaware individuals into care
3) For each subgroup, describes the respective activities essential to referring unaware individuals into care
    a. Describes which essential activities are able to be implemented immediately
    b. Describes which essential activities are proposed but NOT able to be implemented immediately
        i. Describes the timeline associated with when each essential activity will be implemented
        ii. Describes the parties responsible for ensuring each of these essential activities are implemented according to the timeline described

Link: 5 Points

e. The applicant describes a feasible **plan to link** unaware individuals to care that includes the following:

1) Describes the activities essential to ensuring access to care regardless of where any newly identified HIV positive individual enters into the continuum of care
    a. Describes current activities
    b. Describes proposed activities
        i. Describes the timeline associated with when each essential activity will be implemented
        ii. Describes the parties responsible for ensuring each of these essential activities are implemented according to the timeline described

2) For any newly identified HIV positive individual referred into a Ryan White funded program, describes the activities undertaken (post-referral) to verify that care/services were accessed
    a. Describes current activities
    b. Describes proposed activities
        i. Describes the timeline associated with when each essential activity will be implemented

ii. Describes the parties responsible for ensuring each of these essential activities are implemented according to the timeline described

3) Describes the activities undertaken to form and maintain relationships with private HIV care providers for the purpose of verifying that individuals referred into private care have accessed care post-referral
   a. Describes current efforts
   b. Describes proposed efforts
      i. Describe the timeline associated with when each essential activity will be implemented
      ii. Describe the parties responsible for ensuring each of these essential activities are implemented according to the timeline described
4) Describes the efforts to remove legal barriers, including State laws and regulations, to routine testing

Data: 5 Points

f. The applicant describes the following **Data**:
1) For CY09, Reports the Estimated Size of HIV Positive individuals Who Are Unaware of Their HIV Status
2) For CY09, Reports the Total Number of HIV Tests Conducted Using Local, State & Federal Funds, including the following:
   a. Of the total number tested, reports the number of individuals informed of their HIV status (regardless of positive or negative HIV result), also list as percentage
   b. Of the total number tested, reports the number of individuals NOT informed of their HIV status (regardless of positive or negative HIV result), also list as percentage
   c. Of the number NOT informed of their HIV status, reports the number of HIV positive individuals, also list as percentage
   d. Of the number informed of their HIV status, reports the number of HIV positive individuals, also list as percentage
   e. Of the number informed of their HIV positive status, reports the number of individuals referred into care, also list as percentage
3) Describes how the above data will impact the Quality Management Plan

Criterion 3: RESPONSE (total of 8 points)
Plan for FY 2011 and Access to HIV/AIDS Care

a. The applicant describes a comprehensive continuum of HIV/AIDS care services that is accessible to eligible PLWH/A within the EMA/TGA.

b. The applicant describes the mechanisms within the EMA/TGA that enable newly infected, underserved, hard-to-reach individuals and/or disproportionately impacted communities of color to access and remain in primary medical care.

c. The applicant provides a table that includes at least one service goal with time-limited and measurable program objectives for four core medical services and two support

service priority areas to which the Planning Council or community planning process allocated the largest amounts of funds for FY 2011.

d. For each objective stated, the table includes all of the following elements:

1) A service unit definition that is a clear and consistently measures of the objective (e.g. a one-hour face-to-face encounter, one round-trip bus ride, one primary care visit);
2) The number of people who will be served;
3) The total number of service units that will be provided. These should be consistent with the service unit definition;
4) The time frame to meet each objective (with beginning and ending dates); and
5) The estimated cost (funded by Part A) for meeting each objective during the time periods. If possible, the funding should be divided among individual objectives.

e. The applicant provides a narrative that is based on the FY 2011 Implementation Plan, and the table above that expands and clarifies the information presented and describes the following:

1) How the EMA/TGA logically connects its latest needs assessment (including results of the HRSA/HAB Unmet Need Framework), Comprehensive Plan, service priorities, and the FY 2011 Implementation Plan;
2) Whether there are any prioritized core medical services to which no Ryan White funding is allocated and explains why;
3) How the Plan will provide increased access to the HIV continuum of care for 1) communities where HIV (not AIDS) prevalence is increasing 2) minority communities disproportionately impacted by HIV disease and 3) persons who know their HIV status but are not in HIV/AIDS primary medical care;
4) How the Plan will address the needs of emerging populations;
5) How the Plan will encourage PLWH/A to remain engaged in HIV/AIDS primary medical care and adhere to HIV treatments;
6) How the Plan will promote parity of HIV services throughout the EMA/TGA. Parity of services should be addressed in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness;
7) How the services and their goals and objectives relate to the goals of the Healthy People 2020 initiative, particularly those indicated in Chapter 13 of the Healthy People 2020 document;
8) How the Plan will ensure that culturally and linguistically appropriate services are delivered by providers;
9) How the Plan will ensure that resource allocations for services to women, infants, children, and youth are in proportion to the percentage of the EMA/TGA AIDS cases represented by each population; and
10) How the EMA/TGA will use MAI funding to further enhance the quality of care and health outcomes in communities of color disproportionately impacted by the HIV epidemic; and how those activities are integral to the over-all services listed in the Plan for FY 2011.

Criterion 4: EVALUATIVE MEASURES (total of 10 points)
Grantee Administration and Accountability

a. The applicant describes the local agency responsible for the grant and identifies the entity responsible for administering Part A program. Included should be the department, unit, staffing levels (including any vacancies, FTEs), fiscal and/or management agents, planning and evaluation bodies, and in-kind support staff.

b. The applicant describes the EMA/TGA processes and requirements for reporting and monitoring rates of utilization of funds by contractor/subcontractor (sub-recipient), including how the grantee takes action if contractors/subcontractors are non-compliant with programmatic and fiscal requirements. This should include a discussion of:

1) The process used to ensure timely monitoring and redistribution of unexpended funds;
2) The process used in fiscal and program monitoring, including frequency of reports;
3) The frequency of fiscal and programmatic monitoring site visits during a program year;
4) The process and timelines for corrective actions when a fiscal or programmatic-related concern is identified;
5) The total number of contractors funded in FY 2010; and the number and percentage of contractors that received a fiscal and/or programmatic monitoring site visit during the FY 2009 grant year;
6) Any improper charges or other findings in FY 2010 and a summary of the corrective actions planned or taken to address these findings;
7) The number of contractors that received technical assistance (TA) for FY 2010 (types, scope, and timeline of TA);
8) The number and percentage of contractors compliant with the audit requirement in OMB Circular A-133; and
9) If there were findings in any subcontractors' A-133 audit reports, what the grantee has done to ensure that subcontractors have taken appropriate corrective action.

c. The applicant describes the process for reporting and reconciling program expenditures with fiscal staff. This should include a discussion of:

1) The process of receiving vouchers or invoices from contractors/subcontractors.
2) The process of payments made to contractors/subcontractors, from receipt of voucher/invoice to reimbursement.
3) The role and responsibilities of program and/or fiscal staff in reporting and reconciling program expenditures; the applicant should include an organizational chart for fiscal staff, if fiscal staff is not within the program staff personnel.
4) The process and coordination of program and/or fiscal staff in ensuring adequate reporting, reconciliation, and tracking of program expenditures.

d. The applicant describes how the EMA/TGA assures that clients who are eligible for third-party payments (including Medicaid and Medicare) enroll in these programs and that Ryan White HIV/AIDS Program funds are used only as a payer of last resort. This should also include a discussion of:

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

Review criteria for all applicants except Baton Rouge TGA and Charlotte TGA:

e. The applicant includes a discussion of the results of the Planning Council's assessment of the administrative mechanism in terms of:

1) Activities such as timely payments to contractors and data collection;
2) Corrective action or suggested methods of improvement that were recommended; and
3) If any deficiencies were noted, the applicant described these deficiencies, the grantee's response to those deficiencies, and the current status of the grantee's response.

Review criteria for the Baton Rouge TGA and the Charlotte TGA <u>ONLY</u>:

f. The applicant includes a discussion of the process used to assess that the distribution of program funds is done in an efficient and effective manner.

g. The applicant includes a discussion that describes the ***results*** of the TGA assessment of the administrative mechanism in terms of:

1) Activities such as timely payments to contractors and data collection;
2) Corrective action or suggested methods of improvement that were recommended; and
3) If any deficiencies were noted, the applicant describes what those deficiencies were, the grantee's response to any deficiencies that were noted, and the current status of the grantee's response.

Criterion 5: PLANNING AND RESOURCE ALLOCATION (total of 5 points)

Planning and Resource Allocation

Review criteria for all applicants except Baton Rouge TGA and Charlotte TGA:

a. The Letter of Assurance signed by the Planning Council Chair(s) addresses the following components.

1) That the FY 2010 Formula and Supplemental funds awarded to the EMA/TGA are being expended according to the priorities established by the Planning Council;
2) That all FY 2010 Conditions of Award for the Formula and Supplemental grants to the EMA/TGA that relate to the Planning Council have been addressed;
3) That the FY 2011 priorities were determined by the Planning Council, and the approved process for establishing those priorities was used by the Planning Council;

4) That Planning Council membership training took place; and
5) That the Planning Council is representative and reflective of the epidemic in the EMA/TGA. If any vacancies or deficiencies on the Council were noted, the applicant provided a plan and timeline for addressing each vacancy or deficiency. The applicant noted if there were any variations between the demographics of the non-aligned consumers and the HIV disease prevalence of the EMA/TGA.

b. The applicant clearly describes an organized, fully inclusive priority setting and allocation process. It demonstrates that PLWH/A were encouraged to fully and actively participate and that consumers' needs and preferences are addressed as well as the needs of those not in care and those from historically underserved populations.

c. The applicant describes how data were used by the Planning Council in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the EMA/TGA.

d. The applicant discusses how changes and trends in the HIV/AIDS epidemiology data have been considered in the priority setting and allocation process.

e. The applicant documents the effective use of cost data by the Planning Council in making funding allocation decisions.

f. The applicant discusses how unmet need data were used by the Planning Council in making priority and allocation decisions.

g. The applicant clearly describes a proactive planning process by describing a systematic process for prospectively addressing any funding increases or decreases in the Part A grant award.

h. The Applicant describes how MAI funding was considered during the planning process to enhance services to minority populations.

i. The applicant describes how PC assessed the need for service-related capacity development funded by MAI and reflected in the decision to allocate MAI funds for this purpose.

j. If applicable, the applicant includes any language developed by the Planning Council regarding how each priority should be met. **Note: HRSA is responsible for reviewing Planned Allocations (services) for compliance with the Part A 75 percent Core Medical Services Waiver Requirement.**

Review criteria for the Baton Rouge TGA and the Charlotte TGA <u>only</u>:

k. The applicant provided a description of the structure of the community input process.

l. The applicant demonstrates how PLWH/A were encouraged to fully and actively participate in the planning and allocation processes; and how consumers' needs and preferences are addressed as well as the needs of those not in care and those from historically underserved populations.

m. The applicant describes how data were used in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the EMA/TGA.

n. The applicant discusses how changes and trends in the HIV/AIDS epidemiology data have been considered in the priority setting and allocation process.

o. The applicant documents the effective use of cost data in making funding allocation decisions.

p. The applicant discusses how unmet need data were used in making priority and allocation decisions.

q. The applicant clearly describes a proactive planning process by describing a systematic process for prospectively addressing any funding increases or decreases in the Part A grant award.

r. If applicable, the applicant includes any language developed during the community planning process regarding how each priority should be met. **Note: HRSA is responsible for reviewing Planned Allocations (services) for compliance with the Part A 75 percent Core Medical Services Waiver Requirement.**

Criterion 6: SUPPORT REQUESTED (total of 5 points):

Budget and MOE documentation

a. The applicant includes a completed SF 424A with the required categories.

b. The applicant includes a budget justification with descriptions that explain the amounts requested for each line in the budget.

c. The applicant includes documentation describing how they met the MOE legislative requirement. The applicant provides a list of core medical service and support service budget elements and a description of the tracking systems used to document the elements. The applicant provides a list of the entities and/or departments of local government reporting eligible HIV-related expenditures and a description of the methodology used to track and report on the maintenance of effort.

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

Criterion 7: SPECIFIC PROGRAM CRITERIA (total of 5 points):

Clinical Quality Management

a. The applicant describes the overall purpose and identifies the goal(s) of the clinical quality management program that meets the minimum HAB clinical quality management expectations outlined in the Part A Guidance.

b. The applicant makes it clear that a formal process for overseeing and managing the clinical quality management program has been established and identifies the roles of the staff or committees responsible for the clinical quality management program including the resources allocated for the program.

c. The applicant demonstrates that the administrative agency has a system in place to monitor and conduct periodic assessments of its clinical quality management program and describes specific activities that have been implemented to assess the quality of services provided by provider/subcontractors. These should include such activities as ensuring that clinical practices adhere to HHS (PHS) guidelines and that other health services provided by providers/subcontractors adhere to the EMA/TGA established standards of care (if developed within the EMA/TGA).

d. The applicant identifies the specific indicators for primary medical care and case management that are being monitored by service category and include a description of how each indicator is measured.

e. The applicant describes ongoing activities and/or specific concrete plans to use data to show how Part A funded services, including support services, are improving HIV-related clinical health outcomes of PLWH/A in the EMA/TGA.

f. The applicant discusses the data collection strategy including how data are collected, what data have been collected to date, and the results.

g. The applicant demonstrates that an information loop exists between the administrative agency and Planning Council or community planning process regarding clinical quality management findings. The narrative clearly suggests that the Planning Council or community planning process considered the quality efforts as a component of the priority setting and resource allocation process within the EMA/TGA.

h. The applicant discusses quality improvement projects that have been undertaken to improve service delivery and what improvements have been seen.

i. The applicant discusses the process for implementation and development of the quality management program.

2. Review and Selection Process

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

Applications that pass the initial HRSA eligibility screening will be reviewed and rated by a panel based on the program elements and review criteria presented in relevant sections of this program 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

We expect to fund applicants by March 1, 2011.

VI. Award Administration Information

1. Award Notices

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

The Notice of Award sets forth the amount of funds granted, the terms and conditions of the grant, the effective date of the grant, the budget period for which initial support will be given, the non-Federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant agency's Authorized Representative, and reflects the only authorizing document. It will be sent prior to the start date of March 1, 2011, so long as the Ryan White HIV/AIDS Program legislation has been extended.

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

Cultural and Linguistic Competence
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 published by HHS. This document is available online at http://www.omhrc.gov/CLAS.

Trafficking in Persons
Awards issued under this guidance 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.htm. If you are unable to access this link, please contact the Grants Management Specialist identified in this guidance to obtain a copy of the Term.

PUBLIC POLICY ISSUANCE

HEALTHY PEOPLE 2020

Healthy People 2020 is a national initiative led by HHS that set priorities for all HRSA programs. The initiative has two major goals: (1) to increase the quality and years of a healthy life; and (2) eliminate our country's health disparities. The program consists of 28 focus areas and 467 objectives. HRSA has actively participated in the work groups of all the focus areas, and is committed to the achievement of the Healthy People 2020 goals.

Healthy People 2010 and the conceptual framework for the forthcoming Healthy People 2020 process can be found online at http://www.healthypeople.gov/.

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, healthcare or early childhood development services are provided to children.

3. Reporting

The successful applicant under this guidance must comply with the following reporting and monitoring 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 www.whitehouse.gov/omb/circulars;

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

c) Status Reports

1) Submit a Federal Financial Report (FFR – SF 425). A financial status report is required within 90 days of the end of each budget period. The report is an accounting of expenditures under the project that year. More specific information will be included in the award notice;

2) Submit a Progress Report(s). Further information will be provided in the award notice.

3) Acceptance of this award indicates that the grantee assures that it will comply with data requirements of the Ryan White Data Report (RDR) and that it will mandate compliance by each of its contractors and subcontractors. The RDR is due annually. The Ryan White Services Report (RSR) captures information necessary to demonstrate program performance and accountability. All Ryan White core service and support service providers are required to submit client-level data for Calendar Year 2011. Please refer to the HIV/AIDS Program Client Level Data website at http://hab.hrsa.gov/manage/CLD.htm for additional information

4) Must report expenditures for Women, Infants, Children and Youth for the previous budget year within 120 days of the end of the grant year as mandated by the Ryan White HIV/AIDS Program.

VII. Agency Contacts

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

Neal I. Meyerson, MPA, CRA
Lead Grants Management Specialist
Government & Special Focus Branch
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 11A-02
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-5906
Fax: (301) 594-6686
E-mail: nmeyerson@hrsa.gov

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

Douglas Morgan, M.P.A.
Director, Division of Service Systems
HIV/AIDS Bureau, HRSA
5600 Fishers Lane Room 7A-55
Rockville, Maryland 20857
Telephone: 301-443-6745
Fax: 301-443-8143
DMorgan@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. 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
Phone: 1-800-518-4726
E-mail: support@grants.gov

VIII. Tips for Writing a Strong Application

A concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at **http://www.hhs.gov/asrt/og/grantinformation/apptips.html.**

Appendix A

FY 2011 AGREEMENTS AND COMPLIANCE ASSURANCES
Ryan White HIV/AIDS Treatment Extension Act of 2009

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

Pursuant to Section 2602(a)(2)[1,2]
The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)
The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last five years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2602(b)(4)
The EMA/TGA Planning Council will determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

Pursuant to Section 2603(c)
The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)
The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council.

Pursuant to Section 2604 (a)
The EMA/TGA will expend funds according to priorities established by the Planning Council, and for core medical services, support services, and administrative expenses only.

Section 2604(c)
The EMA/TGA will expend not less than 75% of service dollars for core medical services, unless waived by the Secretary.

Pursuant to Section 2604(f)

[1] All statutory references are to the Public Health Service Act, unless otherwise specified.
[2] The five new TGAs (Baton Rouge, Charlotte, Indianapolis, Memphis, and Nashville) are exempted from these requirements, but must provide a process for obtaining community input as described in **Section 2609(d)(1)(A**).

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

Pursuant to Section 2604(g)
The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary**.**

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)
The EMA/TGA will expend no more than 10 percent of the grant on administrative costs, and in accordance with the legislative definition of administrative activities and the allocation of funds to entities and subcontractors, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)
The EMA/TGA will establish a Clinical Quality Management Program that meets HRSA requirements and that funding for this program shall not exceed the lesser of 5% of program funds or $3 million.

Pursuant to Section 2604(i)
The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)
With regard to the use of funds,

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

Pursuant to Section 2605(a)(3)
The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating early-intervention services for individuals diagnosed as being HIV positive.

Pursuant to Section 2605(a)(5)
The EMA/TGA will participate in an established HIV community-based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)
Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any State compensation program, insurance policy, or any Federal or State health

benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)
Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)
Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)
A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

Pursuant to Section 2605(a)(8)
The EMA/TGA has participated in the Statewide Coordinated Statement of Need process initiated by the State, and the services provided under the EMA/TGA's comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)
The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)
The EMA/TGA will submit audits every two years to the lead state agency under Part B of Title XXVI of the Public Health Service Act.

Pursuant to Section 2605(e)
The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)
Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684
No funds shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

_____ Date_____
Signature

_____
Title