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OMB No. 0920-New
Expiration Date: XXXXXXXX

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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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.

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ORGANIZATIONAL SUMMARY

Date:

Name of CBO/Lead Partner:

Business Address:

City: State: Zip Code: -

Website:

Name of Executive Director:

Name and Title of Person Completing the CBA Assessment Tool:

Business E-mail:

Business Phone Number: () -

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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.

Component #1: Formalized Collaborations

A1. Do you need CBA to update/improve the service agreements you currently have with medical care providers for your HIV+ populations? <i>(check all that apply)</i>	A1.1. <input type="checkbox"/> HIV Testing	A1.2. <input type="checkbox"/> Partner Services	A1.3. <input type="checkbox"/> Linkage to care and treatment	A1.4. <input type="checkbox"/> Retention in care and treatment	A1.5. <input type="checkbox"/> 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? <i>(check all that apply)</i>	A2.1. <input type="checkbox"/> HIV Testing	A2.2. <input type="checkbox"/> Partner Services	A2.3. <input type="checkbox"/> Linkage to prevention and treatment	A2.4. <input type="checkbox"/> Medication adherence	A2.5. <input type="checkbox"/> None Needed
A3. Do you need CBA for any of the following? <i>(check all that apply)</i>	A3.1. <input type="checkbox"/> Revising or improving Memorandum of Understanding (MOU)	A3.2. <input type="checkbox"/> Communication with collaborators	A3.3. <input type="checkbox"/> Referrals	A3.4. <input type="checkbox"/> Billing	A3.5. <input type="checkbox"/> 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.).

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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? <i>(check all that apply)</i>	B1.1. <input type="checkbox"/> Referral from another agency or clinic (testing site, ER, crisis center, etc.)	B1.2. <input type="checkbox"/> Referral from within your agency's programs	B1.3. <input type="checkbox"/> Peer/partner referral, core group referrals	B1.4. <input type="checkbox"/> Ads on social media or apps	B1.5. <input type="checkbox"/> Public Service Announcements (TV, Radio, Billboards)
B2. Please identify your agency/partnership's recruitment strategies for high-risk HIV-negative persons <i>(check all that apply)</i>	B2.1. <input type="checkbox"/> Referral from another agency or clinic (testing site, ER, crisis center, etc.)	B2.2. <input type="checkbox"/> Referral from within your agency's programs	B2.3. <input type="checkbox"/> Peer/partner referral, core group referrals	B2.4. <input type="checkbox"/> Ads on social media or apps	B2.5. <input type="checkbox"/> Public Service Announcements (TV, Radio, Billboards)
B3. What capacity building needs does your agency/partnership have regarding recruitment? <i>(check all that apply)</i>	B3.1. <input type="checkbox"/> None	B3.2. <input type="checkbox"/> Training for staff	B3.3. <input type="checkbox"/> Planning for recruitment	B3.4. <input type="checkbox"/> Locating target population (s)	B3.5. <input type="checkbox"/> 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.

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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. <input type="radio"/> Yes C1b. <input type="radio"/> No	C1c. <input type="radio"/> Yes C1d. <input type="radio"/> No C1e. <input type="radio"/> N/A	C1f. <input type="radio"/> Yes C1g. <input type="radio"/> No C1h. <input type="radio"/> N/A
C2. Is your agency/partnership currently implementing Couples HIV Testing and Counseling?	C2a. <input type="radio"/> Yes C2b. <input type="radio"/> No	C2c. <input type="radio"/> Yes C2d. <input type="radio"/> No C2e. <input type="radio"/> N/A	C2f. <input type="radio"/> Yes C2g. <input type="radio"/> No C2h. <input type="radio"/> N/A
C3. Does your agency/partnership conduct integrated screening for STDs, viral hepatitis, and TB using CDC funds?	C3a. <input type="radio"/> Yes C3b. <input type="radio"/> No	C3c. <input type="radio"/> Yes C3d. <input type="radio"/> No C3e. <input type="radio"/> N/A	C3f. <input type="radio"/> Yes C3g. <input type="radio"/> No C3h. <input type="radio"/> N/A
C4. Is your agency/partnership currently implementing Personalized Cognitive Counseling (PCC) with men who have sex with men who are repeat testers?	C4a. <input type="radio"/> Yes C4b. <input type="radio"/> No	C4c. <input type="radio"/> Yes C4d. <input type="radio"/> No C4e. <input type="radio"/> N/A	C4f. <input type="radio"/> Yes C4g. <input type="radio"/> No C4h. <input type="radio"/> N/A
C5. In <u>250</u> 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.			
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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.*

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?	D1.1.a. <input type="checkbox"/> Assigned patient navigator at your clinic or the Collaborator/ Partner's clinic	D1.1.b. <input type="checkbox"/> Reminder calls, texts or emails for the first medical appointment	D1.1.c. <input type="checkbox"/> Incentive for completing the first medical appointment (e.g. monetary, transportation, provision of child care)	D1.1.d. <input type="checkbox"/> Peer/navigator accompanies client to the first appointment	D1.1.e. <input type="checkbox"/> Using contact self-addressed card to submit to medical agency which is then returned to your agency	D1.1.f. <input type="checkbox"/> Other, please specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
D1.2. Please identify your agency's strategies for ensuring follow-through and engagement in medical care for HIV+ persons?	D1.2.a. <input type="checkbox"/> Assigned patient navigator at your clinic or the Collaborator/ Partner's clinic	D1.2.b. <input type="checkbox"/> Reminder calls, texts or emails for medical appointments	D1.2.c. <input type="checkbox"/> Incentives for completed appointments (monetary, transportation, provision of child care)	D1.2.d. <input type="checkbox"/> Face-to-face or home visit	D1.2.e. <input type="checkbox"/> Using contact information given for family members, friends others	D1.2.f. <input type="checkbox"/> Other, please specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
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+ persons in medical care. <div style="border: 1px solid black; height: 60px; width: 100%;"></div>						

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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. <input type="radio"/> Yes D2.1b. <input type="radio"/> No	D2.1c. <input type="radio"/> Yes D2.1d. <input type="radio"/> No
D2.2. Is your agency able to consistently link 90% of newly diagnosed persons to HIV medical care?	D2.2a. <input type="radio"/> Yes D2.2b. <input type="radio"/> No	D2.2c. <input type="radio"/> Yes D2.2d. <input type="radio"/> No
D2.3. Is your agency able to retain 90% of HIV+ persons in HIV medical care?	D2.3a. <input type="radio"/> Yes D2.3b. <input type="radio"/> No	D2.3c. <input type="radio"/> Yes D2.3d. <input type="radio"/> 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. <input type="radio"/> Yes D2.4b. <input type="radio"/> No	D2.4c. <input type="radio"/> Yes D2.4d. <input type="radio"/> No
D2.5. In <u>250</u> words or less, please share/explain your priority CBA needs for your agency/partnership's linkage and retention activities.		
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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)	D3.1.a. <input type="radio"/> Yes D3.1.b. <input type="radio"/> No	D3.1.c. <input type="radio"/> Yes D3.1.d. <input type="radio"/> No D3.1.e. <input type="radio"/> N/A	D3.1.f. <input type="radio"/> Yes D3.1.g. <input type="radio"/> No D3.1.h. <input type="radio"/> N/A
D3.2. Every Dose Every Day Mobile Application	D3.2.a. <input type="radio"/> Yes D3.2.b. <input type="radio"/> No	D3.2.c. <input type="radio"/> Yes D3.2.d. <input type="radio"/> No D3.2.e. <input type="radio"/> N/A	D3.2.f. <input type="radio"/> Yes D3.2.g. <input type="radio"/> No D3.2.h. <input type="radio"/> N/A
D3.3. Peer Support	D3.3.a. <input type="radio"/> Yes D3.3.b. <input type="radio"/> No	D3.3.c. <input type="radio"/> Yes D3.3.d. <input type="radio"/> No D3.3.e. <input type="radio"/> N/A	D3.3.f. <input type="radio"/> Yes D3.3.g. <input type="radio"/> No D3.3.h. <input type="radio"/> N/A
D3.4. Sharing Medication Adherence Responsibilities Together (SMART Couples)	D3.4.a. <input type="radio"/> Yes D3.4.b. <input type="radio"/> No	D3.4.c. <input type="radio"/> Yes D3.4.d. <input type="radio"/> No D3.4.e. <input type="radio"/> N/A	D3.4.f. <input type="radio"/> Yes D3.4.g. <input type="radio"/> No D3.4.h. <input type="radio"/> N/A
D3.5. Helping Enhance Adherence to Antiretroviral Therapy (HEART)	D3.5.a. <input type="radio"/> Yes D3.5.b. <input type="radio"/> No	D3.5.c. <input type="radio"/> Yes D3.5.d. <input type="radio"/> No D3.5.e. <input type="radio"/> N/A	D3.5.f. <input type="radio"/> Yes D3.5.g. <input type="radio"/> No D3.5.h. <input type="radio"/> N/A
D3.6. Local intervention for Medication Adherence Services	D3.6.a. <input type="radio"/> Yes D3.6.b. <input type="radio"/> No	D3.6.c. <input type="radio"/> Yes D3.6.d. <input type="radio"/> No D3.6.e. <input type="radio"/> N/A	D3.6.f. <input type="radio"/> Yes D3.6.g. <input type="radio"/> No D3.6.h. <input type="radio"/> N/A

D3.7. In 250 words or less, please share/explain your **priority** CBA needs for your agency/partnership's medication adherence interventions.

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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. <input type="radio"/> Yes D4.1b. <input type="radio"/> No	D4.1c. <input type="radio"/> Yes D4.1d. <input type="radio"/> No D4.1e. <input type="radio"/> N/A	D4.1f. <input type="radio"/> Yes D4.1g. <input type="radio"/> No D4.1h. <input type="radio"/> N/A
D4.2.Partner Elicitation	D4.2a. <input type="radio"/> Yes D4.2b. <input type="radio"/> No	D4.2c. <input type="radio"/> Yes D4.2d. <input type="radio"/> No D4.2e. <input type="radio"/> N/A	D4.2f. <input type="radio"/> Yes D4.2g. <input type="radio"/> No D4.2h. <input type="radio"/> N/A
D4.3.Partner Services	D4.3a. <input type="radio"/> Yes D4.3b. <input type="radio"/> No	D4.3c. <input type="radio"/> Yes D4.3d. <input type="radio"/> No D4.3e. <input type="radio"/> N/A	D4.3f. <input type="radio"/> Yes D4.3g. <input type="radio"/> No D4.3h. <input type="radio"/> N/A
D4.4.d-Up	D4.4a. <input type="radio"/> Yes D4.4b. <input type="radio"/> No	D4.4c. <input type="radio"/> Yes D4.4d. <input type="radio"/> No D4.4e. <input type="radio"/> N/A	D4.4f. <input type="radio"/> Yes D4.4g. <input type="radio"/> No D4.4h. <input type="radio"/> N/A
D4.5.Peers Reaching Out and Modeling Intervention Strategies (PROMISE)	D4.5a. <input type="radio"/> Yes D4.5b. <input type="radio"/> No	D4.5c. <input type="radio"/> Yes D4.5d. <input type="radio"/> No D4.5e. <input type="radio"/> N/A	D4.5f. <input type="radio"/> Yes D4.5g. <input type="radio"/> No D4.5h. <input type="radio"/> N/A
D4.6.MPowerment	D4.6a. <input type="radio"/> Yes D4.6b. <input type="radio"/> No	D4.6c. <input type="radio"/> Yes D4.6d. <input type="radio"/> No D4.6e. <input type="radio"/> N/A	D4.6f. <input type="radio"/> Yes D4.6g. <input type="radio"/> No D4.6h. <input type="radio"/> N/A
D4.7.Opinion Leader (POL)	D4.7a. <input type="radio"/> Yes D4.7b. <input type="radio"/> No	D4.7c. <input type="radio"/> Yes D4.7d. <input type="radio"/> No D4.7e. <input type="radio"/> N/A	D4.7f. <input type="radio"/> Yes D4.7g. <input type="radio"/> No D4.7h. <input type="radio"/> N/A
D4.8.Choosing Life: Empowerment! Action! Results! (CLEAR)	D4.8a. <input type="radio"/> Yes D4.8b. <input type="radio"/> No	D4.8c. <input type="radio"/> Yes D4.8d. <input type="radio"/> No D4.8e. <input type="radio"/> N/A	D4.8f. <input type="radio"/> Yes D4.8g. <input type="radio"/> No D4.8h. <input type="radio"/> N/A
D4.9.Women Involved in Life Learning from Other Women (WILLOW)	D4.9a. <input type="radio"/> Yes D4.9b. <input type="radio"/> No	D4.9c. <input type="radio"/> Yes D4.9d. <input type="radio"/> No D4.9e. <input type="radio"/> N/A	D4.9f. <input type="radio"/> Yes D4.9g. <input type="radio"/> No D4.9h. <input type="radio"/> N/A
D4.10.Healthy Relationships	D4.10a. <input type="radio"/> Yes D4.10b. <input type="radio"/> No	D4.10c. <input type="radio"/> Yes D4.10d. <input type="radio"/> No D4.10e. <input type="radio"/> N/A	D4.10f. <input type="radio"/> Yes D4.10g. <input type="radio"/> No D4.10h. <input type="radio"/> N/A

D4.11.CONNECT	D4.11a. <input type="radio"/> Yes D4.11b. <input type="radio"/> No	D4.11c. <input type="radio"/> Yes D4.11d. <input type="radio"/> No D4.11e. <input type="radio"/> N/A	D4.11f. <input type="radio"/> Yes D4.11g. <input type="radio"/> No D4.11h. <input type="radio"/> N/A
D4.12.Partnerships for Health (PfH)	D4.12a. <input type="radio"/> Yes D4.12b. <input type="radio"/> No	D4.12c. <input type="radio"/> Yes D4.12d. <input type="radio"/> No D4.12e. <input type="radio"/> N/A	D4.12f. <input type="radio"/> Yes D4.12g. <input type="radio"/> No D4.12h. <input type="radio"/> N/A
D4.13.START	D4.13a. <input type="radio"/> Yes D4.13b. <input type="radio"/> No	D4.13c. <input type="radio"/> Yes D4.13d. <input type="radio"/> No D4.13e. <input type="radio"/> N/A	D4.13f. <input type="radio"/> Yes D4.13g. <input type="radio"/> No D4.13h. <input type="radio"/> N/A
D4.14.Locally developed intervention for HIV+ persons?	D4.14a. <input type="radio"/> Yes D4.14b. <input type="radio"/> No	D4.14c. <input type="radio"/> Yes D4.14d. <input type="radio"/> No D4.14e. <input type="radio"/> N/A	D4.14f. <input type="radio"/> Yes D4.14g. <input type="radio"/> No D4.14h. <input type="radio"/> 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.			
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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. <input type="radio"/> Yes D5.1b. <input type="radio"/> No	D5.1c. <input type="radio"/> Yes D5.1d. <input type="radio"/> No D5.1e. <input type="radio"/> N/A	D5.1f. <input type="radio"/> Yes D5.1g. <input type="radio"/> No D5.1h. <input type="radio"/> N/A
D5.2.Screening for STDs, hepatitis, and TB	D5.2a. <input type="radio"/> Yes D5.2b. <input type="radio"/> No	D5.2c. <input type="radio"/> Yes D5.2d. <input type="radio"/> No D5.2e. <input type="radio"/> N/A	D5.2f. <input type="radio"/> Yes D5.2g. <input type="radio"/> No D5.2h. <input type="radio"/> N/A
D5.3.Referrals for the treatment of STDs, viral hepatitis, and TB	D5.3a. <input type="radio"/> Yes D5.3b. <input type="radio"/> No	D5.3c. <input type="radio"/> Yes D5.3d. <input type="radio"/> No D5.3e. <input type="radio"/> N/A	D5.3f. <input type="radio"/> Yes D5.3g. <input type="radio"/> No D5.3h. <input type="radio"/> N/A
D5.4.Pre-Exposure Prophylaxis (PrEP)	D5.4a. <input type="radio"/> Yes D5.4b. <input type="radio"/> No	D5.4c. <input type="radio"/> Yes D5.4d. <input type="radio"/> No D5.4e. <input type="radio"/> N/A	D5.4f. <input type="radio"/> Yes D5.4g. <input type="radio"/> No D5.4h. <input type="radio"/> N/A
D5.5.Post-Exposure Prophylaxis (nPEP)	D5.5a. <input type="radio"/> Yes D5.5b. <input type="radio"/> No	D5.5c. <input type="radio"/> Yes D5.5d. <input type="radio"/> No D5.5e. <input type="radio"/> N/A	D5.5f. <input type="radio"/> Yes D5.5g. <input type="radio"/> No D5.5h. <input type="radio"/> 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.

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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. Program Component #5: 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. <input type="radio"/> Yes for HIV+ Persons E1b. <input type="radio"/> No, Providing referrals for HIV+ Persons E1c. <input type="radio"/> Yes for HRN Persons E1d. <input type="radio"/> No, Providing referrals for HRN Persons
E2. Mental Health Counseling	E2a. <input type="radio"/> Yes for HIV+ Persons E2b. <input type="radio"/> No, Providing referrals for HIV+ Persons E2c. <input type="radio"/> Yes for HRN Persons E2d. <input type="radio"/> No, Providing referrals for HRN Persons
E3. Substance Abuse Treatment and Services	E3a. <input type="radio"/> Yes for HIV+ Persons E3b. <input type="radio"/> No, Providing referrals for HIV+ Persons E3c. <input type="radio"/> Yes for HRN Persons E3d. <input type="radio"/> No, Providing referrals for HRN Persons
E4. Housing Services	E4a. <input type="radio"/> Yes for HIV+ Persons E4b. <input type="radio"/> No, Providing referrals for HIV+ Persons E4c. <input type="radio"/> Yes for HRN Persons E4d. <input type="radio"/> No, Providing referrals for HRN Persons
E5. Employment Services	E5a. <input type="radio"/> Yes for HIV+ Persons E5b. <input type="radio"/> No, Providing referrals for HIV+ Persons E5c. <input type="radio"/> Yes for HRN Persons E5d. <input type="radio"/> No, Providing referrals for HRN Persons
E6. Basic Education Services	E6a. <input type="radio"/> Yes for HIV+ Persons E6b. <input type="radio"/> No, Providing referrals for HIV+ Persons E6c. <input type="radio"/> Yes for HRN Persons E6d. <input type="radio"/> No, Providing referrals for HRN Persons
E7. Sex/HIV Education	E7a. <input type="radio"/> Yes for HIV+ Persons E7b. <input type="radio"/> No, Providing referrals for HIV+ Persons E7c. <input type="radio"/> Yes for HRN Persons E7d. <input type="radio"/> No, Providing referrals for HRN Persons
E8. In <u>250</u> 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.	
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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
<p>F1. Is your agency directly implementing a Condom Distribution Program for HIV+ & HRN persons, or providing referrals to other organizations?</p> <p>F1.a. <input type="radio"/> Yes for HIV+ Persons</p> <p>F1.b. <input type="radio"/> No, Providing referrals for HIV+ Persons</p> <p>F1.c. <input type="radio"/> Yes for HRN Persons</p> <p>F1.d. <input type="radio"/> No, Providing referrals for HRN Persons</p>	<p>F1.1. Does your agency need CBA for the following related to your condom distribution program? <i>(check all that apply)</i></p> <p>F1.1.a. <input type="checkbox"/> Finalizing/Updating MOUs</p> <p>F1.1.b. <input type="checkbox"/> Training for staff</p> <p>F1.1.c. <input type="checkbox"/> Developing/Updating protocols and strategies for HIV+ Persons</p> <p>F1.1.d. <input type="checkbox"/> Developing/Updating protocols and strategies for HRN Persons</p> <p>F1.1.e. <input type="checkbox"/> Providing referrals to increase access to condom distribution and related services</p> <p>F1.1.f. <input type="checkbox"/> Educational materials that are appropriate to the target population</p> <p>F1.1.g. <input type="checkbox"/> Other</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div> <p>F1.1.h. <input type="checkbox"/> N/A</p>
<p>F2. In <u>250</u> words or less, please share/explain your priority CBA needs for your agency/partnership's condom distribution program.</p> <div style="border: 1px solid black; height: 50px; width: 100%;"></div>	

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

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. <input type="radio"/> Yes
	G1b. <input type="radio"/> No
G1. 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?	G2a. <input type="radio"/> Yes
	G2b. <input type="radio"/> No
	G2c. <input type="radio"/> N/A
G3. In <u>250</u> words or less, please share/explain your specific needs to improve and/or update your agency/partnership's organizational strategic plan.	
<div style="border: 1px solid #ccc; padding: 5px;"> <div style="border-bottom: 1px solid #ccc; height: 15px;"></div> <div style="border-bottom: 1px solid #ccc; height: 15px;"></div> <div style="border-bottom: 1px solid #ccc; height: 15px;"></div> </div>	

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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. For those agencies involved in a Partnership, the lead agency should respond for their agency only and NOT the Partnership.

H. Program Summary

What are your agency's **primary strengths** related to the implementation of your HIP program?

(Limit 250 words)

In what ways would **you like to see** your agency's HIP program strengthened in the next 12 months?

(Limit 250 words)

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This section of the tool is intended to assess your agency's monitoring and evaluation CBA needs. 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 for your HIP program

I1. Does your agency have staff to oversee monitoring and evaluation activities?

I1 a. Yes (agency staff)

I1 b. No (contractor/consultant is used)

I1 c. No

I2. In 250 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.

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This section of the tool is intended to assess your QA CBA needs. 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) for your HIP program

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.

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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. Do you need capacity building assistance to improve your agency's governance structure?
K1.1a. 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.

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K2. Resource Development

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.

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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.

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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:

K4.2. 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.

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K5. Technology


K5.1. Does your agency have in-house Information Technology (IT) staff?	K5.1a. <input type="radio"/> Yes K5.1b. <input type="radio"/> No K5.1c. <input type="radio"/> Other <div data-bbox="1000 464 1787 625" style="border: 1px solid black; height: 113px;"></div>
K5.2. Does your agency have a contract for IT support?	K5.2a. <input type="radio"/> Yes K5.2b. <input type="radio"/> No K5.2c. <input type="radio"/> Other <div data-bbox="1000 729 1787 891" style="border: 1px solid black; height: 113px;"></div>
K5.3. In <u>250</u> words or less, please share/explain your agency's IT needs for which you would like to receive CBA within the next 12 months <div data-bbox="285 929 1812 1019" style="border: 1px solid black; height: 63px;"></div>	

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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.

What do you feel is working well regarding your agency's infrastructure?


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

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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?
↑ ↓

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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?

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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.).

O1. Program Component:	<input type="text"/>
O2. Program Component:	<input type="text"/>
O3. Program Component:	<input type="text"/>
O4. Program Component:	<input type="text"/>

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