Form Approved
OMB No. 0920-New
Expiration Date: XX/XX/XXXX

Capacity Building Assistance Assessment for HIV Prevention

Attachment 3

CBO CBA Assessment Tool

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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. <u>All CBOs should Complete Section O</u>.**

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:	A1.1. ☐	A1.2. ☐	A1.3. ☐	A1.4. ☐	A1.5. ☐
A1. Do you need CBA to update/improve the service agreements you currently	HIV Testing	Partner Services	Linkage to care and treatment	Retention in care and	None Needed

have with medical care providers for your HIV+ populations? *(check all that apply)*				treatment	
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.

A. Component #1: Formalized Collaborations

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

B. 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	B2.1. ☐ Referral from another agency	B2.2. ☐ Referral from within your	B2.3. ☐ Peer/partner referral, core	B2.4. ☐ Ads on social media or apps	B2.5. ☐ Public Service Announcements

for high-risk HIV-negative persons	or clinic (testing site, ER, crisis center, etc.)	agency's programs	group referrals		(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.

C. 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. ☐ Yes C1b. ☐ No	C1c. ☐ Yes C1d. ☐ No	C1e. ☐ Yes C1f. ☐ No
C2. Is your agency/partnership currently implementing Couples HIV Testing and Counseling?	C2a. ☐ Yes C2b. ☐ No	C2c. ☐ Yes C2d. ☐ No	C2e. ☐ Yes C2f. ☐ No
C3. Does your agency/partnership conduct integrated screening for STDs, viral hepatitis, and TB using CDC funds?	C3a. ☐ Yes C3b. ☐ No	C3c. ☐ Yes C3d. ☐ No	C3e. ☐ Yes C3f. ☐ No
C4. Is your agency/partnership currently implementing Personalized Cognitive Counseling (PCC) with men who have sex with men who are repeat testers?	C4a. ☐ Yes C4b. ☐ No	C4c. ☐ Yes C4d. ☐ 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 <u>Linkage to and Retention in Medical Care</u> activities, interventions, and services your agency/partnership is implementing, and whether CBA is needed. ***Please check all responses that apply.***

D. 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 <u>250</u> 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. ☐ Yes D2.1b. ☐ No	D2.1c. ☐ Yes D2.1d. ☐ No
D2.2. Is your agency able to consistently link 90% of newly diagnosed persons to HIV medical care?	D2.2a. ☐ Yes D2.2b. ☐ No	D2.2c. ☐ Yes D2.2d. ☐ No
D2.3. Is your agency able to retain 90% of HIV+ persons in HIV medical care?	D2.3a. ☐ Yes D2.3b. ☐ No	D2.3c. ☐ Yes D2.3d. ☐ 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. ☐ Yes D2.4d. ☐ 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. ☐ Yes D3.1b. ☐ No	D3.1c. ☐ Yes D3.1d. ☐ No D3.1e. ☐ N/A	D3.1f. ☐ Yes D3.1g. ☐ No D3.1h. ☐ N/A
D3.2. Every Dose Every Day Mobile Application	D3.2a. ☐ Yes D3.2b. ☐ No	D3.2c. ☐ Yes D3.2d. ☐ No D3.2e. ☐ N/A	D3.2f. ☐ Yes D3.2g. ☐ No D3.2h. ☐ N/A
D3.3. Peer Support	D3.3a. ☐ Yes D3.3b. ☐ No	D3.3c. ☐ Yes D3.3d. ☐ No D3.3e. ☐ N/A	D3.3f. ☐ Yes D3.3g. ☐ No D3.3h. ☐ N/A
D3.4. Sharing Medication Adherence Responsibilities Together (SMART Couples)	D3.4a. ☐ Yes D3.4b. ☐ No	D3.4c. ☐ Yes D3.4d. ☐ No D3.4e. ☐ N/A	D3.4f. ☐ Yes D3.4g. ☐ No D3.4h. ☐ N/A

D3.5. Helping Enhance Adherence to Antiretroviral Therapy (HEART)	D3.5a. ☐ Yes D3.5b. ☐ No	D3.5c. ☐ Yes D3.5d. ☐ No D5.5e. ☐ N/A	D3.5f. ☐ Yes D3.5g. ☐ No D3.5h. ☐ N/A
D3.6. Local intervention for Medication Adherence Services	D3.6a. ☐ Yes D3.6b. ☐ No	D3.6c. ☐ Yes D3.6d. ☐ No D3.6e. ☐ N/A	D3.6f. ☐ Yes D3.6g. ☐ No D3.6h. ☐ 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. ☐ Yes D4.1d. ☐ No D4.1.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. ☐ No D4.2e. ☐ N/A	D4.2f. ☐ Yes D4.2g. ☐ No D4.1h. ☐ N/A
D4.3. Partner Services	D4.3a. ☐ Yes D4.3b. ☐ No	D4.3c. ☐ Yes D4.3d. ☐ No D4.3e. ☐ N/A	D4.3f. ☐ Yes D4.3g. ☐ No D4.3h. ☐ N/A
D4.4. d-Up	D4.4a. ☐ Yes D4.4b. ☐ No	D4.4c. ☐ Yes D4.4d. ☐ No D4.4e. ☐ N/A	D4.4f. ☐ Yes D4.4g. ☐ No D4.4h. ☐ N/A
D4.5. Peers Reaching Out and Modeling Intervention Strategies (PROMISE)	D4.5a. ☐ Yes D4.5b. ☐ No	D4.5c. ☐ Yes D4.5d. ☐ No D4.5e. ☐ N/A	D4.5f. ☐ Yes D4.5g. ☐ No D4.5h. ☐ N/A
D4.6. MPowerment	D4.6a. ☐ Yes D4.6b. ☐ No	D4.6.c. ☐ Yes D4.6d. ☐ No D4.6e. ☐ N/A	D4.6f. ☐ Yes D4.6g. ☐ No D4.6h. ☐ N/A
D4.7. Opinion Leader (POL)	D4.7a. ☐ Yes	D4.7c. ☐ Yes	D4.7f. ☐ Yes

	D3.7b. ☐ No	D4.7d ☐ No D4.7e. ☐ N/A	D4.7g. ☐ No D4.7h. ☐ N/A
D4.8. Choosing Life: Empowerment! Action! Results! (CLEAR)	D4.8a. ☐ Yes D4.8b. ☐ No	D4.8c. ☐ Yes D4.8d. ☐ No D4.8e. ☐ N/A	D4.8f. ☐ Yes D4.8g. ☐ No D4.8h. ☐ N/A
D4.9. Women Involved in Life Learning from Other Women (WILLOW)	D4.9a. ☐ Yes D4.9b. ☐ No	D4.9c. ☐ Yes D4.9d. ☐ No D4.9e. ☐ N/A	D4.9f. ☐ Yes D4.9g. ☐ No D4.9h. ☐ N/A
D4.10. Healthy Relationships	D4.10a. ☐ Yes D4.10b. ☐ No	D4.10c. ☐ Yes D4.10d. ☐ No D4.10e. ☐ N/A	D4.10f. ☐ Yes D4.10g. ☐ No D4.10h. ☐ 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 ☐ No D4.11h ☐ N/A
D4.12. Partnerships for Health (PfH)	D4.12a. ☐ Yes D4.12b. ☐ No	D4.12c. ☐ Yes D4.12d. ☐ No D4.12e. ☐ N/A	D4.12f. ☐ Yes D4.12g ☐ No D4.12h. ☐ N/A
D4.13. START	D4.13a. ☐ Yes D4.13b. ☐ No	D4.13c. ☐ Yes D4.13d. ☐ No D4.13e. ☐ N/A	D3.13f. ☐ Yes D4.13g. ☐ No D4.13h. ☐ N/A
D4.14. Locally developed intervention for HIV+ persons?	D4.14a. ☐ Yes D4.14b. ☐ No	D4.14c. ☐ Yes D4.14d. ☐ No D4.14e. ☐ N/A	D4.14f. ☐ Yes D4.14g. ☐ No D4.14h. ☐ N/A
D4.15. In <u>250</u> 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	D5.1a. ☐ Yes	D5.1c. ☐ Yes D5.1d. ☐ No	D5.1f. ☐ Yes D5.1g. ☐ No

Services	D5.1b. ☐ No	D5.1e. ☐ N/A	D5.1h. ☐ N/A
D5.2. Screening for STDs, hepatitis, and TB	D5.2a. ☐ Yes D5.2b. ☐ No	D5.2c. ☐ Yes D5.2d. ☐ No D5.2e. ☐ N/A	D5.2f. ☐ Yes D5.2g. ☐ No D5.2h. ☐ N/A
D5.3. Referrals for the treatment of STDs, viral hepatitis, and TB	D5.3a. ☐ Yes D5.3b. ☐ No	D5.3c ☐ Yes D5.3d. ☐ No D5.3e. ☐ N/A	D5.3f. ☐ Yes D5.3g. ☐ No D5.3h. ☐ N/A
D5.4 Pre-Exposure Prophylaxis (PrEP)	D5.4a. ☐ Yes D5.4b. ☐ No	D5.4c. ☐ Yes D4.4d. ☐ No D5.4e ☐ N/A	D5.4f. ☐ Yes D5.4g. ☐ No D5.4h. ☐ N/A
D5.5. Post-Exposure Prophylaxis (nPEP)	D5.5a ☐ Yes D5.5b. ☐ No	D5.5c. ☐ Yes D5.5d. ☐ No D5.5e. ☐ N/A	D5.5f. ☐ Yes D5.5g. ☐ No D5.5h. ☐ 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.

E. 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+ Persons E1b. ☐ No, Providing referrals for HIV+ Persons E1c. ☐ Yes for HRN Persons E1d. ☐ No, Providing referrals for HRN Persons
E2. Mental Health Counseling	E2a. ☐ Yes for HIV+ Persons E2b. ☐ No, Providing referrals for HIV+ Persons E2c. ☐ Yes for HRN Persons E2d. ☐ No, Providing referrals for HRN Persons
E3 Substance Abuse Treatment and Services	E3a. ☐ Yes for HIV+ Persons E3b. ☐ No, Providing referrals for HIV+

	Persons E3c. ☐ Yes for HRN Persons E3d. ☐ No, Providing referrals for HRN Persons
E4. Housing Services	E4a. ☐ Yes for HIV+ Persons E4b. ☐ No, Providing referrals for HIV+ Persons E4c. ☐ Yes for HRN Persons E4d. ☐ No, Providing referrals for HRN Persons
E5. Employment Services	E5a. ☐ Yes for HIV+ Persons E5b. ☐ No, Providing referrals for HIV+ Persons E5c. ☐ Yes for HRN Persons E5d. ☐ No, Providing referrals for HRN Persons
E6. Basic Education Services	E6a. ☐ Yes for HIV+ Persons E6b. ☐ No, Providing referrals for HIV+ Persons E6c. ☐ Yes for HRN Persons E6d. ☐ No, Providing referrals for HRN Persons
E7. Sex/HIV Education	E7a. ☐ Yes for HIV+ Persons E7b. ☐ No, Providing referrals for HIV+ Persons E7c. ☐ Yes for HRN Persons E7d. ☐ 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.***

F. 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+ Persons F1b. ☐ No, Providing Referrals for HIV+ Persons F1c. ☐ Yes for HRN Persons F1d. ☐ 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 staff F1.1c. ☐ Developing/Updating protocols and strategies for HIV+ Persons F1.1d. ☐ Developing/Updating protocols and strategies for HRN Persons F1.1e. ☐ Providing referrals to increase access to condom distribution and related services F1.1f. ☐ 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's condom distribution program. _____ _____ _____	

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

G. 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. ☐ Yes G1b. ☐ 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. ☐ Yes G1b. ☐ No G1b. ☐ N/A
G3. In 250 words or less, please share/explain your **specific** needs to improve and/or update your agency/partnership's organizational 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 <u>their agency only</u> and <u>NOT</u> the Partnership.

H. Program Summary

H1. What are your agency's **<u>primary strengths</u>** related to the implementation of your HIP program? (Limit 250 words)

_____
_____
_____

H2. In what ways would **<u>you like to see</u>** 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 <u>HIP program</u>. 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 <u>their agency only</u> and <u>NOT</u> 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 <u>250</u> words or less, please share/explain your **specific** needs to improve and/or update your agency/partnership's monitoring 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. ☐ Yes J1b. ☐ 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's Quality 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's governance 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

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 contractor

K3.1c. ☐ Agency uses internal staff and an outside contractor

K3.1d. ☐ 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. ☐ Agency Staff responsible (job title) _____

K4.1b. ☐ Agency uses an outside contractor

K4.1c. ☐ Agency uses internal staff and an outside contractor

K4.1d. ☐ 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. ☐ No K5.2c. 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? _____ _____ _____

O. 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.).

Top Priority Needs to be addressed
O1. Program Component: _____ _____ _____
O2. Program Component: _____ _____ _____
O3. Program Component: _____ _____ _____
O4. Program Component: _____ _____ _____

Thank you