

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



Health Resources & Services Administration

HIV/AIDS Bureau
Division of Metropolitan HIV/AIDS Programs

***Ryan White HIV/AIDS Program Part A
HIV Emergency Relief Grant Program***

Funding Opportunity Number: HRSA-20-063
Funding Opportunity Type: Competing Continuation
Assistance Listings (CFDA) Number: 93.914

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2020

Application Due Date: September 30, 2019

Ensure your SAM.gov and Grants.gov registrations and passwords are current immediately! HRSA will not approve deadline extensions for lack of registration. Registration in all systems, including SAM.gov and Grants.gov, may take up to 1 month to complete.

Issuance Date: July 1, 2019

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Authority: Public Health Service Act, Sections 2601-2610, and 2693 (42 USC 300ff-11 – 300ff-20, and 300ff-121), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87).

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2020 Ryan White HIV/AIDS Program (RWHAP) Part A HIV Emergency Relief Grant Program. The purpose of this program is to provide direct financial assistance to an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA) that has been severely affected by the HIV epidemic. This competition is open only to Part A jurisdictions to provide RWHAP services in the geographic service areas described in [Appendix B](#). Eligible jurisdictions may apply for an amount up to the defined funding ceiling listed in [Appendix B](#), which represents a level five percent above the final FY 2019 award.

Funding Opportunity Title:	Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program
Funding Opportunity Number:	HRSA-20-063
Due Date for Applications:	September 30, 2019
Anticipated Total Annual Available FY 2020 Funding:	\$620,000,000, of which approximately \$10,600,000 will be used for priority funding, and \$51,000,000 will be available for Minority AIDS Initiative funding.*
Estimated Number and Type of Award(s):	Up to 52 grants
Estimated Award Amount:	Varies, see Appendix B
Cost Sharing/Match Required:	No
Project Period/Period of Performance:	March 1, 2020 through February 28, 2021 (one (1) year)
Eligible Applicants:	RWHAP Part A recipients that are classified as an EMA or as a TGA and continue to meet the eligibility criteria as defined in the statute are eligible to apply for these funds. See Section III-1 of this notice of funding opportunity (NOFO) for complete eligibility information.

*Estimated annual available funding level based on current projections.

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide*, available online at <http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf>, except where instructed in this NOFO to do otherwise.

Technical Assistance

All interested applicants are encouraged to participate in a technical assistance (TA) webinar for this funding opportunity. The purpose of this webinar is to assist potential applicants in preparing applications that address the requirements of this funding notice. Participation in the pre-application TA webinar is optional.

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Thursday, August 1, 2019

Time: 2:00 p.m. – 4 p.m. ET

Call-In Number: 1-800-369-1990

Participant Code: 3479507#

Web link:

https://hrsa.connectsolutions.com/rwhap_part_a_fy_20_nofa_ta_webinar/

Playback Number: Recorded webinar will be available on the [TargetHIV website](#).

Table of Contents

I. PROGRAM FUNDING OPPORTUNITY DESCRIPTION.....	1
1. PURPOSE	1
2. BACKGROUND	3
II. AWARD INFORMATION	6
1. TYPE OF APPLICATION AND AWARD	6
2. SUMMARY OF FUNDING	7
III. ELIGIBILITY INFORMATION	8
1. ELIGIBLE APPLICANTS	8
2. COST SHARING/MATCHING.....	8
3. OTHER ELIGIBILITY INFORMATION	9
IV. APPLICATION AND SUBMISSION INFORMATION.....	9
1. ADDRESS TO REQUEST APPLICATION PACKAGE.....	9
2. CONTENT AND FORM OF APPLICATION SUBMISSION	10
<i>i. Project Abstract</i>	10
<i>ii. Project Narrative</i>	11
<i>iii. Budget</i>	26
<i>iv. Budget Narrative</i>	27
<i>v. Attachments</i>	31
3. DUN AND BRADSTREET DATA UNIVERSAL NUMBERING SYSTEM (DUNS) NUMBER AND SYSTEM FOR AWARD MANAGEMENT	33
4. SUBMISSION DATES AND TIMES	33
5. INTERGOVERNMENTAL REVIEW.....	34
6. FUNDING RESTRICTIONS	34
V. APPLICATION REVIEW INFORMATION.....	35
1. REVIEW CRITERIA	35
2. REVIEW AND SELECTION PROCESS.....	40
3. ASSESSMENT OF RISK	40
VI. AWARD ADMINISTRATION INFORMATION	41
1. AWARD NOTICES	41
2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS	41
3. REPORTING	41
VII. AGENCY CONTACTS.....	42
VIII. OTHER INFORMATION	43
APPENDIX A.....	44
APPENDIX B.....	47

I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for funding under the Ryan White HIV/AIDS Program (RWHAP) Part A HIV Emergency Relief Grant Program. The purpose of this program is to provide direct financial assistance to an eligible metropolitan area (EMA) or a transitional grant area (TGA) that has been severely affected by the HIV epidemic. Grant funds assist eligible jurisdictions to develop or enhance access to a comprehensive continuum of high quality, community-based care for people with HIV who are low-income through the provision of formula, supplemental, and Minority AIDS Initiative (MAI) funds.

RWHAP Part A recipients must provide comprehensive primary health care and support services throughout the entire designated geographic service area. The goal is to provide optimal HIV care and treatment for people with HIV who are low-income, uninsured, and underserved, to improve their health outcomes. **Your application must address the entire service area, as defined in [Appendix B](#).**

Comprehensive HIV care consists of core medical services and support services that enable people with HIV and those affected by HIV to access and remain in HIV primary medical care to improve their medical outcomes. Based on an annual assessment of the services and gaps in the HIV care continuum within a jurisdiction, HIV Planning Councils/Planning Bodies (PCs/PBs) and RWHAP recipients identify specific service categories to fund. Funded service categories should facilitate improvements at specific stages of the HIV care continuum.

RWHAP Part A EMAs and TGAs must use grant funds to support, further develop, and/or expand systems of care to meet the needs of people with HIV, who are low-income, within the EMA/TGA and strengthen strategies to reach disproportionately impacted subpopulations. The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) requires EMAs/TGAs to collect data to identify need, set priorities, make allocations, and validate the use of RWHAP funding. A comprehensive application should reflect how you have used those data to develop and expand the system of care in EMA/TGA jurisdictions. HRSA encourages innovation and collaboration with other agencies and organizations to maximize impact on health outcomes and effectively meet the needs of people with HIV within the EMA/TGA.

Important Notes:

- **Budget:** You must submit a detailed budget narrative/justification as part of the application. You may apply for no more than the published ceiling amount in [Appendix B](#). Please note that your application budget that is approved, or subsequently amended during the award process, will be your approved budget for the FY 2020 project period.
- **Unmet Need:** HAB has integrated the Unmet Need requirement in this NOFO into the Demonstrated Need section. Separate and new estimates for unmet

need should not be submitted with this application. Please review carefully when preparing this section of your application.

The following information will assist you in understanding and completing your FY 2020 application:

- **Policy Clarification Notices:** Information on the RWHAP and HAB Policy Clarification Notices (PCNs) are available online at <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>. Please note that the following PCNs have been updated: [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds](#) - updated as of 10/22/2018, [PCN 15-02 Clinical Quality Management](#) - updated as of 11/30/2018, and [PCN 13-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements](#) – updated as of May 1, 2019.
- **Allowable Services and Service Category Definitions:** Core medical services are listed in Section 2604(c)(3) of the Public Health Service (PHS) Act. Support services allowed under RWHAP Part A are limited to services that are needed for people with HIV to achieve their medical outcomes, as defined by RWHAP. The service definitions effective for awards issued on or after October 1, 2016, are listed in [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds](#).
- **Core Medical Services Waiver:** RWHAP Part A funds are subject to Section 2604(c) of the PHS Act, which requires that not less than 75 percent of the funds remaining after reserving funds for administration and Clinical Quality Management (CQM) be used to provide core medical services. Applicants may seek a waiver of the core medical services requirement. A waiver request must be submitted prior to submission of the grant application, with this application, or up to four (4) months after the budget period start date. Submission should be in accordance with [PCN 13-07 Uniform Standard for Waiver of Core Medical Services Requirement for Grantees Under Parts A, B, and C](#). You can find sample letters to fulfill the requirements of the Core Medical Services Waiver at <https://hab.hrsa.gov/sites/default/files/hab/Global/samplereqwaiverletters.pdf>.

In addition, your RWHAP Part A core medical services waiver request must include funds awarded under MAI. HAB will not consider a waiver request that does not include MAI funds. If you submit the core medical services waiver request and allocation table with the application, both should be included as **Attachment 9**. The waiver request counts toward the 100-page limit.

- **Agreements and Compliance Assurances:** The agreements and assurances, found in [Appendix A](#) of this NOFO, require the signature of the chief elected official (CEO), or the CEO's designee. Include this document as **Attachment 2**.

2. Background

This program is authorized by the [PHS Act, Sections 2601-2610, and 2693 \(42 USC 300ff-11– 300ff-20, and 300ff-121\)](#), as amended by the [Ryan White HIV/AIDS Treatment Extension Act of 2009 \(Public Law 111-87\)](#). Fifty-two (52) eligible metropolitan jurisdictions receive Part A formula, supplemental, and MAI funding through this program.

According to the Centers for Disease Control and Prevention (CDC), at the end of 2016 in the United States, an estimated 1.1 million people aged 13 years and older had HIV infection, including an estimated 162,500 (14 percent) people whose infections had not been diagnosed. The focus of CDC and HRSA HIV programs is to diagnosis all people who have HIV and engage them in HIV care and treatment so that they reach viral suppression, which results in a near normal lifespan and effectively no HIV transmission to others.

Ending the HIV Epidemic: A Plan for America

In February 2019, the Administration announced a new initiative, [Ending the HIV Epidemic: A Plan for America](#). This 10-year initiative beginning FY 2020 seeks to achieve the important goal of reducing new HIV infections in the United States to less than 3,000 per year by 2030. The first phase of the initiative will focus on 48 counties, Washington, D.C., San Juan, PR, and 7 states that have a substantial rural HIV burden. By focusing on these jurisdictions in the first phase of the initiative, HHS plans to reduce new HIV infections by 75 percent within 5 years. Across the United States, the initiative will promote and implement four Pillars to substantially reduce HIV transmissions – Diagnose, Treat, Protect, and Respond. This NOFO focuses on implementing activities in Pillar Two (Treat) and Pillar Four (Respond) for this important initiative. The initiative is a collaborative effort among key HHS agencies, primarily HRSA, the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

National HIV/AIDS Strategy: Updated to 2020

The National HIV/AIDS Strategy for the United States: Updated to 2020 (NHAS 2020) is a 5-year plan that details principles, priorities, and actions to guide the national response to the HIV epidemic. The RWHAP promotes robust advances and innovations in HIV health care using the National HIV/AIDS Strategy to end the epidemic as its framework. Therefore, to the extent possible, activities funded by RWHAP focus on addressing these four goals:

- 1) Reduce new HIV infections;
- 2) Increase access to care and improve health outcomes for people with HIV;
- 3) Reduce HIV-related health disparities and health inequities; and
- 4) Achieve a more coordinated national response.

To achieve these shared goals, recipients should align their organization's efforts, within the parameters of the RWHAP statute and program guidance, to ensure that people with HIV are linked to and retained in care, and have timely access to HIV treatment and the supports needed (e.g., mental health and substance use disorders services) to

achieve HIV viral suppression

HIV Care Continuum

Diagnosing people with HIV, linking people with HIV to HIV primary care, and people with HIV achieving viral suppression are important public health steps toward ending the HIV epidemic in the United States. The HIV care continuum has five main “steps” or stages that include: HIV diagnosis, linkage to care, retention in care, antiretroviral use, and viral suppression. The HIV care continuum depicts a series of stages in which people with HIV engage in HIV care: from initial diagnosis through their successful treatment with HIV medication. It also demonstrates the proportion of individuals living with HIV who are engaged at each stage. The HIV care continuum allows recipients and planning groups to measure progress and to direct HIV resources most effectively.

RWHAP recipients are encouraged to assess the outcomes of their programs along this continuum of care. Recipients should work with their community and public health partners to improve outcomes across the HIV care continuum. HRSA encourages recipients to use the [performance measures](#) developed for the RWHAP at their local level to assess the efficacy of their programs and to analyze and improve the gaps along the HIV care continuum.

According to recent data from the [2017 Ryan White Services Report \(RSR\)](#), the RWHAP has made tremendous progress toward ending the HIV epidemic in the United States. From 2010 to 2017, HIV viral suppression among RWHAP patients who have had one or more medical visits during the calendar year and at least one viral load with a result of <200 copies/mL reported, has increased from 69.5 percent to 85.9 percent; additionally, racial/ethnic, age-based, and regional disparities have decreased.¹ These improved outcomes mean more people with HIV in the United States will live near normal lifespans and have a reduced risk of transmitting HIV to others.² Scientific advances have shown antiretroviral therapy (ART) preserves the health of people with HIV and prevents sexual HIV transmission. This means that people who take ART daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. Such findings underscore the importance of supporting effective interventions for linking people with HIV into care, retaining them in care, and helping them adhere to their ART.

Integrated Data Sharing and Use

HRSA and CDC’s Division of HIV/AIDS Prevention support integrated data sharing, analysis, and utilization for the purposes of program planning, needs assessments, unmet need estimates, reporting, quality improvement, the development of your HIV care continuum, and public health action. HRSA strongly encourages RWHAP Part A recipients to:

¹ Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2017. <http://hab.hrsa.gov/data/data-reports>. Published December 2018. Accessed April 1, 2019.

² National Institute of Allergy and Infectious Diseases (NIAID). Preventing Sexual Transmission of HIV with Anti-HIV Drugs. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2016 Mar 29]. Available from: <https://clinicaltrials.gov/> NCT00074581 NLM Identifier: NCT00074581.

- Follow the principles and standards in the [Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action](#).
- Establish data sharing agreements between surveillance and HIV programs to ensure clarity about the process and purpose of the data sharing and utilization.

Integrated HIV data sharing, analysis, and utilization approaches by state and territorial health departments can help further progress toward reaching the NHAS 2020 goals and improve outcomes on the HIV care continuum.

To fully benefit from integrated data sharing, analysis, and utilization, HRSA strongly encourages complete CD4/viral load (VL) reporting to the state and territorial health departments' HIV surveillance systems. CD4 and VL data can be used to identify cases, stage HIV disease at diagnosis, and monitor disease progression. These data can also be used to evaluate HIV testing and prevention efforts, determine entry into and retention in care, measure viral suppression, and assess unmet health care needs. Analyses at the national level to monitor progress against HIV can only occur if all HIV-related CD4 and VL test results are reported by all jurisdictions. CDC requires that all CD4 results (counts and percentages) and all VL results (undetectable and specific values) be reported to the National HIV Surveillance System (NHSS). Where laws, regulations, or policies are not aligned with these recommendations, states/territories should consider strategies to best implement these recommendations within current parameters or consider steps to resolve conflicts with these recommendations. In addition, NHSS also requires reporting HIV-1 nucleotide sequences from genotypic resistance testing to monitor prevalence of all antiretroviral drug resistance and HIV genetic diversity subtypes and transmission patterns.

Minority HIV/AIDS Funds from the HHS Secretary's Office, HAB Technical Assistance, and Special Projects of National Significance (SPNS) Program

Through Minority HIV/AIDS Funds from the HHS Secretary's Office and through HAB Technical Assistance Cooperative Agreements, HRSA HAB has a number of projects that may be useful for RWHAP recipients to consider. Some select examples are:

- **Building Futures: Supporting Youth Living with HIV** at <https://targethiv.org/library/hrsa-hab-building-futures-supporting-youth-living-hiv>
- **The Center for Engaging Black MSM Across the Care Continuum (CEBACC)** at <https://targethiv.org/cebacc>
- **E2i: Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV** at <https://targethiv.org/e2i>
- **Using Community Health Workers to Improve Linkage and Retention in Care** at <https://targethiv.org/chw>

Below are additional examples for specific populations, co-morbidities, and program areas: <https://targethiv.org/help/ta-directory>.

Through its SPNS Program, HRSA HAB funds demonstration project initiatives focused on the development of effective interventions to respond quickly to emerging needs of

people with HIV receiving assistance under the RWHAP. Through these demonstration projects, SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of innovative treatment models, while promoting dissemination, replication, and uptake of successful interventions. SPNS findings have demonstrated promising new approaches to linking and retaining underserved and marginalized people with HIV into care. All RWHAP recipients are encouraged to review and integrate a variety of SPNS evidence-informed tools within their HIV system of care in accordance with the allowable service categories defined in [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds](#) as resources permit. SPNS related tools may be found at the following locations:

- **Integrating HIV Innovative Practices (IHIP)** (<https://targethiv.org/ihip>)
Resources on the IHIP website include easy-to-use training manuals, curricula, case studies, pocket guides, monographs, and handbooks, as well as informational handouts and infographics about SPNS generally. IHIP also hosts technical assistance (TA) training webinars designed to provide a more interactive experience with experts, and a TA help desk exists for you to submit additional questions and share your own lessons learned.
- **Replication Resources from the SPNS Systems Linkages and Access to Care** (<https://targethiv.org/library/replication-resources-spons-systems-linkages-and-access-care>)
There are intervention manuals for patient navigation, care coordination, state bridge counselors, data to care, and other interventions developed for use at the state and regional levels to address specific HIV care continuum outcomes among hard-to-reach people with HIV.
- **Dissemination of Evidence-Informed Interventions** (<https://www.targethiv.org/library/dissemination-evidence-informed-interventions>)
The Dissemination of Evidence-Informed Interventions initiative runs from 2015-2020 and disseminates four adapted linkage and retention interventions from prior SPNS and the Minority HIV/AIDS Funds from the HHS Secretary's Office initiatives to improve health outcomes along the HIV care continuum. The end goal of the initiative is to produce four evidence-informed care and treatment interventions (CATIs) that are replicable, cost-effective, capable of producing optimal HIV care continuum outcomes, and easily adaptable to the changing health care environment. Manuals are currently available at the link provided and will be updated on an ongoing basis.

II. Award Information

1. Type of Application and Award

Type(s) of applications sought: Competing Continuation.

HRSA will provide funding in the form of a grant.

The amount of funding awarded to each RWHAP recipient will be determined according to a non-discretionary formula that includes MAI funds and discretionary awards for supplemental as described in the Summary of Funding section below.

2. Summary of Funding

HRSA expects approximately \$620,000,000 to be available annually to fund 52 RWHAP recipients. Approximately \$10,600,000 will be used for priority funding, and \$51,000,000 will be available for MAI funding. You may apply for no more than the published ceiling amount in [Appendix B](#). HRSA established ceiling amounts based on current funding with a five (5) percent increase to accommodate fluctuations in formula and supplemental funding. The actual amount available will not be determined until enactment of the final FY 2020 appropriation. This program notice is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds in a timely manner. The period of performance is March 1, 2020, through February 28, 2021 (one (1) year). HRSA will send notification of awards to the CEO or to the delegated administrative agency responsible for dispersing RWHAP Part A funds.

The RWHAP Part A provides non-discretionary formula grants that include MAI funds and discretionary supplemental awards. These funds assist eligible areas in developing or enhancing access to a comprehensive continuum of high quality, community-based care for people with HIV who are low-income within the EMA/TGA and strengthening strategies to reach minority populations. HRSA awards two-thirds of the funds available for EMAs and TGAs according to a formula based on the number of living cases of HIV/AIDS in the EMAs and TGAs. HRSA awards the remaining funds as discretionary supplemental awards based on 1) the demonstration of additional need by the eligible EMAs and TGAs, and 2) MAI funding. HRSA determines MAI awards based on the number of minorities living with HIV and AIDS in a jurisdiction. Further, if determined eligible for priority funding, HRSA will calculate the additional amount awarded, and that amount will be included in the final award.

Eligible jurisdictions may apply for an amount up to the funding ceiling listed in [Appendix B](#). If the RWHAP Part A award calculation results in an amount less than the budget submitted with your application, your budget will be proportionally reduced across all budget categories to reflect the actual award amount. If your award calculation results in an amount greater than the budget submitted with the application, you may be required to submit a revised budget prior to the Notice of Award (NOA) being issued. Establishing realistic ceiling amounts ensures that there will be an approved project budget in place at the beginning of the project period.

HRSA will send an NOA to the CEO or to the delegated administrative agency responsible for dispersing RWHAP Part A funds.

Please note that the U.S. Secretary of Health and Human Services (Secretary) may reduce the amounts of grants under the RWHAP Part A to an EMA/TGA for a FY if, with respect to such grants for the second preceding FY, the subdivision fails to prepare audits in accordance with the procedures of Section 7502 of Title 31, United States Code. See Section 2682(a) of the PHS Act.

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements at [45 CFR part 75](#).

Please see [Policy Clarification Notice 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D](#) along with the [FAQs](#) for information regarding the statutory 10 percent limitation on administrative costs.

III. Eligibility Information

1. Eligible Applicants

Eligibility for RWHAP Part A grants is based in part on the number of confirmed AIDS cases within a statutorily specified “metropolitan area.” The Secretary uses the Office of Management and Budget’s (OMB) census-based definitions of a Metropolitan Statistical Area (MSA) in determining the geographic boundaries of a RWHAP metropolitan area. HHS utilizes the OMB geographic boundaries that were in effect when a jurisdiction was initially funded under RWHAP Part A. For all newly eligible areas, the boundaries are based on current OMB MSA boundary definitions.

RWHAP Part A recipients that are classified as an EMA or as a TGA and continue to meet the status as an eligible area as defined in statute are eligible to apply for these funds. For an EMA, this is more than 2,000 cases of AIDS reported and confirmed during the most recent five (5) calendar years, and for a TGA, this is at least 1,000, but fewer than 2,000 cases of AIDS reported and confirmed during the most recent five (5) calendar years for which such data are available. In addition, for three (3) consecutive years, recipients must not have fallen below **both** the required incidence levels already specified, and required prevalence levels (cumulative total of living cases of AIDS reported to and confirmed by the Director of CDC, as of December 31 of the most recent calendar year for which such data are available). For an EMA, the required prevalence is 3,000 living cases of AIDS. For a TGA, the required prevalence is 1,500 or more living cases of AIDS. However, for a TGA with five (5) percent or less of the total amount from grants awarded to the area under Part A unobligated, as of the end of the most recent fiscal year, the required prevalence is at least 1,400 (and fewer than 1,500) living cases of AIDS.

This competition is open to eligible Part A jurisdictions to provide comprehensive primary health care and support services for people with HIV who are low income, uninsured, and underserved in their service areas as listed in [Appendix B](#).

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other Eligibility Information

HRSA will consider any application that exceeds the ceiling amount non-responsive and will not consider it for funding under this notice.

HRSA will consider any application that fails to satisfy the deadline requirements referenced in [Section IV.4](#) non-responsive and will not consider it for funding under this notice.

Maintenance of Effort (MOE)

The recipient must agree to maintain non-federal funding for award activities at a level that is not less than expenditures for such activities during a period prior to receiving the award, as required by Section 2605(a)(1)(B) of the PHS Act. Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation. RWHAP Part A recipients must document they have met the MOE requirement (complete and include as **Attachment 11**).

HRSA will consider any application that fails to satisfy the requirement to provide MOE information non-responsive and will not consider it for funding under this notice.

Other Eligibility Limitations

NOTE: Multiple applications from an organization are not allowable.

If for any reason (including submitting to the wrong funding opportunity number or making corrections/updates) an application is submitted more than once prior to the application due date, HRSA will only accept your **last** validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA **requires** you to apply electronically. HRSA encourages you to apply through [Grants.gov](#) using the SF-424 workspace application package associated with this NOFO following the directions provided at <http://www.grants.gov/applicants/apply-for-grants.html>.

The NOFO is also known as “Instructions” on Grants.gov. You must provide your email address when reviewing or preparing the workspace application package in order to receive notifications including modifications and/or republications of the NOFO on Grants.gov before its closing date. Responding to an earlier version of a modified notice may result in a less competitive or ineligible application. *Please note you are ultimately responsible for reviewing the [For Applicants](#) page for all information relevant to desired opportunities.*

2. Content and Form of Application Submission

Section 4 of HRSA's [SF-424 Application Guide](#) provides instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program-specific information below. You are responsible for reading and complying with the instructions included in HRSA's [SF-424 Application Guide](#) except where instructed in the NOFO to do otherwise. You must submit the application in the English language and in the terms of U.S. dollars (45 CFR § 75.111(a)).

See Section 8.5 of the *Application Guide* for the Application Completeness Checklist.

Application Page Limit

The total size of all uploaded files may not exceed the equivalent of **100 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this NOFO. Standard OMB-approved forms that are included in the workspace application package do not count in the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) do not count in the page limit. **We strongly urge you to take appropriate measures to ensure your application does not exceed the specified page limit.**

Applications must be complete, within the specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline to be considered under this notice.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

- 1) You, on behalf of the applicant organization certify, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
- 2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321.)
- 3) If you are unable to attest to the statements in this certification, an explanation shall be included in Attachment 13: Other Relevant Documents.

See Section 4.1 viii of HRSA's [SF-424 Application Guide](#) for additional information on all certifications.

Program-Specific Instructions

In addition to application requirements and instructions in Section 4 of HRSA's [SF-424 Application Guide](#) (including the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract), include the following:

i. Project Abstract

See Section 4.1.ix of HRSA's [SF-424 Application Guide](#). Your abstract should be limited to one page and include the following information in this order:

- A general overview of the HIV epidemic in the EMA/TGA, including epidemiologic, demographic, and geographic information. You may present this information as a table.
- A description of the comprehensive system of care in the entire EMA/TGA, including the available core medical and support services funded by RWHAP Part A and by other sources, where services are located, and how clients access those services, including services for disproportionately impacted subpopulation(s) supported by MAI funds.
- The overall viral suppression rate for the EMA/TGA. Use readily available and validated data and indicate whether it represents data for RWHAP-eligible clients only, or is population-based. Also, if available and appropriate, provide any meaningful subpopulation data that highlights disparities in this outcome measure.

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory, consistent with forms and attachments, and well organized so that reviewers can understand the proposed project.

Successful applications will contain the information below. Please use the following section headers for the narrative:

- ***INTRODUCTION -- Corresponds to Section V's Review Criterion #1***

This section must briefly describe how the EMA/TGA will utilize RWHAP Part A grant funds in support of a comprehensive continuum of high-quality care and treatment for people with HIV in the RWHAP Part A service area, as defined in [Appendix B](#).

- ***NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion #1***

The purpose of this section is to demonstrate the severity of the HIV epidemic in the EMA/TGA using quantifiable data on HIV epidemiology, the HIV care continuum, co-occurring conditions, complexity of providing care, service needs of emerging populations, past unmet need estimates, and unique service delivery challenges as required and cited in Section 2603(b)(2)(B) of the PHS Act.

A. Demonstrated Need

The Demonstrated Need section includes Epidemiological Overview, HIV Care Continuum, Co-occurring Conditions, and Complexities of Providing Care subsections.

Since 2003, unmet need has been defined as the number of individuals with HIV in a jurisdiction who are **aware** of their HIV status and are *not in care*. HAB continues to consider the best approach to developing a new framework

and methodology for accurately estimating unmet need based on current HIV treatment guidelines. No new unmet need estimates are required. For this NOFO, unmet need elements (as specified in [Section 2603\(b\)\(2\)\(B\) of PHS Act](#)) are captured in the Epidemiologic Overview and the Complexities of Providing Care sub-sections below. You may use your past unmet need estimate to help inform planning, resource allocation, and work plan development for this application.

HAB will target supplemental funds to eligible areas where epidemiologic data demonstrate that HIV infection prevalence rates are increasing, where there is documented demonstrated need and service gaps, and where there is a demonstrated disproportionate impact on vulnerable populations.

1) Epidemiologic Overview

An epidemiologic overview provides a description of the demonstrated need for HIV care in the population of an area in terms of socio-demographic, geographic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, people with HIV, and persons at higher risk for infection. Understanding the populations affected by HIV provides the basis for setting priorities, identifying appropriate interventions and services, allocating funding to HIV care services, implementing appropriate service standards, and evaluating programs and policies.

The epidemiologic overview should focus on the most recent year for which data are available; when presenting trends, HRSA recommends a minimum of three (3) years of data. Please cite data sources. Submit the HIV/AIDS Demographic Table as **Attachment 3**.

- a)** Provide a summary of the HIV epidemic in your EMA/TGA geographic area.
- b)** Describe the socio-demographic characteristics of: (1) persons newly diagnosed, (2) people with HIV, and (3) persons at higher risk for HIV infection in the service area. Include the following, as available in the geographical region of the jurisdiction:
 - i.** Demographic data (e.g., race, age, sex, transmission category, current gender identity) and
 - ii.** Socioeconomic data (e.g., percentage of federal poverty level (FPL), income, education, health insurance status, language barriers).
- c)** Describe the relative rates of increase in HIV diagnosed cases within new and emerging populations.
 - i.** Include information on how you identified emerging populations, any unique challenges, and estimated costs to the RWHAP Part A program, if applicable, and
 - ii.** Describe the increasing need for HIV-related services based on the relative increase of HIV cases.

2) HIV Care Continuum

Provide a graphic depiction of the HIV care continuum for the jurisdiction using the most current calendar year data. The definitions of the numerator and the denominator must be clearly stated for each step of the care continuum. Use readily available and validated data and indicate whether it represents data for RWHAP-eligible clients only or is population-based. In addition, describe the viral suppression rates for three of the most disproportionately impacted minority populations that highlight disparities. Pay special attention to populations where specific sub-populations may experience the greatest health disparities, for example, young black men who have sex with men (YBMSM) ages 13-24.

The steps of the *diagnosed-based* HIV care continuum using the HHS indicators are found at <https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum>.

3) Co-occurring Conditions

Using the list below, provide quantitative evidence (i.e., incidence, prevalence, and estimates) describing the conditions co-occurring with HIV in the EMA/TGA in a table format (submit as **Attachment 4**) and document the data sources used. The table must include:

- a) Hepatitis C virus
- b) Sexually transmitted infection rates, including syphilis, gonorrhea, and chlamydia
- c) Mental illness
- d) Substance use disorder
- e) Homeless/unstably housed
- f) Former incarceration

Note: you may include additional conditions unique to your jurisdiction, as applicable.

4) Complexities of Providing Care

- a) If the EMA/TGA experienced a reduction in RWHAP Part A formula funding last year (FY 2019), provide a narrative that addresses both the impact and response to the funding reduction, as follows:
 - i. Impact: The specific services that were eliminated or reduced, and by how much, and
 - ii. Response: Any cost containment measures implemented (e.g., waiting lists, client cost sharing, or other measures), PC/PB response to the reduction in formula funding, and any transitional planning for clients receiving services that were either eliminated or reduced.
- b) Provide, in a table format, current estimates on poverty and health care coverage status of people with HIV in your jurisdiction. Include the following information, as available:
 - i. The number and percentage of people with HIV who are enrolled in Medicaid, Medicare, and other health care coverage;

- ii. The number and percentage of people with HIV who are uninsured; and
 - iii. The number and percentage of people with HIV living at or below 138 percent and 400 percent of the 2019 federal poverty level (FPL). Also, include the percentage of FPL used to determine RWHAP eligibility in the jurisdiction.
- c) Discuss any relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, language barriers, or other major social determinants of health. Also, describe any service gaps, especially for people with HIV who are not in care, and how these service gaps will be addressed with FY 2020 RWHAP Part A funding.

B. Early Identification of Individuals with HIV/AIDS (EIIHA)

The purpose of this section is to describe the data and information associated with ensuring that individuals who are unaware of their HIV status are identified, informed of their status, referred to supportive services, and linked to medical care if HIV test is positive. The goals of the EIIHA initiative are to present a strategy for: (1) identifying individuals with HIV who do not know their HIV status; (2) making such individuals aware of their status and enabling them to use the health and support services; and (3) reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities. See Section 2603(b)(2)(A) of the PHS Act.

- 1) Describe the planned EMA/TGA EIIHA activities for the 2020 project period. Include the following information:
 - a) The primary activities that will be undertaken, including system level interventions that will positively impact outcomes along the HIV care continuum (e.g., routine testing in clinical settings, expanding partner services);
 - b) Major collaborations with other programs and agencies, including HIV prevention and surveillance programs; and
 - c) The anticipated outcomes of the jurisdiction's overall EIIHA strategy.
- 2) Select three (3) distinct target populations for the EIIHA Plan in the FY 2020 project period. For each selected target population describe:
 - a) Why you chose the target population and how the epidemiological data, social determinants of health, or other data supports that decision;
 - b) Specific challenges or opportunities for working with the target population; and
 - c) The specific strategies that will be utilized with the target population.
- 3) Describe any planned efforts to remove legal barriers, including state laws and regulations, to routine HIV testing in medical settings, or program/policy efforts to expand implementation of routine HIV testing.

C. AIDS Pharmaceutical Assistance (i.e., Local Pharmaceutical Assistance Program) – Not Scored

Only complete this section if requesting funds for a Local Pharmaceutical Assistance Program (LPAP) that will be **newly funded** in the 2020 project period. The purpose of this section is to describe the need for an LPAP, including a description of the systems and activities required to effectively operate an LPAP. The RWHAP Part A needs assessment must determine that the state/territory's AIDS Drug Assistance Program (ADAP) does not adequately address the medication assistance needs of clients in the jurisdiction (e.g., existence of an ADAP waiting list, restrictive ADAP financial eligibility criteria, or a limited ADAP formulary). The needs assessment must also demonstrate that other resources are inadequate to meet the medication needs of clients residing in the jurisdiction.

The [National Monitoring Standards and the LPAP letter](#) of clarification sent to RWHAP Parts A and B recipients on August 29, 2013, outline the systemic requirements necessary to comply with the LPAP service category definition. Implementation of an LPAP requires the development of a drug distribution system that includes, but is not limited to a client enrollment and eligibility determination screening process for ADAP and LPAP eligibility, with rescreening at a minimum every six months; an LPAP advisory board; uniform benefits for all enrolled clients; compliance with RWHAP requirement of payor of last resort; a drug formulary approved by the local advisory committee/board; and a recordkeeping system for distributed medications. An LPAP may not be used to provide short-term or emergency medication assistance. Please refer to the RWHAP Part A [National Monitoring Standards](#) and [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds](#) for a complete list of LPAP requirements.

If you are planning to fund LPAP **for the first time** in the 2020 project period, describe the following:

- 1) The need for an LPAP in detail: include how the ADAP, other RWHAP funded service categories, and other resources (e.g., pharmaceutical assistance programs, patient assistance programs, local/state funded medication assistance programs) are failing to meet the jurisdiction's medication needs.
- 2) How the LPAP will be coordinated with the ADAP.
- 3) The client enrollment and eligibility process, including how you ensure the payor of last resort requirement.
- 4) The LPAP advisory board composition. Describe the process and timeframe for development of the LPAP advisory board.
- 5) How the recipient ensures that the LPAP follows the most recent [HHS HIV/AIDS Clinical Guidelines](#).
- 6) The mechanism to ensure "best price" for medications (e.g., 340B Drug Pricing Program and/or Prime Vendor Program).

- *METHODOLOGY -- Corresponds to Section V's Review Criteria #2 & #4*

A. Impact of the Changing Health Care Landscape

The availability of health care coverage options have an impact on RWHAP service needs and how services are provided in jurisdictions.

- 1) Provide an overall description of health care coverage options available to all people with HIV in the jurisdiction.
 - a) Explain how coverage options in the jurisdiction negatively or positively influence access to direct health care services and health outcomes.
- 2) Describe how changes in the health care landscape affect the following:
 - a) Service provision and the complexity of providing care to people with HIV in the EMA/TGA.
 - b) Changes in RWHAP Part A allocations, including activities related to health insurance premium and cost sharing assistance.

B. Planning Responsibilities

Section 2602(b)(4)(C) of the PHS Act requires PCs/PBs to determine the priority for RWHAP allowable services and service allocations of RWHAP Part A funds every year. To fulfill this responsibility, EMA/TGA PCs/PBs set service priorities and allocate RWHAP Part A funds based on the size, demographics, and needs of people with or affected by HIV, with particular focus on individuals who know their HIV status, but are not in care. The RWHAP Part A PCs/PBs also are responsible for evaluating the efficiency of the recipient in distributing funds to service providers.

PCs/PBs analyze information to develop an in-depth understanding of the current HIV epidemic and its impact on the service area. PCs/PBs review needs assessment data, HIV epidemiologic data, and co-occurring conditions data. The review includes service utilization data related to complexity of providing care, including service availability and unit cost per service, as well as service needs of emerging populations. The purpose of these data reviews is to guide decisions about HIV-related services and resources in the EMA/TGA. Furthermore, planning and implementation of the RWHAP Part A is driven by overall comprehensive planning and the recently developed Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need, Calendar Year (CY) 2017-2021 as a roadmap for relevant goals, objectives, and strategies for delivering RWHAP Part A services along the HIV care continuum. Locally developed Ending the HIV Epidemic plans, where available, might also serve as a valuable roadmap.

Please see the December 4, 2013, [letter](#) to RWHAP Part A recipients regarding transitioning TGA and PC expectations and responsibilities moving forward.

1) Planning and Resource Allocation

The purpose of this section is to document the existence of a functioning planning process in the EMA/TGA that is consistent with RWHAP and HRSA

program requirements. Such a planning process is imperative for effective local and state decision making to develop systems of prevention and care that are responsive to the needs of persons at risk for HIV infection and people with HIV. HRSA and CDC support activities that facilitate collaboration and/or develop a joint planning body to address prevention and care. Community engagement is an essential component for planning comprehensive, effective HIV prevention and care programs in the United States.

The composition of the PC/PB must reflect the demographics of the HIV epidemic in the EMA/TGA and be representative of various required categories of membership as cited in Sec. 2602(b)(1)-(2) of the PHS Act. PC/PB members must be trained regarding their legislatively mandated responsibilities and other competencies necessary for full participation in collaborative decision-making. PCs/PBs are encouraged to educate members about service issues related to the prevention of intimate partner violence, opioid and other drug use, and trauma informed care as part of their ongoing training. PCs/PBs should also consider recruiting members who are knowledgeable about these issues.

a) Description of the Community Input Process

Describe the overall community input process and how it informs the PC/PB priority setting and resource allocation process for the jurisdiction and include a summary of how the process was conducted. Also, include a discussion of how the input process has helped inform the RWHAP Part A service priorities and resource allocations, as well as a description of how the input process is interwoven into your RWHAP Part A activities.

Specifically, address:

- i. How people with HIV were involved in the planning and allocation processes and how their priorities were considered in the process;
- ii. How the input of the community was considered and whether the community input process adequately addressed any funding increases or decreases in the RWHAP Part A award;
- iii. How MAI funding was considered during the planning process to enhance services to minority populations;
- iv. How data were used in the priority setting and allocation processes to increase access to core medical services, ensure access to services for women, infants, children, and youth (WICY) and to reduce disparities in access to HIV care in the EMA/TGA; and
- v. Any significant changes in the prioritization and allocation process from 2019 to 2020 project periods and the rationale for making those changes.

2) Administrative Assessment

The RWHAP authorizing legislation mandates that PCs/PBs assess the efficiency of the administrative mechanism to rapidly allocate funds to the

areas of greatest need within the EMA/TGA. See section 2602(b)(4)(E) of the PHS Act. Include in your application a narrative that describes the results of the PC/PB assessment of the administrative mechanism in terms of the following:

- a) Assessment of grant recipient activities to ensure timely allocation/contracting of funds and payments to contractors; and
- b) The RWHAP Part A jurisdiction's response to any deficiencies identified by the PC/PB and the status of your corrective actions in response to administrative assessment findings.

3) Letter of Assurance from Planning Council Chair(s) or Letter of Concurrence from Planning Body

Provide a letter of assurance signed by the PC chair(s) or a letter of concurrence signed by PB leadership as **Attachment 6**. The letter must address the following:

- a) How all 2019 project period Conditions of Award relative to the PC or PB have been addressed;
- b) How the 2019 project period formula, supplemental, and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the PC or PB;
- c) How the PC or PB determined the 2020 project period priorities, and how the PC or PB used the approved process for establishing those priorities; and
- d) That ongoing, annual membership training occurred, including the date(s).

4) Resource Inventory

RWHAP Part A EMA/TGA planning efforts should expand the availability of services, reduce duplication of services, coordinate with all other public funding for HIV, and bring newly diagnosed people with HIV into care or engage people with HIV who know their status, but are not presently in HIV care. RWHAP Part A planning efforts should also consider service needs not currently being met (defined as service gaps).

a) Coordination of Services and Funding Streams

- i. Provide, in a table format, a jurisdictional HIV resources inventory that includes: (1) public funding sources for HIV prevention, care, and treatment services in the jurisdiction (RWHAP Parts B-D and F, federal/state and local); (2) the dollar amount and the percentage of the total available funds in the 2019 project period for each funding source; and 3) how the resources are being used (i.e., services delivered). Submit as **Attachment 5**.
- ii. Provide a narrative description identifying any needed resources and/or services in the jurisdiction that are not being provided and the steps taken to secure them.

- *WORK PLAN -- Corresponds to Section V's Review Criteria #2 & #4*

The purpose of this section is to provide tables and a narrative summary describing the EMA/TGA service provision proposed for the 2020 project period. It should describe how RWHAP Part A funded services are used to have a positive impact on the HIV care continuum. The EMA/TGA system of HIV care should be consistent with HRSA's goals of increasing access to services and decreasing HIV health disparities among affected subpopulations and historically underserved communities.

Under RWHAP Part A, MAI formula funding provides core medical and related support services to improve access and reduce disparities in health outcomes. The services have to be consistent with the epidemiologic data.

Similar to other components of the RWHAP, the goal of the MAI is improved health outcomes among people with HIV who are racial and ethnic minorities demonstrated by viral suppression. MAI funds must be used to deliver services designed to address the unique barriers and challenges faced by hard-to-reach, disproportionately impacted individuals within the EMA/TGA.

A. HIV Care Continuum Table and Narrative

1) FY 2020 HIV Care Continuum Table

Based on your HIV care continuum, develop the HIV Care Continuum Table that is either prevalence-based or diagnosed-based. The prevalence-based HIV care continuum describes the number of people who are at each step of the continuum as a percentage of the total number of people with HIV (known as HIV prevalence). Prevalence includes people with diagnosed and undiagnosed HIV. The diagnosed-based HIV care continuum shows each step as a percentage of the number of people living with diagnosed HIV.

The table is comprised of the stages of the HIV care continuum, baseline indicators for each stage, the desired target outcome to be achieved during the project period, and the RWHAP-funded service categories to achieve the desired outcome. The target outcome must be developed based on one of the seven common indicators for HHS funded HIV programs and services or one of the [HAB Core Performance Measures](#) that corresponds to each stage of the HIV care continuum. You must express each baseline and target indicator as a numerator and denominator, as well as a percentage. List the service categories funded by the RWHAP Part A that will aid in achieving the desired target outcomes in the last column of the HIV Care Continuum Table. Submit as **Attachment 7**.

2) HIV Care Continuum Narrative

Please provide a narrative on your HIV care continuum addressing the following:

- a) How you currently utilize the HIV care continuum in planning and prioritizing RWHAP Part A funding, in addition to monitoring available

resources in response to the needs of people with HIV in order to maximize the impact on health outcomes in the jurisdiction.

- b) Any changes in your HIV care continuum from CY 2016 to CY 2018, or the most current three (3) years for which data are available, the impact those changes had on your program, and how you responded or addressed those identified changes.

B. Funding for Core and Support Services

RWHAP Part A funds are subject to Section 2604(c) of the PHS Act, which requires that RWHAP Part A recipients expend 75 percent of RWHAP Part A funds **remaining after reserving funds for administration and CQM** on core medical services for individuals with HIV who are identified and eligible under the RWHAP.

1) Service Category Plan

Please provide a Service Category Plan in table format as described below that utilizes core medical and support service categories as prioritized and funded by the PC or through local community planning processes. The plan should consist of both RWHAP Part A and MAI funds. **Please indicate if you have already submitted, submitted with this application, or intend to submit a core medical services waiver for the 2020 project period. Allocations in the Service Category Plan should match the submitted or intended waiver. If you are not submitting a core medical services waiver for the 2020 project period, the allocations must align with the 75 percent core medical services requirement.** The Service Category Plan must also correlate with the budget and budget narrative section of the application. Please note that pending waiver requests that are not approved will necessitate the submission of a revised budget and Service Category Plan that adheres to the 75/25 legislative requirement.

a) Service Category Plan Table

The Service Category Plan Table illustrates how you fund RWHAP Part A and MAI core medical and support services in the EMA/TGA. It is comprised of service categories, priority number, funding amount, unduplicated clients served, service unit definition, number of service units, and target populations (MAI only) for the 2019 and 2020 project periods.

For every service category funded by RWHAP Part A in the jurisdiction, provide in table format the following (submit as **Attachment 8**):

i. RWHAP Part A

- (a) 2019 project period service categories with priority number, allocated funding amount, and number of projected unduplicated clients to be served per the Service Category Plan Table submitted with the 2019 grant application, service unit definitions, and number of service units (note: alternatively, you may submit actual allocations based on the 2019 award). Include total dollar amounts and percentages of expenditures for core and support services.

- (b) 2020 project period service categories with priority number, anticipated funding amount, anticipated number of unduplicated clients to be served, service unit definitions, and anticipated number of service units. Include total dollar amounts and percentages of expenditures for core and support services.

ii. MAI

- (a) 2019 project period service categories with priority number, allocated funding amount, and number of projected unduplicated clients to be served per the Service Category Plan Table submitted with the 2019 grant application, service unit definitions, and service units. Include total dollar amounts and percentages of expenditures for core and support services and subpopulations.
- (b) 2020 project period service categories with priority number, anticipated funding amount, anticipated number of unduplicated clients to be served, service unit definitions, and anticipated number of service units. Include total dollar amounts and percentages of expenditures for core and support services and subpopulations.

b) MAI Service Category Plan Narrative

Describe how the services included in the MAI Service Category Plan Table are specific and population-tailored, with special emphasis on the three subpopulations identified in the Demonstrated Need/HIV Care Continuum section. Explain how you target activities to improve HIV-related health outcomes, reduce existing racial and ethnic health disparities, and increase the bars/percentages on the HIV care continuum. Also, describe how these activities address the unique needs of the targeted MAI populations.

c) Core Medical Services Waiver (if applicable – not scored, counts toward page limit)

You must provide a separate allocation table that is reflective of the results of the priority setting and resource allocation process, **only if you submit a core medical services waiver with this application**. The allocation table must be consistent with the waiver request. Include the allocation table and the core medical services waiver request as **Attachment 9**.

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion(a) #2*

In lieu of a narrative for this section, HAB suggests providing information on implementing both the RWHAP Part A overall and the HIV care continuum in table format with the following headers: Challenges/Barriers, Proposed Resolutions, Intended Outcomes, and Current Status.

Please consider the following when completing your table:

- Challenges and barriers identified in the larger context of implementing the RWHAP Part A (e.g., changes in the health care landscape, community engagement, barriers for populations experiencing inequities in health outcomes);
 - Proposed resolutions to challenges and barriers that have been encountered in integrating the HIV care continuum into planning and implementing the RWHAP Part A (e.g., test to care and retention strategies);
 - Intended outcomes once the proposed resolution is implemented; and
 - Status of implementing the proposed resolution.
- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion #3*

A. Clinical Quality Management (CQM) Program

Section 2604(h)(5)(A) of the PHS Act requires RWHAP Part A recipients to establish a clinical quality management program to:

- Assess the extent to which HIV health services provided to clients under the grant are consistent with the most recent PHS Guidelines (otherwise known as the HHS Guidelines) for the treatment of HIV disease and related opportunistic infections and
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

Please describe:

- 1) How performance measure data are analyzed to evaluate disparities in care, and actions taken in the last grant year to eliminate disparities; and
- 2) How CQM data have been used to improve patient care, health outcomes, or patient satisfaction and/or change service delivery in the jurisdiction, including strategic long-range service delivery planning.

You can find more information about the HRSA RWHAP expectations for CQM programs in:

- [PCN 15-02 Clinical Quality Management](#) and [Frequently Asked Questions](#)
- [HIV/AIDS Bureau Performance Measures](#)
- [HHS HIV/AIDS Clinical Guidelines](#)
- [HIV/AIDS Bureau RWHAP Part A Monitoring Standards](#) (RWHAP Part A specific, Universal Monitoring Standards, and Frequently Asked Questions)
- [Part A Manual](#)

- ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion #5

A. Grant Administration

The purpose of this section is to demonstrate the extent to which the CEO or designee in the EMA/TGA has met the legislative requirements to disburse funds quickly, closely monitor their use, and ensure the RWHAP is the payor of last resort. RWHAP stresses the importance of timely obligation of RWHAP funds. Timely obligation of RWHAP funds ensures that services can be provided as rapidly as possible and decreases the possibility that unobligated funds will remain at the end of the program year. Please refer to Section 2603(c) of the PHS Act regarding the RWHAP Part A formula and supplemental unobligated balance (UOB) requirement, as well as [PCN 12-02 Part A and Part B Unobligated Balances and Carryover](#). The UOB requirement does not apply to MAI funds. **If the recipient reports unobligated formula funds of five (5) percent or less, HRSA does not impose penalties, although a future year award may be subject to an offset.**

Note: UOB Penalties

If the UOB of a formula award exceeds five (5) percent, two penalties are imposed:

- The future year award is reduced by the amount of the UOB, less the amount of approved carryover; and
- The grant recipient is not eligible for a future year supplemental award.

Note that, like all other recipients with a UOB, the amount of the UOB not covered by a waiver for carryover is subject to an offset.

Supplemental Funds

Under the RWHAP legislation, unobligated supplemental funds cannot be carried over, but are subject to an offset. If a grant recipient has a UOB of supplemental funds, the recipient remains eligible for a future year RWHAP Part A award, including supplemental funds.

1) Program Organization

- a) Describe how RWHAP Part A funds are administered within the EMA/TGA with reference to the staff positions, including program and fiscal staff, described in the budget narrative and the program organizational chart included as **Attachment 10**. The narrative should describe the local agency responsible for the grant and identify the entity responsible for administering the RWHAP Part A, including the department, unit, staffing levels (full-time equivalent staff [FTE], including any vacancies), fiscal agents, PC/PB staff, and in-kind support staff. Please note that HRSA expects that the staff person responsible for management of the RWHAP Part A grant (i.e., the Project Director/Coordinator) should have at least 0.5 FTE allocated to the Part A program (this can be a combination of budgeted grant funds and/or other sources) to ensure sufficient oversight

and monitoring of all grant activities including subrecipients. Describe the approaches to fill vacant staff positions that are essential for delivery, oversight, and monitoring of the RWHAP Part A and MAI services/activities. Submit a staffing plan, job descriptions, and biographical sketches for key personnel as **Attachment 1**.

- b) If you administer the RWHAP Part A funds by a contractor or fiscal agent, describe the staffing, fiscal agent scope of work or services to be provided, and how you will evaluate the performance of the work or services being provided.

2) Grant Recipient Accountability

HRSA holds recipients accountable for the expenditure of funds awarded under RWHAP Part A and requires recipients to monitor subrecipient fiscal and programmatic compliance. Recipients also are required to have on file a copy of each subrecipient's procurement document (contracts), and fiscal, program, and site visit reports. Also see the requirements outlined in the [Uniform Administrative Requirements, Cost Principles, and Audit Requirement for HHS Awards \(45 CFR part 75\)](#) - Subrecipient Monitoring and Management (45 CFR § 75.351 and 352) and [National Monitoring Standards](#).

- a) **Monitoring** - Provide a narrative that describes the following:

- i. The three most common program and fiscal subrecipients' monitoring findings for the 2019 project period to date or for the 2018 project period, and the process and timeline for corrective actions;
- ii. The process for ensuring subrecipient compliance with the single audit requirement in Subpart F of the [Uniform Administrative Requirements, Cost Principles, and Audit Requirement for HHS Awards \(45 CFR part 75\)](#); and
- iii. If there were findings in any subrecipient single audit or program-specific audit reports, describe what you have done to ensure that subrecipients have taken appropriate corrective action. Corrective actions may include, but are not limited to, HRSA sponsored technical assistance and training requests from the grant recipient of record.

b) Third Party Reimbursement

The RWHAP is the payor of last resort and you must vigorously pursue alternate sources of payments. You must certify eligibility every twelve (12) months/annually and recertify at least every six (6) months (see [PCN 13-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements](#)). Recipients and subrecipients are required to use effective strategies to coordinate between RWHAP Part A and third party payers who are ultimately responsible for covering the cost of services provided to eligible or covered persons. Subrecipients providing Medicaid eligible services must be Medicaid certified.

Provide a narrative that describes the following:

- i. The process used to ensure that subrecipients are pursuing third party reimbursement and the contract language or another mechanism to ensure that this takes place;
 - ii. The process to conduct screening and eligibility to ensure the RWHAP is the payor of last resort; and
 - iii. How you monitor and track the source and use of any program income earned at both the recipient and subrecipient levels.
- c) Fiscal Oversight** - Provide a narrative that describes the following:
- i. The process used by program and fiscal staff to coordinate activities, ensuring adequate reporting, reconciliation, and tracking of program expenditures (e.g., meeting schedule, information sharing regarding subrecipient expenditures, UOB, and program income);
 - ii. The process used to separately track formula, supplemental, MAI, and carryover funds, including information on the data systems utilized; and
 - iii. The process for reimbursing subrecipients, from the time a voucher/invoice is received to payment.

B. Maintenance of Effort (MOE)

The RWHAP legislation requires RWHAP Part A recipients to maintain, as a condition of award, EMA/TGA political subdivision expenditures for HIV-related core medical services and support services at a level equal to the FY preceding the FY for which the recipient is applying to receive a RWHAP Part A grant. Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the PHS Act and [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds](#). RWHAP Part A recipients must document that they will meet the MOE requirement.

You must submit the following information as **Attachment 11**:

- 1) A table that identifies the baseline aggregate for actual non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services during your most recently completed FY prior to the application deadline, and an estimate for your next FY, and
- 2) A description of the process and elements used to determine the amount of expenditures in the MOE calculations.

NARRATIVE GUIDANCE	
<p>To ensure that you fully address the review criteria, this table provides a crosswalk between the narrative language and where each section falls within the review criteria. Any attachments referenced in a narrative section may be considered during the objective review.</p>	
<u>Narrative Section</u>	<u>Review Criteria</u>
Introduction	(1) Need
Needs Assessment <ul style="list-style-type: none"> • Demonstrated Need • Early Intervention of Individuals with HIV/AIDS 	(1) Need
Methodology <ul style="list-style-type: none"> • Impact of Funding • Planning Responsibilities 	(2) Response and (4) Impact
Work Plan <ul style="list-style-type: none"> • FY 2020 HIV Care Continuum Table and Narrative • Funding for Core and Support Services 	(2) Response and (4) Impact
Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity <ul style="list-style-type: none"> • Clinical Quality Management 	(3) Evaluative Measures and (5) Resources/Capabilities
Organizational Information <ul style="list-style-type: none"> • Grant Administration 	(5) Resources/Capabilities
Budget and Budget Narrative	(6) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.

iii. Budget

See Section 4.1.iv of HRSA’s [SF-424 Application Guide](#). Please note: the directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Follow the instructions included in the Application Guide and the additional budget instructions provided below. A budget that follows the Application Guide will ensure that, if HRSA selects the application for funding, you will have a well-organized plan and, by carefully following the approved plan, can avoid audit issues during the

implementation phase.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the recipient to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement, as applicable.

In addition, the RWHAP Part A HIV Emergency Relief Grant Program requires the following:

The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245), Division B, § 202 states, “None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.” See Section 4.1.iv Budget – Salary Limitation of HRSA’s [SF-424 Application Guide](#) for additional information. Note that these or other salary limitations may apply in the following FY, as required by law.

Completion of Sections A, B, and F of the SF-424A Budget Information – Non-Construction Programs form. In Section B, the **three** required columns are:

- (1) Administrative (Part A and MAI)
- (2) CQM (Part A and MAI)
- (3) HIV Services (Part A and MAI)

Caps on expenses: RWHAP Part A grant administration costs (including PC or PB support) may **not** exceed ten (10) percent of the grant award. The aggregate total of administrative expenditures for subrecipients, including all indirect costs, may **not** exceed ten (10) percent of the aggregate amount of all subawards. Please see [PCN 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D](#) along with the [Frequently Asked Questions](#) for information regarding the statutory ten (10) percent limitation on administrative costs.

Recipients are allowed to allocate up to five (5) percent of the total grant award or \$3,000,000 (whichever is less) for CQM activities.

iv. Budget Narrative

See Section 4.1.v. of HRSA’s [SF-424 Application Guide](#). **Note:** Upload the Budget Narrative/Justification required for this application under Budget Narrative in grants.gov.

In addition, the RWHAP Part A HIV Emergency Relief Grant Program requires the following:

In order to evaluate your adherence to RWHAP Part A legislative budget requirements, you must submit a program-specific budget narrative/justification. To reduce the burden of recipient reporting that previously required multiple post-award

budget revisions, you must submit a budget that does not exceed the ceiling amount listed for the service area in [Appendix B](#). The MAI component of your budget must not exceed a five (5) percent increase from your FY 2019 MAI award. In addition, the total amount requested on the SF-424A and the total amount listed on the budget narrative/justification must match. The budget allocations must relate to the activities proposed in the project narrative, including the work plan.

You should submit the budget narrative/justification in table format. When completing the budget narrative/justification submit an overall summary table and a separate table for each of the cost categories. It should list separately by funding type (Part A and MAI), the program cost categories: Administrative, CQM, and HIV Services across the top and object class categories (i.e., Personnel, Fringe Benefits, Travel, Equipment, Supplies, Contractual, Other, and Indirect Charges) in a column down the left-hand side. If the EMA/TGA is administered by a contractor or fiscal agent, clearly detail the costs for administering the grant in the budget narrative/justification. You must also show a separate PC/PB support budget narrative/justification.

Each of the specific budget narrative/justification tables should describe and adequately justify how every item with a cost associated under each object class category makes a contributing impact and supports the overall RWHAP Part A HIV service delivery system.

Additional cost category information to use when completing the RWHAP Part A grant budget narrative/justification tables is as follows:

- A. Administrative Costs** are costs associated with the administration of the RWHAP Part A grant. By law, no more than **10 percent** of the RWHAP Part A budget can be spent on administrative costs. You should allocate staff activities that are administrative in nature to administrative costs. Please note that it is expected that the staff person responsible for management of the RWHAP Part A grant (i.e., the Project Director/Coordinator) should have at least 0.5 FTE allocated to the Part A program (this can be a combination of budgeted grant funds and/or other sources) to ensure sufficient oversight and monitoring of all grant activities including subrecipients. All costs associated with grant administration and PC/PB support are all subject to the 10 percent limit on costs associated with administering the award. Recipients must determine the amounts necessary to cover all administrative and program support activities. The RWHAP Part A recipient must also ensure adequate funding for PC/PB mandated functions within the administrative line item. PC/PB support should cover *reasonable and necessary costs* associated with carrying out legislatively mandated functions.

If a RWHAP Part A grant recipient has contracted with an entity to provide regional RWHAP management and fiscal oversight (i.e., the entity is acting on behalf of the recipient), the cost of that contract, exclusive of subawards to providers, would count toward the recipient's 10 percent administrative cap. Providers that have contracted to provide health care services for the lead agency are considered subrecipients of the recipient and are subject to the aggregate 10 percent administrative cap for subrecipients. Likewise,

recipients who provide services directly should apply administrative costs related to the provision of such service to the aggregate 10 percent administrative cost cap.

The aggregate total of administrative expenditures for subrecipients, including all indirect costs, may **not** exceed 10 percent of the aggregate amount of all subawards. Subrecipient administrative activities include:

- Usual and recognized overhead activities, **including established indirect rates** for agencies;
- Management oversight of specific programs funded under the RWHAP; and
- Other types of program support such as quality assurance, quality control, and related activities (exclusive of RWHAP CQM).

As a reminder: All indirect costs charged by the subrecipient are considered an administrative cost subject to the 10 percent aggregate limit. If applicable, submit your federally negotiated indirect cost rate agreement as **Attachment 12**.

For further guidance on the treatment of costs under the 10 percent administrative limit, refer to [PCN 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D](#) and [Frequently Asked Questions](#).

B. CQM Costs are costs required to maintain a CQM program to assess the extent to which services are consistent with the current HHS guidelines for the treatment of HIV and to develop strategies to improve access to and quality of services. Examples of CQM costs include:

- Implementation of CQM program;
- Clinical quality management activities;
- Data collection for CQM purposes (collect, aggregate, analyze, and report on measurement data on a quarterly basis at a minimum);
- Recipient CQM staff training/TA (including travel and registration) - this includes HRSA sponsored or HRSA approved training; and
- Training of subrecipients on CQM.

Please note that quality assurance activities are **not** considered CQM costs.

For further guidance on CQM, refer to [PCN 15-02 Clinical Quality Management](#).

C. HIV Services costs are associated with the provision of core medical and support services to RWHAP eligible clients. Core medical and support services are important to assist in the diagnosis of HIV infection, linkage to care for people with HIV, retention in care, and the provision of HIV treatment. To be an allowable cost under the RWHAP, all services must

relate to HIV diagnosis, care, and support, and must adhere to established HIV clinical practice standards consistent with HHS treatment guidelines. In addition, all providers must be appropriately licensed and in compliance with state and local regulations. Recipients are required to work toward the development and adoption of service standards for all RWHAP-funded services.

For further guidance on core medical and support services, refer to [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds](#).

1) Core Medical Services Costs

At least 75 percent of the award – minus amounts for administrative costs, including planning/evaluation – must be used to provide core medical services. You may submit a budget consistent with a core medical services waiver request if applicable.

2) Support Services Costs

Support services are those services needed by people with HIV to achieve optimal HIV medical outcomes.

Object Class Category Details

The budget narrative/justification should explain how the amounts requested support the overall service delivery system and include justification for any of the following applicable object class categories: Personnel, Fringe Benefits, Travel, Equipment, Supplies, Contractual, Construction, Other, and Indirect Charges. For employees who are less than one (1) FTE on the award, please identify all funding sources outside of RWHAP Part A funding for personnel and fringe benefits costs.

Personnel: All costs must include the name, position title, the annual salary, program FTE, and program salary subtotal for each staff position. Provide a written justification that clearly explains how the roles have an impact on the RWHAP Part A HIV service delivery system and/or program outcomes/goals. Please list personnel separately by position title and name or note if a position is vacant. Descriptions must be specific to the cost category. A general description for personnel repeated across the categories is not acceptable. HRSA will consider a general personnel description across categories as non-responsive. For personnel whose duties occur across categories, the FTE allocation must not exceed 1.0.

Contractual: Provide a clear explanation of the purpose of each contract, how you estimated the costs, and the specific contract deliverables. List the amounts allocated for personnel or services contracted to outside providers for all HIV services (subrecipients). Show the amount allocated to any activities that are not conducted “in-house” on the Contractual line. Subrecipients providing services under this award must adhere to the same requirements as the recipient. All RWHAP Part A legislative requirements, the requirements outlined in [45 CFR](#)

[part 75](#), and program expectations that apply to recipients also apply to subrecipients. Your organization is accountable for your subrecipients' performance of the project, program, activity, and appropriate expenditure of funds under the award.

NOTE: HRSA recommends that the budgets be converted or scanned into PDF format for submission. Do not submit Excel spreadsheets.

v. **Attachments**

Provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit.

You must clearly label **each attachment**.

Attachment 1: Staffing Plan, Job Descriptions, and Biographical Sketches for Key Personnel (required; see Section 4.1.vi. of the HRSA's [SF-424 Application Guide](#)).

Attachment 2: FY 2020 Agreements and Compliance Assurances, Certifications (required).

Submit the RWHAP Part A Grant Program FY 2020 Agreements and Compliance Assurances signed by the CEO or the CEO's designee (see [Appendix A](#)).

Attachment 3: HIV/AIDS Demographic Table (required),

Attachment 4: Co-occurring Conditions Table (required).

Attachment 5: Coordination of Services and Funding Streams Table (required).

Provide in table format a jurisdictional HIV resources inventory, that includes: (1) public and private funding sources for HIV prevention, care, and treatment services in the jurisdiction; (2) the dollar amount and the percentage of the total available funds in the 2019 project period for each funding source; and (3) how the resources are being used (e.g., services delivered).

Attachment 6: Letter of Assurance from Planning Council Chair/Letter of Concurrence from Planning Body (required).

Attachment 7: HIV Care Continuum Table (required).

Attachment 8: Service Category Plan Table(s) (required).

Attachment 9: Core Medical Services Waiver Request and Allocation Table (if applicable).

Attachment 10: Program Organizational Chart (required).

Provide a one-page illustration that depicts the organizational structure of the program. Include the names of department and/or program managers and coordinators.

Attachment 11: Maintenance of Effort Documentation (required).

Provide a baseline aggregate for actual non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services during the most recently completed FY prior to the application deadline and an estimate for the next FY using a table similar to the one below. Also, include a description of the process and elements used to determine the amount of expenditures in the MOE calculations. [See Section 2605(a)(1)(B) of the PHS Act. Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation and HRSA service definitions distributed to all recipients.] HRSA will enforce statutory MOE requirements through all available mechanisms.

NON-FEDERAL EXPENDITURES	
<p>FY Prior to Application (Actual)</p> <p>Actual prior FY non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services.</p> <p>Amount: \$ _____</p>	<p>Current FY of Application (Estimated)</p> <p>Estimated current FY non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services.</p> <p>Amount: \$ _____</p>

Attachment 12: Federally Negotiated Indirect Cost Rate Agreement (if applicable, not counted in the page limit).

Attachment 13: Other Relevant Documents – Letters of Agreement, Memorandum of Understanding, Intergovernmental Agreements, and Other Relevant Documents (optional—will count toward page limit).

Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.).

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number and System for Award Management

You must obtain a valid DUNS number, also known as the Unique Entity Identifier, for your organization/agency and provide that number in the application. You must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or has an exception approved by the agency under 2 CFR § 25.110(d)).

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If you have already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (<http://www.dnb.com/duns-number.html>)
- System for Award Management (SAM) (<https://www.sam.gov>)
- Grants.gov (<http://www.grants.gov/>)

For further details, see Section 3.1 of HRSA's [SF-424 Application Guide](#).

SAM.GOV ALERT: For your SAM.gov registration, you must submit a [notarized letter](#) appointing the authorized Entity Administrator. The review process changed for the Federal Assistance community on June 11, 2018.

If you fail to allow ample time to complete registration with SAM or Grants.gov, you will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Submission Dates and Times

Application Due Date

The due date for applications under this NOFO is *September 30, 2019 at 11:59 p.m. ET*. HRSA suggests submitting applications to Grants.gov at least **three (3) calendar days before the deadline** to allow for any unforeseen circumstances. See Section 8.2.5 – Summary of emails from Grants.gov of HRSA's [SF-424 Application Guide](#) for additional information.

5. Intergovernmental Review

The RWHAP Part A Emergency Relief Grant Program is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

See Section 4.1 ii of HRSA's [SF-424 Application Guide](#) for additional information.

6. Funding Restrictions

You may request funding for a period of performance of up to one (1) year, at no more than ceiling amounts as posted in [Appendix B](#) (inclusive of direct **and** indirect costs).

The General Provisions in Division B of the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245) are in effect at the time this NOFO is posted. Please see Section 4.1 of HRSA's [SF-424 Application Guide](#) for additional information. Awards will be made subsequent to enactment of the FY2020 appropriation. The NOA will reference the FY2020 appropriation act and any restrictions that may apply. Note that these or other restrictions will apply in the next fiscal year, as required by law.

You cannot use funds under this notice for the following purposes:

- Cash payment to intended recipients of RWHAP services;
- Construction (minor alterations and renovations to an existing facility to make it more suitable for the purpose of the program are allowable with prior HRSA approval);
- International travel;
- Pre-exposure prophylaxis (PrEP) or Post-Exposure Prophylaxis (PEP) medications or the related medical services (see the [June 22, 2016, RWHAP and PrEP program letter](#));
- [Syringe Services Programs](#) (SSPs). Some aspects of SSPs are allowable with HRSA's prior approval and in compliance with HHS and HRSA policy;
- Payment for any item or service to the extent that payment has been made (or reasonably can be expected to be made), with respect to that item or service, under any state compensation program, insurance policy, federal or state benefits program, or any entity that provides health services on a prepaid basis, (except for a program administered by or providing the services of the Indian Health Service); and
- Development of materials designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

Please see [PCN 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D](#) and [Frequently Asked Questions](#) for information regarding the statutory ten (10) percent limitation on administrative costs.

You can find other non-allowable costs in [45 CFR part 75 – Subpart E Cost Principles](#).

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

All program income generated as a result of awarded funds must be used for approved project-related activities. The program income alternative applied to the award(s) under the program will be the addition/additive alternative. You can find post-award requirements for program income at [45 CFR § 75.307](#)

For RWHAP Part A, allowable costs are limited to core medical services, support services, CQM and administrative expenses [Section 2604(a)(2) of the PHS Act]. Program income may be utilized for elements of the program that are otherwise limited by statutory provisions, such as administrative and CQM activities that might exceed statutory caps, or unique services that are needed to maintain a comprehensive program approach, but that would still be considered allowable under the award. (See [PCN 15-03 Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income.](#))

V. Application Review Information

1. Review Criteria

The RWHAP Part A HIV Emergency Relief Grant Program is both a formula-based and competitive program. HRSA has procedures for assessing the technical merit of applications and to assist you in understanding the standards against which your application will be reviewed. HRSA will review each application for completeness and eligibility, all required documents, and compliance with the requirements outlined in this NOFO. These criteria are the basis upon which the reviewers will evaluate and score the merit of the application. The entire proposal will be considered during objective review.

The RWHAP Part A HIV Emergency Relief Grant Program has six review criteria. See the review criteria outlined below with specific detail and scoring points.

Criterion 1: NEED (66 points) – Corresponds to Section IV ii, Project Narrative: Introduction, Needs Assessment, Demonstrated Need, including the Epidemiologic Overview, HIV Care Continuum, Co-occurring Conditions, and Complexities of Providing Care and associated attachments. Note: This section includes EIIHA, which is worth 33 points, per Section 2602(b)(4)(D)(vi) of the PHS Act.

The extent to which the application demonstrates the problem and associated contributing factors to the problem.

A. Demonstrated Need (33 points): Provides a description of the demonstrated needs of people with HIV, both those in care and not in care. The needs assessment provides information on the size, geographic distribution, and the socio-demographics of the HIV population within the EMA/TGA. It also provides information on strategies for reducing barriers to accessing care as well as services targeted to individuals who are aware of and those unaware of their HIV status.

1) Epidemiological Profile (9 points)

- a) Provides a clear and comprehensive description of the HIV epidemic in the EMA/TGA geographic area.
- b) Clarity and completeness of the HIV/AIDS Demographic Table(s) (**Attachment 3**), including use of the most recent data available and clearly cited sources of data.
- c) Clearly describes any increases in rates of HIV cases within emerging populations, how emerging populations were identified, and justifies the need for HIV-related services.

2) HIV Care Continuum (8 points)

- a) Provides a clear graphic depiction of the HIV care continuum of the jurisdiction using the most current calendar year data.
- b) Clearly describes viral suppression rates for three of the most disproportionately impacted minority populations that highlight disparities, with special attention on populations where specific sub-populations experience the greatest health disparities.

3) Co-occurring Conditions (7 points)

The strength of the table that quantifies the co-occurring conditions discussed in this section and clearly cites the data sources used (**Attachment 4**).

4) Complexities of Providing Care (9 points)

- a) Demonstrates a thorough understanding of both the impact and response to funding reduction (if applicable). Provides a clear and comprehensive description of any cost containment measures implemented, (e.g., waiting lists, client cost sharing, or other measures); PC or community PB response to the reduction in formula funding; and any transitional planning for clients receiving services that were either eliminated or reduced.
- b) Provides comprehensive estimates on poverty and health care coverage of people with HIV in table format.
- c) Demonstrates a thorough understanding of relevant factors that limit access to health care in the jurisdiction, including adequacy of health care coverage, geographic variation, language barriers, and service gaps related to people with HIV who have fallen out of care.

B. Early Identification of Individuals with HIV/AIDS (EIIHA) (33 points)

1) EIIHA Plan (12 points)

The strength and clarity of the EIIHA Plan that includes the following:

- a) Primary activities which will be undertaken, including system level interventions (e.g., routine testing in clinical settings, expanding partner services);
 - b) Major collaborations with other programs and agencies, including HIV prevention and surveillance programs; and
 - c) Anticipated outcomes of the program's overall EIIHA strategy.
- 2) Appropriateness of the description of three (3) distinct target populations, which includes a clear explanation of the following: **(18 points)**
- a) Why the target populations were chosen and how the epidemiological data, social determinants of health, or other data supports that decision;
 - b) Specific challenges or opportunities presented by the target populations; and
 - c) Specific strategies to be utilized with the target populations.
- 3) Clarity and completeness of plans to address legal barriers, including state laws and regulations, to routine HIV testing in medical settings, or program/policy efforts to expand implementation of routine HIV testing. **(3 points)**

Criterion 2: RESPONSE (12 points) – Corresponds to Section IV. ii. Project Narrative: Methodology/Planning Responsibilities, Work Plan/Funding for Core and Support Services, Resolution of Challenges, and associated attachments.

The extent to which the proposed project responds to the "Purpose" included in the program description.

Methodology (5 points)

- 1) Strength and clarity of the Community Input Process description that includes people with HIV and community involvement, MAI needs, and utilization of data in priority setting and resource allocation.
- 2) Completeness of description of any significant changes in the prioritization and allocation processes from 2019 to 2020 project periods and clarity of rationale for making those changes.
- 3) Clarity and completeness of the Coordination of Services and Funding Streams table (**Attachment 5**) and the narrative identifying any needed resources and/or services in the jurisdiction, which are not provided, and the feasibility of the proposed steps to secure them.
- 4) Completeness of the description for the assessment of the recipient's process to ensure timely allocation/contracting and payments to contractors, and recipient's response to any deficiencies identified.
- 5) Letter of Assurance from PC Chair(s) or Letter of Concurrence from PB (**Attachment 6**) fully addresses and provides evidence that 2019 project period funding was expended according to PC/PB priorities, that the PC/PB approved a process for determining 2020 project period priorities and provided evidence of annual membership training.

B. Work Plan (5 points)

Funding for Core Medical and Support Services

a) Service Category Plan (Attachment 8) (3 points)

The clarity and completeness of the table(s) that illustrates how RWHAP Part A and MAI core medical and support services are funded in the EMA/TGA as evidenced by the inclusion of complete data on service categories, priority number, funding amount, unduplicated clients, service unit definition, service units, and target populations (for MAI services only) for 2019 and 2020 project periods.

b) MAI Service Category Plan Narrative (2 points)

Clearly describes how the services included in the MAI Service Category Plan Table are specific and population-tailored, with special emphasis on the three subpopulations identified in the Demonstrated Need/HIV Care Continuum subsection. Clearly explains how targeted activities improve HIV-related health outcomes, reduce existing racial and ethnic health disparities, and increase the bars/percentages on the HIV care continuum, along with a description of how these activities address the unique needs of the targeted MAI populations.

C. Resolution of Challenges (2 points)

The strength and feasibility of approaches to resolve challenges and barriers identified throughout the application (e.g., changing health care landscape, community engagement), as well as challenges encountered in integrating the HIV care continuum into planning and implementing the RWHAP Part A grant.

Criterion 3: EVALUATIVE MEASURES (2 points) – Corresponds to Section IV. ii. Project Narrative: Evaluation and Technical Support Capacity/CQM

The strength and effectiveness of the method proposed to monitor and evaluate the program. Evidence that the evaluative measures will be able to assess: 1) to what extent the program objectives have been met and 2) to what extent these can be attributed to the project.

- 1) Fully describes how performance data are used to evaluate disparities in care, and the strength of the actions taken in the last grant year to eliminate disparities.
- 2) Clearly describes how CQM data are used to improve and/or change service delivery in the jurisdiction.

Criterion 4: IMPACT (10 points) – Corresponds to Section IV. ii. Project Narrative: Methodology/Impact of Funding, Work Plan/HIV Care Continuum Table, and associated attachments.

- 1) The strength and completeness of the HIV Care Continuum Table depicting how RWHAP-funded services will aid in achieving the desired target outcomes and have a positive impact on the HIV care continuum (**Attachment 7**).

- 2) A clear description of how the HIV care continuum is utilized in planning and prioritizing RWHAP Part A funding, in addition to monitoring available resources in response to the needs of people with HIV in order to maximize the impact on health outcomes in the jurisdiction.
- 3) Clearly demonstrates a thorough understanding of the changes in the HIV care continuum from CY 2016 to CY 2018, or most current three years for which data are available, and the impact the changes have had on the program, including a clear description of how those changes were addressed.
- 4) Demonstrates a thorough understanding of how changes in the health care landscape, including, but not limited to service provision, changes in allocations, and health care coverage options, affect health outcomes of people with HIV in the EMA/TGA.

Criterion 5: RESOURCES/CAPABILITIES (5 points) – Corresponds to Section IV. ii. Project Narrative: Organizational Information/Grant Administration and associated attachments.

The extent to which project personnel are qualified by training and/or experience to implement and carry out the project. The capabilities of the applicant organization and the quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project.

1) Program Organization (2 points)

The completeness and appropriateness of the Staffing Plan, Job Descriptions, and Biographical Sketches for Key Personnel (**Attachment 1**) and Program Organizational Chart (**Attachment 10**) that includes the names of managers and/or coordinators and that demonstrates capacity of the department, unit, staffing levels (FTEs, including any vacancies), fiscal and/or management agents, planning and evaluation bodies, and in-kind support staff necessary to carry out the project.

2) Recipient Accountability (3 points)

a) Monitoring

The strength and completeness for the description of the FY 2019 (if available) or FY 2018 subrecipients' most common findings, corrective actions to address findings, and compliance with single audit requirements.

b) Third Party Reimbursement

The strength and completeness of the process used to ensure RWHAP is the payor of last resort by vigorously pursuing alternate sources of payment, tracking source and use of program income earned at recipient and subrecipient levels, and conducting annual RWHAP eligibility determinations and recertifications.

c) Fiscal Oversight

The strength and effectiveness of the process used to ensure adequate reporting, timely payment, reconciliation, and tracking of program expenditures separately by formula, supplemental, MAI, and carryover funds.

Criterion 6: SUPPORT REQUESTED (5 points) – Corresponds to Section IV. ii. Project Narrative: Organizational Information/MOE, Budget and associated attachments.

The reasonableness of the proposed budget for the project period in relation to the objectives, the complexity of the activities, and the anticipated results.

- 1) The extent to which costs, as outlined in the budget, are reasonable given the scope of work, and aligned with demonstrated need and the Service Category Table.
- 2) The extent to which the budget reflects that key personnel have adequate time (FTEs) devoted to the project and allocated to appropriate budget categories.

2. Review and Selection Process

The objective review process provides an objective evaluation to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below. See Section 5.3 of HRSA's [SF-424 Application Guide](#) for more details.

Funding Priorities

This program includes a funding priority, as authorized by section 2603(b)(2)(C) of the PHS Act]. HAB will determine the funding factor as outlined below.

HRSA sets aside a portion of the Part A supplemental funding to award priority funds in conformance with this statutory requirement. Applicants eligible for supplemental funding that received greater than a 20 percent loss in their RWHAP Part A formula award when comparing their FY 2006 award to their FY 2020 award are eligible for and will receive priority funding.

3. Assessment of Risk

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory or other requirements ([45 CFR § 75.205](#)).

HRSA reviews applications receiving a favorable objective review for other considerations that include past performance, as applicable, cost analysis of the project/program budget, assessment of your management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. HRSA may ask you to submit additional programmatic or administrative information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that HRSA will make an award. Following review of all applicable information, HRSA's approving and business management officials will

determine whether HRSA can make an award, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

Effective January 1, 2016, HRSA is required to review and consider any information about your organization that is in the [Federal Awardee Performance and Integrity Information System \(FAPIIS\)](#). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider any of your comments, in addition to other information in [FAPIIS](#) in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

HRSA will report to FAPIIS a determination that an applicant is not qualified ([45 CFR § 75.212](#)).

VI. Award Administration Information

1. Award Notices

HRSA will issue the NOA prior to the start date of March 1, 2020. See Section 5.4 of HRSA's [SF-424 Application Guide](#) for additional information.

2. Administrative and National Policy Requirements

See Section 2.1 of HRSA's [SF-424 Application Guide](#).

Requirements of Subawards

The terms and conditions in the NOA apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NOA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients under awards. See [45 CFR § 75.101 Applicability](#) for more details.

3. Reporting

Award recipients must comply with Section 6 of HRSA's [SF-424 Application Guide](#) and the following reporting and review activities:

- 1) **Program Terms Report and Program Submission.** The RWHAP Part A recipient must submit a Program Terms Report and Program Submission to HRSA 90 days after the final award is issued. The CQM Plan is included within the Program Submission reporting requirement. Further information will be available in the NOA.

- 2) **Estimated Unobligated Balance (UOB).** The recipient must submit an estimate of anticipated UOB and an estimate of anticipated carryover funding to HRSA no later than December 31, 2020. Further information will be available in the NOA.
- 3) **RWHAP Part A & MAI Final Expenditure Report.** The recipient must submit a RWHAP Part A & MAI Final Expenditure Report no later than 90 days after the end of the FY2020 budget period. Further information will be available in the NOA.
- 4) **Annual Progress Report.** The recipient must submit an Annual Progress Report no later than 90 days after the end of the FY2020 budget period. Further information will be available in the NOA.
- 5) **Carryover Request.** If applicable, the RWHAP Part A recipient must submit a Carryover Request no later than 30 days after the Federal Financial Report (FFR) submission deadline. Further information will be available in the NOA.
- 6) **Ryan White HIV/AIDS Program Services Report (RSR).** Acceptance of this award indicates that you assure that you will comply with data requirements of the RSR and that you will mandate compliance by each of your subrecipients. The RSR captures information necessary to demonstrate program performance and accountability. All RWHAP core medical and support service providers are required to submit client level data as instructed in the RSR manual. Please refer to the Ryan White HIV/AIDS Program Client Level Data website at <http://hab.hrsa.gov/manageyourgrant/clientleveldata.html> for additional information. Further information will be available in the NOA.
- 7) **Integrity and Performance Reporting.** The NOA will contain a provision for integrity and performance reporting in [FAPIS](#), as required in [45 CFR part 75 Appendix XII](#).

VII. Agency Contacts

You may request additional information and/or technical assistance regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Olusola Dada
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: (301) 443-0195
Email: ODada@hrsa.gov

You may request additional information regarding the overall program issues and/or technical assistance related to this NOFO by contacting:

Steven R. Young, MSPH
Director, Division of Metropolitan HIV/AIDS Programs
Attn: HIV/AIDS Bureau
Health Resources and Services Administration

5600 Fishers Lane, Room 09W12
Rockville, MD 20857
Telephone: (301) 443-9091
Fax: (301) 443-5271
Email: SYoung@hrsa.gov

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, 7 days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
Email: support@grants.gov
Self-Service Knowledge Base:
<https://grants-portal.psc.gov/Welcome.aspx?pt=Grants>

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Contact Center, Monday–Friday, 8 a.m. to 8 p.m. ET, excluding federal holidays at:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
Web: <http://www.hrsa.gov/about/contact/ehbhelp.aspx>

VIII. Other Information

Technical Assistance

HRSA has scheduled following technical assistance:

Webinar

Day and Date: Thursday, August 1, 2019

Time: 2:00 p.m. – 4 p.m. ET

Call-In Number: 1-800-369-1990

Participant Code: 3479507#

Web link:

https://hrsa.connectsolutions.com/rwhap_part_a_fy_20_nofa_ta_webinar/

Playback Number: Recorded webinar will be available on the [TargetHIV website](#).

Tips for Writing a Strong Application

See Section 4.7 of HRSA's [SF-424 Application Guide](#).

Appendix A

FY 2020 AGREEMENTS AND COMPLIANCE ASSURANCES Ryan White HIV/AIDS Program *Part A HIV Emergency Relief Grant Program*

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

Pursuant to Section 2602(a)(2)^{3, 4}

The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)

The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last 5 years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2602(b)(4)

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

Pursuant to Section 2603(c)

The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)

The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council/Planning Body.

Pursuant to Section 2604(a)

The EMA/TGA will expend funds according to priorities established by the Planning Council/Planning Body, and for core medical services, support services, and administrative expenses only.

³ All statutory references are to the Public Health Service Act, unless otherwise specified.

⁴ TGAs are exempted from the requirement related to Planning Councils, but must provide a process for obtaining community input as described in **section 2609(d)(1)(A)** of the PHS Act. TGAs that have currently operating Planning Councils are strongly encouraged to maintain that structure.

Pursuant to Section 2604(c)

The EMA/TGA will expend not less than 75 percent of service dollars for core medical services, unless waived by the Secretary.

Pursuant to Section 2604(f)

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

Pursuant to Section 2604(g)

The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)

The EMA/TGA will expend no more than 10 percent of the grant on administrative costs (including Planning Council or planning body expenses), and in accordance with the legislative definition of administrative activities, and the allocation of funds to subrecipients will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)

The EMA/TGA will establish a CQM Program that meets HRSA requirements, and that funding for this program shall not exceed the lesser of five percent of program funds or \$3 million.

Pursuant to Section 2604(i)

The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)

With regard to the use of funds,

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

Pursuant to Section 2605(a)(3)

The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the health care system for the purpose of facilitating EIS for individuals diagnosed with HIV infection.

Pursuant to Section 2605(a)(5)

The EMA/TGA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)

Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any state compensation program, insurance policy, or any Federal or state health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)

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

Pursuant to Section 2605(a)(7)(B)

Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)

A program of outreach services will be provided to low-income individuals with HIV disease to inform them of the HIV primary medical care and support services.

Pursuant to Section 2605(a)(8)

The EMA/TGA has participated in the Statewide Coordinated Statement of Need (SCSN) process initiated by the state, and the services provided under the EMA/TGA comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)

The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)

The EMA/TGA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

Pursuant to Section 2605(e)

The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)

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

Pursuant to Section 2684

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

Signature _____ Date _____

Appendix B

Geographic Service Areas

Applications must propose to serve the entire service area, as defined here in Appendix B.

The “Funding Ceiling” column identifies the total funding available for the delivery of comprehensive primary health care and support services for low income, uninsured and underserved people with HIV for each service area. Funding requests must not exceed the published funding ceiling amount. Please note that this amount includes MAI funding. The MAI component of your budget must not exceed a five percent increase from your FY 2019 MAI award.

EMA	City	State	Funding Ceiling	Service area
Atlanta EMA	Atlanta	GA	\$29,075,338	Barrow County, Bartow County, Carroll County, Cherokee County, Clayton County, Cobb County, Coweta County, DeKalb County, Douglas County, Fayette County, Forsyth County, Fulton County, Gwinnett County, Henry County, Newton County, Paulding County, Pickens County, Rockdale County, Spalding County, and Walton County
Baltimore EMA	Baltimore	MD	\$17,522,446	Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Harford County, Howard County, and Queen Anne's County
Boston EMA*	Boston	MA	\$15,671,698	MA: Bristol County, Essex County, Middlesex County, Norfolk County, Plymouth County, Suffolk County, and Worcester County NH: Hillsborough County, Rockingham County, and Strafford County
Chicago EMA	Chicago	IL	\$29,071,855	Cook County, DeKalb County, DuPage County,

				Grundy County, Kane County, Kendall County, Lake County, McHenry County, and Will County
Dallas EMA	Dallas	TX	\$18,965,396	Collin County, Dallas County, Denton County, Ellis County, Henderson County, Hunt County, Kaufman County, and Rockwall County
Detroit EMA	Detroit	MI	\$10,178,855	Lapeer County, Macomb County, Monroe County, Oakland County, St. Clair County, and Wayne County
Fort Lauderdale EMA	Fort Lauderdale	FL	\$16,721,187	Broward County
Houston EMA	Houston	TX	\$25,486,609	Chambers County, Fort Bend County, Harris County, Liberty County, Montgomery County, and Waller County
Los Angeles EMA	Los Angeles	CA	\$46,167,323	Los Angeles County
Miami EMA	Miami	FL	\$27,926,791	Miami-Dade County
Nassau-Suffolk EMA	Mineola	NY	\$5,768,292	Nassau County and Suffolk County
New Haven EMA	New Haven	CT	\$5,841,067	Fairfield County and New Haven County
New Orleans EMA	New Orleans	LA	\$8,361,150	Jefferson Parish, Orleans Parish, Plaquemines Parish, St. Bernard Parish, St. Charles Parish, St. James Parish, St. John the Baptist Parish, and St. Tammany Parish
New York EMA	New York	NY	\$98,944,150	Bronx County, Kings County, New York County, Putnam County, Queens County, Richmond County, Rockland County, and Westchester County
Newark EMA	Newark	NJ	\$13,129,646	Essex County, Morris County, Sussex County,

				Union County, and Warren County
Orlando EMA	Orlando	FL	\$10,590,650	Lake County, Orange County, Osceola County, and Seminole County
Philadelphia EMA*	Philadelphia	PA	\$23,914,710	PA: Bucks County, Chester County, Delaware County, Montgomery County, and Philadelphia County NJ: Burlington County, Camden County, Gloucester County, and Salem County
Phoenix EMA	Phoenix	AZ	\$10,225,888	Maricopa County and Pinal County
San Diego EMA	San Diego	CA	\$12,069,930	San Diego County
San Francisco EMA	San Francisco	CA	\$16,126,350	Marin County, San Francisco County, and San Mateo County
San Juan EMA	San Juan	PR	\$11,400,373	Aguas Buenas Municipality, Barceloneta Municipality, Bayamón Municipality, Canóvanas Municipality, Carolina Municipality, Cataño Municipality, Ceiba Municipality, Comerío Municipality, Corozal Municipality, Dorado Municipality, Fajardo Municipality, Florida Municipality, Guaynabo Municipality, Humacao Municipality, Juncos Municipality, Las Piedras Municipality, Loíza Municipality, Luquillo Municipality, Manatí Municipality, Morovis Municipality, Naguabo Municipality, Naranjito Municipality, Río Grande Municipality, San Juan Municipality, Toa Alta Municipality, Toa Baja Municipality, Trujillo Alto Municipality, Vega Alta Municipality

				Municipality, Vega Baja, and Yabucoa Municipality
Tampa-St. Petersburg EMA	Tampa	FL	\$10,880,856	Hernando County, Hillsborough County, Pasco County, and Pinellas County
Washington, DC EMA*	Washington	DC	\$32,857,662	District of Columbia MD: Calvert County, Charles County, Frederick County, Montgomery County, and Prince George's County VA: Alexandria City, Arlington County, Clarke County, Culpeper County, Fairfax City, Fairfax County, Falls Church City, Fauquier County, Fredericksburg City, King George County, Loudoun County, Manassas City, Manassas Park City, Prince William County, Spotsylvania County, Stafford County, and Warren County WV: Berkeley County and Jefferson County
West Palm Beach EMA	West Palm Beach	FL	\$7,744,006	Palm Beach County

*Service area crosses state lines

Current TGA Recipient	City	State	Funding Ceiling	Service area
Austin TGA	Austin	TX	\$5,353,795	Bastrop County, Caldwell County, Hays County, Travis County, and Williamson County
Baton Rouge TGA	Baton Rouge	LA	\$4,767,410	Ascension Parish, East Baton Rouge Parish, East Feliciana Parish, Iberville Parish, Livingston Parish, Pointe Coupee Parish, St. Helena Parish, West Baton Rouge Parish, and West Feliciana Parish
Bergen-Passaic TGA	Paterson	NJ	\$4,209,473	Bergen County and Passaic County
Charlotte-Gastonia TGA*	Charlotte	NC	\$6,599,866	NC: Anson County, Cabarrus County, Gaston County, Mecklenburg County, and Union County SC: York County
Cleveland-Lorain-Elyria TGA	Cleveland	OH	\$5,008,151	Ashtabula County, Cuyahoga County, Geauga County, Lake County, Lorain County, and Medina County
Columbus TGA	Columbus	OH	\$4,963,370	Delaware County, Fairfield County, Franklin County, Licking County, Madison County, Morrow County, Pickaway County, and Union County
Denver TGA	Denver	CO	\$8,136,445	Adams County, Arapahoe County, Denver County, Douglas County, and Jefferson County
Fort Worth TGA	Fort Worth	TX	\$4,938,109	Hood County, Johnson County, Parker County, and Tarrant County
Hartford TGA	Hartford	CT	\$3,356,404	Hartford County, Middlesex County, and Tolland County

Indianapolis TGA	Indianapolis	IN	\$4,668,885	Boone County, Brown County, Hamilton County, Hancock County, Hendricks County, Johnson County, Marion County, Morgan County, Putnam County, and Shelby County
Jacksonville TGA	Jacksonville	FL	\$6,256,087	Clay County, Duval County, Nassau County, and St. Johns County
Jersey City TGA	Jersey City	NJ	\$5,299,825	Hudson County
Kansas City TGA*	Kansas City	MO	\$4,520,804	MO: Cass County, Clay County, Clinton County, Jackson County, Lafayette County, Platte County, Ray County, and Johnson County KS: Leavenworth County, Miami County, and Wyandotte County
Las Vegas TGA*	Las Vegas	NV	\$6,848,399	NV: Clark County and Nye County AZ: Mohave County
Memphis TGA*	Memphis	TN	\$7,005,578	TN: Fayette County, Shelby County, and Tipton County AR: Crittenden County MS: DeSoto County, Marshall County, Tate County, and Tunica County
Middlesex-Hunterdon-Somerset TGA	New Brunswick	NJ	\$2,986,460	Hunterdon County, Middlesex County, and Somerset County
Minneapolis–St. Paul TGA*	Minneapolis	MN	\$6,129,315	MN: Anoka County, Carver County, Chisago County, Dakota County, Hennepin County, Isanti County, Ramsey County, Scott County, Sherburne County, Washington County, and Wright County WI: Pierce County and St. Croix County

Nashville TGA	Nashville	TN	\$4,257,674	Cannon County, Cheatham County, Davidson County, Dickson County, Hickman County, Macon County, Robertson County, Rutherford County, Smith County, Sumner County, Trousdale County, Williamson County, and Wilson County
Norfolk TGA*	Norfolk	VA	\$6,077,846	VA: Chesapeake City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Suffolk City, Virginia Beach City, Williamsburg City, and York County NC: Currituck County
Oakland TGA	Oakland	CA	\$7,556,009	Alameda County and Contra Costa County
Orange County TGA	Santa Ana	CA	\$6,720,056	Orange County
Portland TGA*	Portland	OR	\$4,247,878	OR: Clackamas County, Columbia County, Multnomah County, Washington County, and Yamhill County WA: Clark County
Riverside-San Bernardino TGA	San Bernardino	CA	\$8,445,692	Riverside County and San Bernardino County
Sacramento TGA	Sacramento	CA	\$3,616,915	El Dorado County, Placer County, and Sacramento County

Saint Louis TGA*	St. Louis	MO	\$6,551,682	MO: Franklin County, Jefferson County, Lincoln County, St. Charles County, St. Louis City, St. Louis County, and Warren County IL: Clinton County, Jersey County, Madison County, Monroe County, and St. Clair County
San Antonio TGA	San Antonio	TX	\$5,882,936	Bexar County, Comal County, Guadalupe County, and Wilson County
San Jose TGA	San Jose	CA	\$3,312,852	Santa Clara County
Seattle TGA	Seattle	WA	\$7,377,585	Island County, King County, and Snohomish County

*Service area crosses state lines