Form Approved

OMB No. 0920-New

Expiration Date: XX/XX/XXXX

**Capacity Building Assistance Assessment for HIV Prevention**

**Attachment 3**

**CBO CBA Assessment Tool**

Public reporting burden of this collection of information is estimated to average 2 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

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**Information about the CBO Capacity Building Assistance Assessment Process**

The community-based organization (CBO) Capacity Building Assistance (CBA) Assessment (CBO CBA Assessment) is designed to assist CBA Providers and the Centers for Disease Control and Prevention (CDC) in identifying areas of CBA needed by your organization to implement your comprehensive High Impact Prevention (HIP) programs and services as required under your Funding Opportunity Announcement. The CBO CBA Assessment Tool must be completed **by all** funded organizations. For those organizations funded as a Partnership, the CBO CBA Assessment Tool should be completed by the **Lead CBO HIV Prevention** Partnership Organization, in consultation with their partners (reflecting the services that are provided by each Partnership member, as a part of the overall Comprehensive High-Impact HIV Prevention program). In addition, the **Lead Partnership Organization should complete Section M for Partnerships only. CBOs funded** specifically for Young Men of Color who have sex with men (MSM) and young Transgender Persons (YTG) of color, **should complete Section N.**  **CBOs not funded for either Partnerships or MSM and YTG should skip to Section O, Prioritization of CBA Needs.** **All CBOs should Complete Section O.**

The process for the assessment includes: (1) Completion and submission of the CBO CBA Assessment Tool by all CBOs or Lead Partnership Organizations; (2) Review of the information in preparation for the site visit/web conference by the CBA Provider; and, (3) Development of a CBA Strategic Plan (CBASP) for each CBO and Partnership. This CBASP will become part of the CBA Request Information System (CRIS) and will be used as a reference for responding to the CBA needs of the CBOs and Partnerships during the course of your five year cooperative agreement.

**ORGANIZATIONAL SUMMARY**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of CBO/Lead Partner:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Executive Director:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name and Title of Person Completing the CBA Assessment Tool:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Phone Number:** **A**1. Do you need CBA to update/improve the service agreements you currently have with medical care providers for your HIV+ populations? *(check all that apply)* |  A1.1. [ ]  HIV Testing  | A1.2. [ ] Partner Services | A1.3. [ ] Linkage to care and treatment | A1.4. [ ] Retention in care and treatment | A1.5. [ ] None Needed |
| A2. Do you need CBA to update/improve the service agreements you currently have with medical care providers for your high-risk negative populations? *(check all that apply)*  |  A2.1. [ ]  HIV Testing  | A2.2. [ ] Partner Services | A2.3. [ ] Linkage to prevention and treatment | A2.4. [ ] Medication adherence | A2.5. [ ] None Needed  |
| A3. Do you need CBA for any of the following? *(check all that apply)* | A3.1. [ ] Revising or improving Memorandum of Understanding (MOU) | A3.2. [ ] Communication with collaborators | A3.3. [ ] Referrals | A3.4. [ ] Billing | A3.5. [ ] None Needed  |
| A4. In 250 words or less, please share/explain other **priority** CBA needs, if any, for improving your formalized collaborations with agencies (e.g. health departments, clinics, other local organizations, etc.). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**For the following, please check the boxes for CBA needed regarding Formalized Collaborations you have with other agencies, to help you address the needs of the populations you have selected for your PS15-1502 program.**

1. **Component #1: Formalized Collaborations**

**For the following, please check the boxes for CBA needed regarding Program Promotion, Outreach and Recruitment.**

1. **Program Component #2: Program Promotion, Outreach, and Recruitment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| B1. Please identify your agency/partnership’s recruitment strategies for HIV+ persons?  *(check all that apply)* | B1.1. [ ] Referral from another agency or clinic (testing site, ER, crisis center, etc.) | B1. 2. [ ] Referral from within your agency’s programs | B1.3. [ ]  Peer/partner referral, core group referrals | B1.4. [ ] Ads on social media or apps | B1.5. [ ] Public Service Announcements (TV, Radio, Billboards)  |
| B2. Please identify your agency/partnership’s recruitment strategies for high-risk HIV-negative persons | B2.1. [ ] Referral from another agency or clinic (testing site, ER, crisis center, etc.) | B2.2. [ ] Referral from within your agency’s programs | B2.3. [ ]  Peer/partner referral, core group referrals | B2.4. [ ] Ads on social media or apps | B2.5. [ ] Public Service Announcements (TV, Radio, Billboards)  |
| B3. What capacity building needs does your agency/partnership have regarding recruitment? *(check all that apply)* | B3.1 [ ]  None | B3.2. [ ]  Training for staff | B3.3. [ ]  Planning for recruitment  | B3.4. [ ]  Locating target population (s) | B3.5. [ ]  Collecting and using data for recruitment,  |
| B4. In 250 words or less, please share/explain other **priority** CBA needs if any, for improving your agency/partnership’s program promotion, outreach and recruitment strategies. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For the following, please indicate Yes or No for the Targeted HIV Testing Interventions and Activities, your agency/partnership is implementing, if staff are trained to implement the intervention or service, and whether CBA is needed.**

1. **Program Component #3: Targeted HIV Testing**

|  |  |  |  |
| --- | --- | --- | --- |
| **Targeted HIV Testing Interventions and Activities** | **Yes/No**  | **Do you have Trained Staff?** | **Need CBA for implementation?** |
| C1. Is your agency/partnership currently implementing targeted HIV testing (e.g., venue-based, mobile, or large scale) among persons at high risk for HIV infection or of unknown HIV status? | C1a. [ ]  YesC1b. [ ]  No | C1c. [ ]  YesC1d. [ ]  No | C1e. [ ]  YesC1f. [ ]  No |
| C2. Is your agency/partnership currently implementing Couples HIV Testing and Counseling? | C2a. [ ]  YesC2b. [ ]  No | C2c. [ ]  YesC2d. [ ]  No | C2e. [ ]  YesC2f. [ ]  No |
| C3. Does your agency/partnership conduct integrated screening for STDs, viral hepatitis, and TB using CDC funds? | C3a. [ ] YesC3b. [ ]  No | C3c. [ ]  YesC3d. [ ]  No | C3e. [ ]  YesC3f. [ ]  No |
| C4. Is your agency/partnership currently implementing Personalized Cognitive Counseling (PCC) with men who have sex with men who are repeat testers? | C4a. [ ]  YesC4b. [ ]  No | C4c. [ ]  YesC4d. [ ]  No | C4e. [ ]  Yes C4f. [ ]  No |
| C5. In 250 words or less, please indicate the type of testing activities you are implementing and share/explain your **priority** CBA needs for improving your agency/partnership’s targeted HIV testing program. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For the following, please indicate Yes or No for Linkage to and Retention in Medical Care activities, interventions, and services your agency/partnership is implementing, and whether CBA is needed. *Please check all responses that apply.***

1. **Program Component #4: Comprehensive HIV Prevention with HIV+ Persons and High-Risk Negative Persons**

**D1. Linkage to and Retention in Medical Care**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| D1.1. Please identify your agency’s strategies for confirming the first appointment for newly identified HIV+ persons?   | D1.1a. [ ]  Assigned patient navigator at your clinic or the Collaborator/Partner’s clinic | D1.1b. [ ]  Reminder calls, texts or emails for the first medical appointment | D1.1c. [ ]  Incentive for completing the first medical appointment (e.g. monetary, transportation, provision of child care)  | D1.1d. [ ]  Peer/navigator accompanies client to the first appointment | D1.1e. [ ]  Using contact self-addressed card to submit to medical agency which is then returned to your agency | D1.1f. [ ]  Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| D1.2. Please identify your agency’s strategies for ensuring follow-through and engagement in medical care for HIV+ persons?  | D1.2.a. [ ]  Assigned patient navigator at your clinic or the Collaborator/Partner’s clinic | D1.2b.[ ]  Reminder calls, texts or emails for medical appointments | D1.2c. [ ]  Incentives for completed appointments (monetary, transportation, provision of child care)  | D1.2d. [ ]  Face-to-face or home visit | D1.2e. [ ]  Using contact information given for family members, friends others  | D1.2f. [ ]  Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| D1.3. In 250 words or less, please share/explain your **priority** CBA needs for improving your agency/partnership’s strategies for confirming the first appointment of newly identified HIV+ persons, and for linking, engaging and retaining HIV positive persons in medical care. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­ |

**For the following, please indicate Yes or No for the Linkage and Retention Activities your agency/partnership is implementing, and whether CBA is needed.**

**D2. Linkage and Retention Activities**

|  |  |  |
| --- | --- | --- |
| **Linkage and Retention Activities** | **Yes/No** | **Need CBA?** |
| D2.1. Does your agency have linkage to care networks and processes for linking HIV+ clients to medical care? | D2.1a. [ ]  YesD2.1b. [ ]  No | D2.1c. [ ]  YesD2.1d. [ ]  No |
| D2.2. Is your agency able to consistently link 90% of newly diagnosed persons to HIV medical care? | D2.2a. [ ]  YesD2.2b. [ ]  No | D2.2c. [ ]  YesD2.2d. [ ]  No |
| D2.3. Is your agency able to retain 90% of HIV+ persons in HIV medical care? | D2.3a. [ ]  YesD2.3b. [ ]  No | D2.3c. [ ]  YesD2.3d. [ ]  No |
| D2.4. Has your agency been able to identify previously diagnosed, out-of-care HIV+ persons to re-engage 90% of them in HIV medical care? | D2.4a. [ ] Yes D2.4b. [ ] No  | D2.4c. [ ]  YesD2.4d. [ ]  No |
| D2.5. In 250 words or less, please share/explain your **priority** CBA needs for your agency/partnership’s linkage and retention activities. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For the following, please indicate Yes or No for the Medication Adherence Interventions your agency/partnership is implementing, if you have staff trained to implement the intervention, and whether CBA is needed. Please indicate N/A for those interventions your agency/partnership is not implementing.**

**D3. Medication Adherence Interventions/Services**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Adherence Interventions** | **Yes/No** | **Currently have trained staff?**  | **Need CBA for implementation?**  |
| D3.1. Anti-Retroviral Treatment and Access to Services (ARTAS) | D3.1a. [ ]  YesD3.1b. [ ]  No | D3.1c. [ ]  YesD3.1d. [ ]  NoD3.1e. [ ]  N/A | D3.1f. [ ]  YesD3.1g. [ ]  NoD3.1h. [ ]  N/A |
| D3.2. Every Dose Every Day Mobile Application | D3.2a. [ ]  YesD3.2b. [ ]  No | D3.2c. [ ]  YesD3.2d. [ ]  NoD3.2e. [ ]  N/A | D3.2f. [ ]  YesD3.2g. [ ]  NoD3.2h. [ ]  N/A |
| D3.3. Peer Support | D3.3a. [ ]  YesD3.3b. [ ]  No | D3.3c. [ ]  YesD3.3d. [ ]  NoD3.3e. [ ]  N/A | D3.3f. [ ]  YesD3.3g. [ ]  NoD3.3h. [ ]  N/A |
| D3.4. Sharing Medication Adherence Responsibilities Together (SMART Couples) | D3.4a. [ ]  YesD3.4b. [ ]  No | D3.4c. [ ]  YesD3.4d. [ ]  NoD3.4e. [ ]  N/A | D3.4f. [ ]  YesD3.4g. [ ]  NoD3.4h. [ ]  N/A |
| D3.5. Helping Enhance Adherence to Antiretroviral Therapy (HEART)  | D3.5a. [ ]  YesD3.5b. [ ]  No | D3.5c. [ ]  YesD3.5d. [ ]  NoD5.5e. [ ]  N/A | D3.5f. [ ]  YesD3.5g. [ ]  NoD3.5h. [ ]  N/A |
| D3.6. Local intervention for Medication Adherence Services  | D3.6a. [ ]  YesD3.6b. [ ]  No | D3.6c. [ ]  YesD3.6d. [ ]  NoD3.6e. [ ]  N/A | D3.6f. [ ]  YesD3.6g. [ ]  NoD3.6h. [ ]  N/A |
| D3.7. In 250 words or less, please share/explain your **priority** CBA needs for your agency/partnership’s medication adherence interventions. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For the following, please indicate Yes or No for the Navigation, Prevention and Essential Support Services and Interventions your agency/partnership is implementing, if you have staff trained to implement the service/intervention, and your priority CBA needs. Please indicate N/A for those services and interventions your agency/partnership is not implementing.**

 **D4. Navigation, Prevention and Essential Support Services and Interventions for HIV+ Persons**

|  |  |  |  |
| --- | --- | --- | --- |
| **Navigation, Prevention and Essential Support Services Interventions** | **Yes/No** | **Currently have trained staff?**  | **Need CBA for implementation?** |
| D4.1 HIV Navigation Services  | D4.1a. [ ]  Yes D4.1b. [ ]  No  | D4.1c. [ ]  YesD4.1d. [ ]  NoD4.1.e. [ ]  N/A  | D4.1f. [ ]  Yes D4.1g. [ ]  No D4.1h. [ ]  N/A  |
| D4.2. Partner Elicitation  | D4.2a. [ ]  Yes D4.2b. [ ]  No  | D4.2c. [ ]  Yes D4.2d. [ ]  NoD4.2e. [ ]  N/A | D4.2f. [ ]  Yes D4.2g. [ ]  NoD4.1h. [ ]  N/A |
| D4.3. Partner Services  | D4.3a. [ ]  Yes D4.3b. [ ]  No  | D4.3c. [ ]  Yes D4.3d. [ ]  NoD4.3e. [ ]  N/A | D4.3f. [ ]  Yes D4.3g. [ ]  NoD4.3h. [ ]  N/A |
| D4.4. d-Up | D4.4a. [ ]  Yes D4.4b. [ ]  No  | D4.4c. [ ]  YesD4.4d. [ ]  NoD4.4e. [ ]  N/A | D4.4f. [ ]  Yes D4.4g. [ ]  NoD4.4h. [ ]  N/A |
| D4.5. Peers Reaching Out and Modeling Intervention Strategies (PROMISE)  | D4.5a. [ ]  Yes D4.5b. [ ]  No  | D4.5c. [ ]  YesD4.5d. [ ]  NoD4.5e. [ ]  N/A | D4.5f. [ ]  Yes D4.5g. [ ]  NoD4.5h. [ ]  N/A |
| D4.6. MPowerment | D4.6a. [ ]  Yes D4.6b. [ ]  No  | D4.6.c. [ ]  YesD4.6d. [ ]  NoD4.6e. [ ]  N/A | D4.6f. [ ]  Yes D4.6g. [ ]  NoD4.6h. [ ]  N/A |
| D4.7. Opinion Leader (POL) | D4.7a. [ ]  Yes D3.7b. [ ]  No  | D4.7c. [ ]  YesD4.7d [ ]  NoD4.7e. [ ]  N/A | D4.7f. [ ]  Yes D4.7g. [ ]  No D4.7h. [ ]  N/A |
| D4.8. Choosing Life: Empowerment! Action! Results! (CLEAR) | D4.8a. [ ]  Yes D4.8b. [ ]  No  | D4.8c. [ ]  YesD4.8d. [ ]  NoD4.8e. [ ]  N/A | D4.8f. [ ]  Yes D4.8g. [ ]  NoD4.8h. [ ]  N/A |
| D4.9. Women Involved in Life Learning from Other Women (WILLOW)  | D4.9a. [ ]  Yes D4.9b. [ ]  No  | D4.9c. [ ]  YesD4.9d. [ ]  NoD4.9e. [ ]  N/A | D4.9f. [ ]  Yes D4.9g. [ ]  NoD4.9h. [ ]  N/A |
| D4.10. Healthy Relationships  | D4.10a. [ ]  Yes D4.10b. [ ]  No  | D4.10c. [ ]  YesD4.10d. [ ]  NoD4.10e. [ ]  N/A | D4.10f. [ ]  Yes D4.10g. [ ]  NoD4.10h. [ ]  N/A |
| D4.11. CONNECT | D4.11a. [ ]  Yes D4.11b. [ ]  No  | D4.11c. [ ]  Yes D4.11d. [ ]  No D4.11.e [ ]  N/A | D4.11f. [ ]  Yes D4.11g [ ]  NoD4.11h [ ]  N/A |
| D4.12. Partnerships for Health (PfH)  | D4.12a. [ ]  Yes D4.12b. [ ]  No  | D4.12c. [ ]  YesD4.12d. [ ]  NoD4.12e. [ ]  N/A | D4.12f. [ ]  Yes D4.12g [ ]  NoD4.12h. [ ]  N/A |
| D4.13. START | D4.13a. [ ]  Yes D4.13b. [ ]  No  | D4.13c. [ ]  YesD4.13d. [ ]  NoD4.13e. [ ]  N/A | D3.13f. [ ]  Yes D4.13g. [ ]  NoD4.13h. [ ]  N/A |
| D4.14. Locally developed intervention for HIV+ persons?  | D4.14a. [ ]  Yes D4.14b. [ ]  No  | D4.14c. [ ]  YesD4.14d. [ ]  NoD4.14e. [ ]  N/A | D4.14f. [ ]  Yes D4.14g. [ ]  NoD4.14h. [ ]  N/A |
| D4.15. In 250 words or less, please share/explain your **priority** CBA needs for your agency/partnership’s navigation, prevention and essential support services and interventions for HIV+ Persons. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For the following, please indicate Yes or No for the services and interventions your agency/partnership is implementing for High-Risk HIV-Negative Persons, if you have staff trained to implement the service or intervention, and whether CBA is needed. Please indicate N/A for those interventions your agency/partnership is not implementing.**

**D5. Comprehensive HIV Prevention with High-risk Negative (HRN) Persons**

|  |  |  |  |
| --- | --- | --- | --- |
| **Interventions/Services for** **High-Risk Negatives** | **Yes/No** | **Currently have trained staff?** | **Need CBA for implementation?** |
| D5.1. Implementing HIV Navigation Services  | D5.1a. [ ]  Yes D5.1b. [ ]  No  | D5.1c. [ ]  YesD5.1d. [ ]  NoD5.1e. [ ]  N/A  | D5.1f. [ ]  Yes D5.1g. [ ]  NoD5.1h. [ ]  N/A  |
| D5.2. Screening for STDs, hepatitis, and TB | D5.2a. [ ]  Yes D5.2b. [ ]  No  | D5.2c. [ ]  YesD5.2d. [ ]  NoD5.2e. [ ]  N/A  | D5.2f. [ ]  Yes D5.2g. [ ]  NoD5.2h. [ ]  N/A  |
| D5.3. Referrals for the treatment of STDs, viral hepatitis, and TB | D5.3a. [ ]  Yes D5.3b. [ ]  No  | D5.3c [ ]  YesD5.3d. [ ]  NoD5.3e. [ ]  N/A  | D5.3f. [ ]  Yes D5.3g. [ ]  NoD5.3h. [ ]  N/A  |
| D5.4 Pre-Exposure Prophylaxis (PrEP) | D5.4a. [ ]  Yes D5.4b. [ ]  No  | D5.4c. [ ]  YesD4.4d. [ ]  NoD5.4e [ ]  N/A  | D5.4f. [ ]  Yes D5.4g. [ ]  NoD5.4h. [ ]  N/A  |
| D5.5. Post-Exposure Prophylaxis (nPEP) | D5.5a [ ]  Yes D5.5b. [ ]  No  | D5.5c. [ ]  YesD5.5d. [ ]  NoD5.5e. [ ]  N/A  | D5.5f. [ ]  Yes D5.5g. [ ]  NoD5.5h. [ ]  N/A  |
| D5.6. In 250 words or less, please share/explain your **priority** CBA needs for your agency/partnership’s interventions and services for High Risk Negative Persons. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For the following, please indicate Yes or No for the services and interventions your agency/partnership is implementing for HIV-positive and High-Risk HIV-Negative Persons, or if you are referring clients to another agency.**

1. **HIP Essential and Support Services with HIV Positive and High-risk Negative (HRN) Persons**

|  |  |
| --- | --- |
| **Essential and Support Services for HIV+ & HRN Persons** | **Referring Clients to another agency**  |
| E1. Insurance, Navigation and Enrollment Services  | E1a. [ ]  Yes for HIV+ PersonsE1b. [ ]  No, Providing referrals for HIV+  PersonsE1c. [ ]  Yes for HRN Persons E1d. [ ]  No, Providing referrals for HRN  Persons |
| E2. Mental Health Counseling  | E2a. [ ]  Yes for HIV+ PersonsE2b. [ ]  No, Providing referrals for HIV+  PersonsE2c. [ ]  Yes for HRN PersonsE2d. [ ]  No, Providing referrals for HRN  Persons |
| E3 Substance Abuse Treatment and Services  | E3a. [ ]  Yes for HIV+ PersonsE3b. [ ]  No, Providing referrals for HIV+ PersonsE3c. [ ]  Yes for HRN PersonsE3d. [ ]  No, Providing referrals for HRN  Persons |
| E4. Housing Services  | E4a. [ ]  Yes for HIV+ PersonsE4b. [ ]  No, Providing referrals for HIV+ PersonsE4c. [ ]  Yes for HRN PersonsE4d. [ ]  No, Providing referrals for HRN  Persons |
| E5. Employment Services  | E5a. [ ]  Yes for HIV+ PersonsE5b. [ ]  No, Providing referrals for HIV+  PersonsE5c. [ ]  Yes for HRN PersonsE5d. [ ]  No, Providing referrals for HRN  Persons  |
| E6. Basic Education Services  | E6a. [ ]  Yes for HIV+ PersonsE6b. [ ]  No, Providing referrals for HIV+  PersonsE6c. [ ]  Yes for HRN PersonsE6d. [ ]  No, Providing referrals for HRN  Persons |
| E7. Sex/HIV Education  | E7a. [ ]  Yes for HIV+ PersonsE7b. [ ]  No, Providing referrals for HIV+  PersonsE7c. [ ]  Yes for HRN PersonsE7d. [ ]  No, Providing referrals for HRN Persons |
| E8. In 250 words or less, please share/explain your **priority** CBA needs for your agency/partnership’s essential and support services for HIV + and high-risk negative persons. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For the following, please check each of the Condom Distribution Activities you are offering for HIV+ and high-risk HIV-negative persons. Please indicate the specific CBA services that are needed, and check N/A if your agency is not offering this service, or if it is not relevant to your program. *Please check all responses that apply.***

1. **Program Component #6: Condom Distribution for HIV+ and high-risk negative (HRN) persons**

|  |  |
| --- | --- |
| **Condom Distribution Activities** | **Implementation of Condom Distribution Program****CBA Needs** |
| F1. Is your agency directly implementing a Condom Distribution Program for HIV+ & HRN persons, or providing referrals to other organizations?F1a. [ ]  Yes for HIV+ PersonsF1b. [ ]  No, Providing Referrals for HIV+ PersonsF1c. [ ]  Yes for HRN PersonsF1d. [ ]  No, Providing Referrals for HRN Persons | F1.1. Does your agency need CBA for the following related to your condom distribution program? (check all that apply):F1.1a. [ ]  Finalizing/updating MOUs F1.1b. [ ]  Training for staffF1.1c. [ ]  Developing/Updating protocols and  strategies for HIV+ PersonsF1.1d. [ ]  Developing/Updating protocols and  strategies for HRN PersonsF1.1e. [ ]  Providing referrals to increase access to condom distribution and related servicesF1.1f. [ ]  Educational materials that are appropriate to the target population F1.1g. [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F1.1h. [ ]  N/A |
| F2. In 250 words or less, please share/explain your **priority** CBA needs for your agency/partnership’scondom distribution program. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**For the following, please indicate Yes or No if CBA is needed to improve your organizational strategic plan for your HIP program.**

1. **Program Component #7: HIV and Organizational Planning**

|  |  |
| --- | --- |
| G1.Do you need capacity building assistance to improve and/or update your agency’s organizational strategic plan to include your funded program? | G1a. [ ]  YesG1b. [ ]  No |
| G2.Do you need capacity building assistance to improve and/or update your agency’s organizational strategic plan to include your collaborative work with the organizations in your Partnership? | G1a. [ ]  YesG1b. [ ]  NoG1b. [ ]  N/A |
| G3. In 250 words or less, please share/explain your **specific** needs to improve and/or update your agency/partnership’sorganizational strategic plan. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**For the following “Program Summary” please share your agency’s primary strengths and the ways you would like to see your agency strengthened in the next 12 months to implement your HIP program. For those agencies involved in a Partnership, the lead agency should respond for their agency only and NOT the Partnership.**

1. **Program Summary**

H1. What are your agency’s **primary strengths** related to the implementation of your HIP program? (Limit 250 words)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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H2. In what ways would **you like to see** your agency’s HIP program strengthened in the next 12 months? (Limit 250 words). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This section of the tool is intended to assess your agency’s monitoring and evaluation CBA needs for your HIP program. Please check Yes or No, or indicate other if yes or no does not apply. For those agencies involved in a Partnership, the lead agency should respond for their agency only and NOT the Partnership.**

**I. Monitoring & Evaluation**

|  |
| --- |
| I1. Does your agency have staff to oversee monitoring and evaluation activities?I1a. [ ]  Yes (agency staff)I1b. [ ]  No (contractor/consultant is used)I1c. [ ]  No |
| I2. In 250 words or less, please share/explain your **specific** needs to improve and/or update your agency/partnership’smonitoring and evaluation plan and activities within the next 12 months.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**This section of the tool is intended to assess the QA CBA needs for your HIP program. Please check Yes or No, or indicate other if yes or no does not apply. For those agencies involved in a Partnership, the lead agency should respond for their agency only and NOT the Partnership.**

 **J. Quality Assurance (QA)**

|  |
| --- |
| J1. Does your agency have staff to oversee quality assurance activities?J1a. [ ]  YesJ1b. [ ]  No (contractor/consultant is used)J1c. [ ]  No |
| J2. In 250 words or less, please share/explain your **specific** needs to improve and/or update your agency/partnership’sQuality Assurance Plan and activities within the next 12 months. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 **K. Organizational Infrastructure**

**The purpose of the following sections is to assess your agency’s infrastructure, (management, operation, systems and resources). Please respond to all items and explain the specific CBA needs in each area.** **For those agencies involved in a Partnership, the lead agency should respond for their agency only and NOT the Partnership.**

**K1. Governance**

|  |
| --- |
| K1.1. Do you need capacity building assistance to improve your agency’sgovernance structure? K.1.1a. [ ]  Yes K1.1b. [ ]  No |
| K1.2. In 250 words or less, please share/explain your **specific** needs to improve your agency’s governance structure within the next 12 months.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**K2. Resource Development**

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| --- |
| K2.1. Does your agency have staff responsible for carrying out your agency’s fundraising plan?K2.1a. [ ] Yes K2.1b. [ ]  No  |
| K2.2. In 250 words or less, please share/explain your **specific** needs to improve your agency’s resource development activities within the next 12 months.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**K3. Fiscal Management**

|  |
| --- |
| K3.1. Who is responsible for the fiscal management systems for your agency?K3.1a. [ ] Agency staff responsible (job title) \_\_\_\_\_\_\_\_\_\_\_\_\_ K3.1b. [ ]  Agency uses an outside contractorK3.1c. [ ]  Agency uses internal staff and an outside contractorK3.1d. [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| K3.2. In 250 words or less, please share/explain your agency’s fiscal management needs for which you would you like to receive CBA within the next 12 months.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**K4. Human Resource Management and Staff Development**

|  |
| --- |
| K4.1. Who is responsible for your agency’s **(including the lead agency for the partnership)** human resources and staff development?K4.1a. [ ] AgencyStaff responsible (job title) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ K4.1b. [ ]  Agency uses an outside contractorK4.1c. [ ]  Agency uses internal staff and an outside contractorK4.1d. [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4.2. In 250 words or less, please share/explain your agency **(including the lead agency for the partnership)** human resource management and staff development needs for which you would you like to receive CBA within the next 12 months. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**K5. Technology**

|  |  |
| --- | --- |
| K5.1. Does your agency have in-house Information Technology (IT) staff?  | K5.1a. [ ] Yes K5.1b. [ ] No K5.1c. [ ] Other: **\_\_\_\_\_\_\_\_\_\_\_** |
| K5.2. Does your agency have a contract for IT support?  | K5.3a. [ ] Yes K5.2b. [ ] NoK5.2c. Other\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_** |
| K5.3. In 250 words or less, please share/explain your agency’s IT needs for which you would you like to receive CBA within the next 12 months\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**L. SUMMARY: Overall CBA Needs**

**The purpose of this section is to summarize the agency’s overall strengths and challenges. Please respond to all items and add any additional information you feel will help explain or clarify your CBA needs. For those agencies involved in a Partnership, the lead agency should respond for their agency only and NOT the Partnership.**

L1. What do you feel is **working well** regarding your agency’s infrastructure?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

L2. What are the **main challenges** regarding your agency’s infrastructure that have impact on the implementation of your CDC-funded HIP program?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**M. Partnership CBA Needs** (to be completed only by the **lead** agency in the Partnership). *Agencies not involved in a partnership should skip to section “O” Prioritization of CBA Needs.*

**The purpose of this section is to determine the CBA needs of the Partnership to effectively and efficiently facilitate and collaborate within the Partnership to implement the Components of their HIP funded program. Please explain or clarify the Partnership’s CBA needs in the appropriate field.**

|  |
| --- |
| M1. Name of Partnership Leader/Manager:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­ |
| M2. Strengths of Partnership: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| M3. What are your CBA Needs related to the Partnership’s ability to work together to implement the HIP funded Program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**N. CBA Needs for Agencies Implementing Comprehensive High Impact Programs specifically for Young Men of Color who have sex with men (MSM) and young Transgender Persons (YTG) of color.** *Agencies, including Partnerships, not funded to specifically target MSM and YTG should skip to section “O” Prioritization of CBA Needs)*

**The purpose of this section is to determine the CBA needs for those agencies funded to effectively reach and engage their target population (YSM of color and YTG persons of color), and to provide competent, cultural sensitive services. Please explain or clarify CBA needs in the appropriate field.**

|  |
| --- |
| N1. Strengths of the agency related to providing culturally sensitive services to YMSM and YTG Persons \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­ |
| N2. What are your CBA Needs related to your agency’s ability to implement your funded Program for YMSM of color and YTG persons of color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. **Prioritization of CBA Needs**

**Please indicate your agency/partnership’s top 4 prioritized CBA needs for your CDC-funded HIP program, that you will like to see addressed? Indicate the Program Component and justify in 250 words or less why this area is prioritized. (e.g. Program Components: Targeted Testing, HIV Prevention with Positive persons, Fiscal Management, etc.).**

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| **Top Priority Needs to be addressed** |
| O1. Program Component: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| O2. Program Component: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| O3. Program Component: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| O4. Program Component: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

***Thank you***