



Request for Applications

RFA # A-328

Regional Networks of Care and Prevention

FUNDING AGENCY: North Carolina Department of Health and Human Services, Division of Public Health
Epidemiology Section/Communicable Disease Branch
HIV/STD Prevention and AIDS Care Programs

ISSUE DATE: August 2, 2016

DEADLINE DATE: October 3, 2016

INQUIRIES AND DELIVERY INFORMATION:

All questions regarding preparation of the application must be submitted by electronic mail to Prevention.Care.RFA@dhhs.nc.gov by 5:00 pm on **August 24, 2016**.

Applications will be received until 5:00 pm on October 3, 2016.
Electronic copies of the application are available by request.

Send all applications directly to the mailing address shown below and electronically to Prevention.Care.RFA@dhhs.nc.gov. Applications must be submitted both in hard copy and via e-mail.

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North Carolina Communicable Disease Branch
1933 Mail Service Center
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Street/Hand Delivery Address:

1200 Front Street, Suite 104
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IMPORTANT NOTE: Include agency/organization name and RFA number on the front of each application envelope or package, along with the RFA deadline date. See Section V, number 3 for details.

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I. INTRODUCTION

The North Carolina Department of Health and Human Services, Division of Public Health (DPH), Communicable Disease Branch, hereafter known as the Branch, is inviting submission of applications to fund and support HIV Care, Prevention and Housing Opportunities for Persons with AIDS (HOPWA) services within 10 geographically defined Regional Networks of Care and Prevention, hereafter known as the Networks and funding for Prevention services only within the Charlotte Transitional Grant Area (TGA). Please see **Appendix 1: Branch Regional Map**, for a map of the 10 Networks, a list of counties that comprise each Network and a list of counties that comprise the Charlotte TGA.

The goals for funding HIV Care, Prevention and HOPWA services are to reduce new HIV infections, increase access to care and improve health outcomes for people living with HIV; reduce HIV-related disparities and health inequities; and achieve a more coordinated national response to the HIV Epidemic consistent with the National HIV AIDS Strategy.

A number of broad objectives have been identified as being crucial to achieving these goals and include:

1. Increasing the amount of HIV testing done among high-risk populations across the state;
2. Getting individuals who are newly diagnosed as HIV-positive into care quickly; and
3. Keeping clients in care and virally suppressed in order to reduce new infections and reduce transmission of HIV.

Activities that facilitate the accomplishment of these objectives include:

1. Testing and linking persons identified as HIV-positive to HIV Infectious Disease medical care as early in the disease process as possible;
2. Providing necessary core medical and support services to keep clients in medical care;
3. Providing necessary HOPWA housing services to ensure clients are stably housed;
4. Tracking clients within and across Networks, identifying and finding clients who have dropped out of care, and working with them to get them back into care. This includes collecting, reporting and tracking CD4 and Viral Load tests to monitor client health outcomes and assure Viral Load suppression;
5. Providing prevention interventions with persons who are HIV positive to reduce the likelihood of continued transmission of infection; and
6. Identifying any needle exchange programs within and across Networks and working with these programs to ensure that HIV/STD and HCV counseling, testing and linkage to care/treatment occur.

Each application will need to demonstrate how Care, Prevention and HOPWA service providers within each of the 10 Networks plan to work together, including sharing data and analyses, to achieve these goals, objectives and activities and document those working relationships as part of the application.

Eligible applicants for this funding opportunity are limited to other State agencies, local governmental agencies, colleges and universities (private and public), and community based organizations (501(C)(3) designated).

Funding will span a period of three years beginning in 2017 and will be awarded annually based on contract compliance, program performance and availability of funds.

II. BACKGROUND

Historically the Branch awarded funding for HIV Prevention and Care services separately. In order to ensure greater collaboration and integration in our HIV Prevention and care services, the Branch has combined the Care, Prevention and HOPWA funding announcements into one announcement. This integration will allow jurisdictions to better align prevention, care, treatment and housing needs in their service areas and accomplish the goals of the National HIV/AIDS Strategy, (NHAS) and the principles and the intent of the HIV Care Continuum. Health departments have been directed to prioritize activities to address those who have fallen out of HIV care and to increase the proportion of individuals included in each state of the HIV Care Continuum posted at <https://www.aids.gov/federal-resources/policies/care-continuum/>. The Branch has adapted this initiative to better identify gaps in HIV Care and Prevention services and to develop strategies to improve engagement in care and outcomes for people living with HIV. The NC HIV Continuum of Care Fact Sheet is posted at epi.publichealth.nc.gov/cd/stds/figures/factsheet_HIV_continuum_of_care_2014.pdf.

HIV/AIDS and sexually transmitted disease (STD) acquisition, transmission and their complications, burdens and costs continue to be a significant public health problem. In North Carolina alone:

- There are an estimated 36,700 persons living with HIV disease in North Carolina (including an estimated 4,900 individuals who may be unaware of their infection, as of December 31, 2014).
- Every county in our State is impacted by HIV disease.
- 26.1% of persons living with HIV disease in North Carolina were estimated to have an unmet need for HIV care in 2014 (no evidence of being in care in the past 12 months).
- In 2014, NC surveillance data suggests that nearly 55% of people were not receiving the full benefit of treatment (they were not virally suppressed).
- In 2014, the rate of new diagnoses for adult/adolescent Black/African American males was 80.4 per 100,000, which was nearly 7 times higher than that of White/Caucasian males (9.3 per 100,000).
- In 2014, the rate of new HIV diagnoses for Hispanic adult/adolescent males was 31.4 per 100,000, which was 3 times greater than the rate among White/Caucasian (non-Hispanic/Latino) males.

- In 2014, the rate of new diagnoses for adult/adolescent Black/African American females was 21.8 per 100,000, which was nearly 13 times higher than that of White/Caucasian females (1.7 per 100,000).
- In 2014, the rate of new HIV diagnoses for Hispanic adult/adolescent females was 9.2 per 100,000, which was nearly 5 times greater than the rate among white non-Hispanic/Latina females.
- 25% of all newly diagnosed HIV disease cases in 2014 were among adolescent males 13-24 years old.
- In 2014, 68% of people newly diagnosed with HIV were men who reported sex with men.
- In 2014, 22% of the people newly diagnosed with HIV were diagnosed with AIDS at the same time, suggesting missed opportunities for these people to receive care earlier in disease progression.
- The number of early syphilis (primary, secondary, and early latent) cases diagnosed in North Carolina in 2014 was 1,113, with a rate of 11.2 per 100,000 populations. This number is an increase from 2013, when 688 early syphilis cases were diagnosed (7.0 per 100,000 populations).
- In 2014, 44% of people diagnosed with syphilis were also co-infected with HIV (co-infection is defined as having HIV prior to or within 30 days of their syphilis diagnosis).
- The reported number of gonorrhea cases in 2014 was 14,952 at a rate of 150.4 per 100,000 populations, compared to 14,114 cases (rate of 143.3 per 100,000 populations) in 2013.
- The CDC estimates that 25% of HIV-infected persons in the US are also co-infected with HCV.
- The number of chlamydia cases diagnosed in North Carolina in 2014 was 49,904 at a rate of 501.9 per 100,000 populations, compared to 49,220 cases (rate of 499.9 per 100,000 populations) in 2013.
- 77% of HOPWA clients who also received a Ryan White Part B service in 2015 were virally suppressed demonstrating that stable housing combined with HIV care is a critical intervention strategy for improving health outcomes for persons living with HIV/AIDS.
- 95% of HOPWA clients receiving Tenant Based Rental Assistance (TBRA) and 100% of HOPWA clients receiving Short-Term Rent, Mortgage and Utility Assistance (STRMU) in 2015 remained stably housed with no risk of eviction or utility disconnection.

The Branch intends to implement the Centers for Disease Control and Prevention's (CDC) High-Impact HIV Prevention approach to reducing new HIV infection. High-Impact HIV Prevention (HIHP) seeks to use combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas. Proven strategies include: HIV testing and linkage to care, antiretroviral therapy, Pre-Exposure Prophylaxis (PrEP), access to condoms, prevention programs for people living with HIV, substance abuse treatment, and screening and treatment for other sexually transmitted infections. This approach promises to increase the impact of HIV prevention efforts

which is an essential step in achieving the goals of the 2015 National HIV and AIDS Strategy.

NHAS lays out the following priorities for increasing the impact of HIV prevention efforts in reducing new infections:

- Intensify HIV prevention efforts in the communities where HIV infection is mostly heavily concentrated,
- Expand efforts to prevent HIV infection using a combination of effective evidence based approaches and
- Educate all Americans with easily accessible, scientifically accurate information about HIV risks, prevention and transmission.

See Appendix 3: High-Impact HIV Prevention (HIHP) & National HIV/AIDS Strategy (NHAS) Overview for more information.

Regional Networks of Care and Prevention

The Branch priority is to ensure Care, Prevention and HOPWA services are provided in each Network. North Carolina is divided into 10 Networks that includes Ryan White Part B Core Medical and Support services, HOPWA, and Prevention services. Providers (funded and non-funded) work together collaboratively to streamline the accessibility and availability of a myriad of medical care, support, housing and prevention services. In addition, North Carolina has one TGA located in Charlotte that is severely affected by the HIV/AIDS epidemic. To be eligible for TGA status, an area must have reported 1,000 to 1,999 AIDS cases in the most recent five years and have a population of at least 50,000. Ryan White Part A grants to TGAs include formula and supplemental components as well as (MAI) funds, which support services targeting minority populations.

The Networks conduct these services to address the goals, objectives and activities of DPH and the Branch. Networks will be expected to provide Care and HOPWA services for clients in every county in the region. Prevention services are required in every region and the Charlotte TGA. Networks and the Charlotte TGA should develop plans to address HIV prevention needs in as many counties and communities most in need of these services. However, it is not required that every county receives prevention services. Available resources as well as unmet need in each county should be taken into consideration when developing plans for funding HIV prevention activities. **See Appendix 1: Branch Regional Map.**

Contractors will be funded for one or more of the following program areas:

1. Integrated Targeted Testing Services (ITTS)
2. Counseling, Testing and Referral in Substance Abuse Centers (SAC)
3. Prevention with Positives (PWP)
4. Ryan White Part B
5. Housing Opportunities for Persons with AIDS (HOPWA)

The Branch has designated funding from the CDC and the Substance Abuse and Mental Health Administration (SAMHSA) to support High Impact Prevention activities in North Carolina. Particular emphasis will be given to programs that

conduct targeted HIV testing and linkage to care. The majority of funds awarded in this RFA will support these activities. Agencies funded for HIV testing should also provide syphilis testing to these clients and hepatitis C testing to all high risk clients. Agencies funded through this announcement will have access to the State Laboratory for Public Health (SLPH) for free HIV, syphilis and hepatitis C testing. Gonorrhea and chlamydia testing should be considered for eligible clients but the SLPH will not be able to process these samples.

With the advent of legal needle exchange programs in NC, agencies funded for HIV/STD prevention should identify any needle exchange programs in their service areas and work with these programs to ensure that HIV/STD and HCV counseling, testing and linkage to care/treatment occur. Agencies should develop MOAs with any needle exchange programs that they work with outlining the services that the HIV/STD prevention agency will provide.

The Branch will also promote the implementation of evidence-based HIV/AIDS interventions and strategies listed on the Effective Interventions website (www.effectiveinterventions.org) for Prevention with Positive activities only. Diffusion of Effective Behavioral Interventions (DEBIs) is HIV prevention activities that have been rigorously evaluated and proven effective. Consideration for funding of interventions will be given to applicants who propose to conduct one or more Prevention with Positives evidence-based interventions and/or public health strategies that are listed in **Appendix 4: Diffusion of Effective Behavioral Interventions (DEBI) and Public Health Strategies** (www.effectiveinterventions.org).

The Branch has also designated funding from Ryan White Part B (direct assistance to States and Territories) from HRSA. The Ryan White Part B Program enables local communities to improve the quality, availability and coordination of outpatient health care and support services for individuals and families living with HIV/AIDS. The Part B Program emphasizes the delivery of a comprehensive continuum of outpatient care for persons living with this disease. Ryan White Part B (non-ADAP) funding is utilized to provide HIV care services in all counties except Anson, Cabarrus, Gaston, Mecklenburg and Union, who are covered by the Charlotte TGA. In addition, this funding also supports the provision of HIV medications through the AIDS Drug Assistance Program (ADAP) for eligible, uninsured North Carolinians. ADAP funding covers all 100 North Carolina counties.

The AIDS Care Program also receives Housing Opportunities for Persons with AIDS (HOPWA) funds from the federal Department of Housing and Urban Development (HUD). These funds are used to address the specific housing needs of persons living with HIV/AIDS and their families. The state HOPWA Program supports tenant-based rental assistance; short-term rent, mortgage and utilities payments; case management, transportation, mental health and other supportive services that facilitate clients remaining in their homes; housing information; identification of housing resources; and operational support for

housing situations. HOPWA funds are utilized to provide housing related services in 82 of the 100 North Carolina Counties. Counties not covered by the State HOPWA Program are Cabarrus, Chatham, Currituck, Durham, Franklin, Gaston, Guilford, Iredell, Johnston, Lincoln, Mecklenburg, Orange, Person, Randolph, Rockingham, Rowan, Union and Wake. These counties are covered by direct funding from HUD.

The AIDS Care Program also collaborates with other Ryan White Parts across the State. These include Part A, which is direct assistance to an Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA); Part C, Early Intervention Services including HIV Counseling and Testing; and Part D, which provides services for women, infants, children and youth. North Carolina has a TGA in Charlotte based at the Mecklenburg County Health Department. The counties that encompass the Charlotte TGA are Anson, Cabarrus, Gaston, Mecklenburg and Union in North Carolina and York County in South Carolina.

Number of potential contracts awarded per region:

This RFA is limited to funding Ryan White Care, HOPWA and Prevention services within the 10 Regional Networks of Care and Prevention (RNCP) and funding Prevention services only within the Charlotte TGA located in North Carolina. The RNCP application may consist of other State agencies, local governmental agencies, colleges and universities (private and public), and community based organizations (501(C)(3) designated) that are eligible to apply for funding under this RFA. The 10 RNCPs are divided into three tiers based upon Census. A list of eligible jurisdictions is located under Section III: Eligibility Information.

The Branch will award contracts to a maximum of three to seven Prevention providers, two Care providers and two HOPWA providers per region. (See chart below.) The Branch will primarily fund providers (agencies) that have historically provided Prevention, Ryan White Care and/or HOPWA direct services to clients, though it is understood that some services may be provided by subcontracting with other direct service providers. There is no limit to the amount of subcontractors a provider can have.

Regions	Prevention Contracts	Care Contracts	HOPWA Contracts
3, 4 and 6	Maximum of 7	Maximum of 2	Maximum of 2
2, 7, 8, 9 and 10	Maximum of 3	Maximum of 2	Maximum of 2
1 and 5	Maximum of 5	Minimum of 2	Maximum of 2
Charlotte TGA	Maximum of 5	N/A	N/A

III. SCOPE OF SERVICES

1. Eligibility

The following agencies are eligible for funding under this application:

- a. Other state agencies
- b. Local governmental agencies
- c. Colleges and Universities, private and public
- d. Community-Based Organizations (501(c)(3) designated)

Many cultural, socioeconomic, and environmental factors have an impact on health disparities for racial, ethnic and sexual minorities. The Branch recognizes that cultural competency is imperative to respond to current demographic trends and promote positive health and behavioral outcomes. Minority and culturally competent service providers are encouraged to apply. All funded services must be provided in a sensitive and non-judgmental manner, by culturally competent staff and providers.

2. Funding Availability

The RFA will be for a three year funding cycle: 2017-2018, 2018-2019, and 2019-2020. Funds will be allocated for one year initially (2017-2018). Funding for the 2nd and 3rd year will depend on both performance of the funded agencies and availability of funds. The next joint Care and Prevention RFA is planned for release in 2019 for both HIV Care and Prevention funding in 2020- 2021, 2021-2022 and 2022-2023.

Program Area	1st Year Funding Cycles
Ryan White	April 1, 2017 – March 31, 2018
HOPWA	October 1, 2017 – September 30, 2018
Integrated Targeted Testing Services (ITTS) & Substance Abuse Centers (SAC) (State & SAMHSA Funding)	June 1, 2017 – May 31, 2018
Integrated Targeted Testing Services (ITTS) & Prevention with Positives (PWP) (Federal Funding)	June 1, 2017 – December 31, 2017

Ryan White Part B funding available per region:

Ryan White Part B funds allocated per region reflect the 2016-2017 Ryan White Part B funding. **If the 2017-2018 Ryan White Part B allocation is lower, the Branch will need to adjust these allocations accordingly.** Similarly, if the base allocation is higher, the Branch will need to review these allocations based on current needs and resources. This will include a review of previous network expenditure rates, as applicable.

The table below represents the Ryan White Part B allocations per region for April 1, 2017 – March 31, 2018.

Region*	Ryan White Part B Funding
1	\$723,687
2	\$378,820
3	\$1,112,389
4	\$956,298
5	\$906,535
6	\$2,039,902
7	\$670,368
8	\$423,244
9	\$329,791
10	\$517,084
TOTAL	\$8,058,118

***The regions listed in the tables below correspond to Appendix 1: Branch Regional Map.**

HOPWA funding available per region:

HOPWA funds allocated per region reflect 2015-2016 HOPWA funding. As is the case for projected Ryan White Part B allocations per region, the HOPWA allocations are based on the Branch, receiving a HOPWA allocation from HUD which is similar to the amount received in the current year. **If the 2017-2018 HOPWA allocation is lower, the Branch will need to adjust these allocations accordingly.** Similarly, if the base allocation is higher, the Branch will need to review these allocations based on current needs and resources. This will include a review of previous network expenditure rates, as applicable.

The table below represents the HOPWA allocations per region for October 1, 2017 – September 30, 2018.

Region*	HOPWA Funding
1	\$484,425
2	\$84,229
3	\$420,034
4	\$33,572
5	\$383,750
6	\$94,878
7	\$188,581
8	\$164,508
9	\$75,053
10	\$211,413
TOTAL	\$2,140,443

***The regions listed in the tables below correspond to Appendix 1: Branch Regional Map.**

Prevention funding available per region:

Approximately \$4,282,099 in State and Federal funds is available to support the HIV prevention part of this RFA. These initial funds will support the first 12 month contract cycle. Funding for subsequent years will depend on both performance of the applicants that are funded and availability of funds. However, the Branch reserves the right to amend funding allocations based on the needs proposed by applicants.

Region**	Average Prevention Funding Allocation**
1	\$178,334
2	\$100,150
3	\$286,508
4	\$508,350
5	\$517,690
6	\$1,123,286
7	\$230,785
8	\$393,490
9	\$59,214
10	\$240,863
TGA	\$643,430
TOTAL	\$4,282,099

***The regions listed in the tables below correspond to Appendix 1: Branch Regional Map.**

****Prevention Agencies may receive 10% above or below the average funding identified in the table above.**

3. Target Populations

In an effort to ensure prevention grant awards are effectively distributed, funding allocations will strive to mirror the diversity of the epidemic. Priority populations include the following:

- **Persons Living with HIV/AIDS (PLWHA)**
- **Men who have Sex with Men (MSM)**
- **African American and Latino men and women**
- **Substance abusers (in care at the locations where they are receiving substance abuse treatment services)**

4. Program Descriptions and Requirements

Applications will be accepted in the following five (5) program areas: (or Contractors will be funded for one or more of the following program areas)

- 1. Integrated Targeted Testing Services (ITTS)**
- 2. Counseling, Testing and Referral in Substance Abuse Centers (SAC)**
- 3. Prevention with Positives (PWP)**
- 4. Ryan White Part B**
- 5. Housing Opportunities for Persons with AIDS (HOPWA)**

Services not included in this Request for Applications (RFA) are:

- Medication Adherence Programs
- Prenatal Counseling and Testing
- Research Based Proposals

While proposals that focus primarily on research are not acceptable, *proposals must include an effective evaluation component.*

In order to be considered for more than one Program Area, applicants must submit a separate program description and budget for each Program Area. Applications must be individually tailored to meet the specifications of each identified program area. Duplicate or identical applications submitted for multiple program areas will be disqualified from consideration.

The Branch reserves the right to make partial awards (i.e., partial funding and/or modified proposed services) and to fund more than one agency for each target population covered in the presented program areas.

REGIONAL NETWORKS OF CARE AND PREVENTION

Conceptualization of a Regional Network of Care and Prevention:

The Network is envisioned as a group of counseling/testing providers, prevention providers, core medical, support, and housing providers in a geographic region that work together to develop a matrix of services that address the goal, objectives and activities of their Network.

The Network can include as many providers as necessary to plan and carry out the goal, objectives and activities of the Network. The Network can and should include all providers for which the network will be requesting ITTS, PWP, SAC, Ryan White Part B and/or HOPWA funding as well as providers for which the Network will not be requesting funds, but who plan to participate in the Network activities.

For example, the Network should include Ryan White Part C and D programs, though these programs provide some services not allowable under Ryan White Part B. This same concept should be utilized for prevention and housing services that may not be allowable under prevention and/or HOPWA funding.

ITTS, PWP, and SAC agencies may provide services in more than one Network region. In such cases, the agency must inform both the primary network region and the additional region of all services. These services must be acknowledged in the RFA application although the agency may not be requesting funding under both network regions RFA applications.

Any agency that applies for funding under a particular network region RFA application must agree to actively participate in network activities including the creation and maintenance of deliverables and participation in network meetings. RW Part B and HOPWA service providers must participate in the creation and

maintenance of the following deliverables: Network Needs Assessment, Evaluation Plan, Client Grievance Policy, Client Satisfaction Assessment, and Quality Management Plan. Prevention providers must participate in the creation and maintenance of each Network Needs Assessment. Network Meetings are held at least quarterly and will be a mandatory requirement of each contract. Each Network must have at least one representative from each funded Prevention, Care, and HOPWA provider present at each HIV Prevention and Care Unit sponsored Provider Meetings held throughout the year. Provider Meetings are mandatory and are a continued condition of award.

Networks should also work closely with the Branch Regional Offices for the purpose of notification and linkage to care for HIV positive people. A list of Branch Regional Offices is in **Appendix 5: NC Branch Regional Offices**.

PROGRAM AREA ONE

Integrated Targeted Testing Services (ITTS)

HIV testing is a gateway to HIV prevention, care and treatment and is an essential component of a High-Impact HIV Prevention Program. Research has shown that when people learn that they are infected, they take steps to protect their own health and prevent HIV transmission to others. Linkage to, retention in and re-engagement with care, treatment and prevention services help ensure people living with HIV receive lifesaving medical care and treatment and help reduce their risk of transmitting HIV. Sexually transmitted diseases (STDs) and hepatitis C (HCV) play a major role in increasing an individual's risk of acquiring and transmitting HIV or developing complications of HIV.

While anyone can become infected, the HIV epidemic is concentrated in key populations and geographic areas. Therefore, testing should follow the epidemiological data of each region and should be cost-effective, scalable interventions that are prioritized in the communities where HIV is most concentrated. The following groups should be primary focus areas of all ITTS projects:

- Men Who Have Sex With Men of All Races and Ethnicities
- African American Women
- People Who Inject Drugs
- Commercial Sex Workers
- Transgender Persons

ITTS projects help to identify persons who are unaware of their HIV status and actively facilitate getting them into treatment and prevention services. They conduct HIV, STD and HCV counseling and testing in areas frequented by persons at high risk of these conditions. These projects ensure that clients testing positive are successfully linked to medical care and other services. They also actively follow-up and make referrals to local providers or Regional Networks of Care and Prevention Coordinators that routinely make calls to providers, arrange transportation and/or provide other support. ITTS projects are required to offer

HIV and syphilis screenings but preference is given to projects that also screen for hepatitis C, gonorrhea and chlamydia.

ITTS projects reach men who have sex with men of all races and ethnicities, racial and ethnic minorities, people who inject drugs, commercial sex workers, transgender persons, people living with HIV/AIDS that are unaware of their status, as well as other at-risk priority groups. Testing is offered in public parks, on street corners, and at other community settings or at fixed testing sites including homeless shelters, jails, drug treatment centers, migrant health centers, mental health facilities, nightclubs and colleges. Testing is offered at hours and locations that are accessible to persons at highest risk for HIV.

ITTS projects integrate social media into testing activities to help spread key messages and increase awareness and access to testing services by key priority groups. Social media helps to reach people when, where and how they want to receive health messages. Projects integrate social media into health campaigns to utilize trends and expand health messages on websites, downloadable applications, SMS text messaging, Facebook, YouTube, Twitter and/or other social media tools to disseminate health messages.

Applicants of Program Area ONE, Integrated Targeted Testing Services (ITTS), must adhere to the following requirements:

1. Applicants must offer HIV and syphilis counseling, testing and referral services at hours and locations that are accessible to persons at highest risk. Applicants are strongly encouraged to offer hepatitis C testing to people who inject drugs or have a history of injecting drugs. Applicants are also encouraged to test for gonorrhea and chlamydia, when appropriate.
2. Applicants must offer testing services to key priority groups including men who have sex with men of all races and ethnicities with an emphasis on young African American MSM, African American women, people who inject drugs, commercial sex workers and transgender persons. Note: 25% of your total tests should be among young African American MSM.
3. Applicants must have a plan in place for targeting the MSM population as well as other key priority groups. The plan should utilize appropriate interventions and/or strategies to reach the target populations, with consideration given to potential testing venues/locations frequented by key priority groups in the community.
4. Applicants must develop strategies to reduce barriers to testing and address health inequities among key groups disproportionately affected by the HIV epidemic.
5. Applicants are encouraged, but not required, to have a social marketing program to enhance testing services and increase awareness of and access to services by key priority groups. Note: 70% of social marketing funds and activities should focus on African American MSM.
 - a. Applicants must demonstrate strategies to recruit members of the key priority groups for testing. These include those at greatest risk for HIV infection and who are unaware of their HIV status.

- b. Applicants should plan and implement a social marketing program which will enhance counseling, testing, and referral services and will increase awareness of and access to these services by young African American MSM.

Applicants should review www.effectiveinterventions.org for examples as follows: a. integrating social media into health campaigns utilizing trends in social media; b. expanding mobile health to include information on mobile websites, downloadable applications and SMS text messaging; and c. utilizing Facebook, YouTube, Twitter and/or other social media tools to disseminate health messages.

6. Applicants must review CDC's Planning and Implementing HIV Testing and Linkage Programs in Non-Clinical Settings: A Guide for Program Managers at www.effectiveinterventions.org to support planning, implementation, and evaluation of HIV testing and linkage services in non-clinical settings.
7. Applicants must offer testing services and identify testing venues that are supported by local and statewide epidemiologic data and Disease Intervention Specialist (DIS).
8. Applicants must complete the Projection Report in **Appendix 25: Projection Report** to establish their annual testing objectives.
9. Applicants must have a Letter of Support from each local health department where services will be offered. All HIV/STD counseling and testing should be conducted with the approval of the local health department in the county where the activities are to occur.
10. Applicants must have a Memorandum of Agreement (MOA) from each established site in which agency/ies intend to conduct testing, condom distribution and linkage activities. Each MOA should describe the specific collaborative activities and commitment of the agency/ies. **See Appendix 16: Sample Memorandum of Agreement (MOA)**
11. Applicants must arrange for physician oversight of their testing program and submit a copy of their Physician's Standing Orders.
12. Applicants must follow the current CDC HIV testing guidelines at <http://www.cdc.gov/hiv/guidelines/testing.html>. Staff providing these services must attend the Branch sponsored HIV CTR Training. Branch staff will be allowed to observe sessions during site visits (with the consent of the client.)
13. Applicants must offer HIV counseling and testing on a voluntary basis that includes informed consent. Informed consent should include why agency is offering HIV testing; agency's commitment to confidentiality and how it will be maintained; how specimens will be handled and processed; and how and when clients will receive their test results. In addition, clients should be required to sign an Informed Patient Consent Form to do HIV testing. A general consent form may be used if HIV testing is offered as part of routine laboratory testing panels as long as the patient is notified that they are being tested for HIV and are given the opportunity to refuse.
14. Applicants must have a plan for post-test counseling. NC law mandates that post-test counseling for persons infected with HIV is required, must be individualized, and shall include referrals for medical and psychosocial

services and N.C. Communicable Disease Control Measures. A physician can delegate the post-test counseling responsibility to agency staff that have attended the Branch sponsored HIV CTR training.

15. Applicants must have a plan in place for ensuring that confirmed positive laboratory results for HIV and other STDs are reported to the local health department. They must have a system for follow-up of positive HIV or syphilis clients to Disease Intervention Specialists (DIS) listed in **Appendix 5: NC Branch Regional Offices** for partner notification, referrals, and linkage to HIV care and treatment, and review of Communicable Disease Control Measures.
16. Applicants must have a system in place to collect, document and track referral activities that will include the number of HIV-positive clients “actively” referred and the number of clients that complete an initial visit with a HIV care provider. If State Bridge Counselors facilitate these activities, agency must have a plan by which they will work with Bridge Counselors to ensure that newly diagnosed HIV-positive clients will be bridged to their first medical appointment. MOAs must be established with HIV Regional Network of Care and Prevention providers.
17. Applicants offering hepatitis C screening must have a system for active referral and follow up of newly identified hepatitis C positive individuals. They must document and track referral activities that include the number of hepatitis C clients “actively” referred. They must have a plan in which they will work with their local/regional providers to bridge newly identified hepatitis C clients to their first medical appointment. MOAs with applicant’s local/regional provider will be required.
18. Applicants are encouraged to identify any needle exchange programs in their service areas and work with these programs to ensure that HIV/STD and HCV counseling, testing and linkage to care/treatment occur. Agencies should develop MOAs with any needle exchange programs that they work with outlining the services that the HIV/STD prevention agency will provide.
19. Applicants must have a current resource list that includes information about available services in the community. Referral services should include HIV care, comprehensive risk reduction services; STD screening and treatment; viral hepatitis testing, treatment and vaccination; tuberculosis testing and treatment; substance abuse counseling and treatment; mental health and addiction treatment services; family planning; and domestic abuse services.
20. Applicants must have a Pre-Exposure Prophylaxis (PrEP) plan. This plan should include the referral process of HIV-negative clients for HIV antiretroviral (ARV) drugs to reduce their risk of becoming infected with HIV, appropriate referral tracking tools and a list of PrEP providers.
21. Applicants must develop a Condom Distribution Program. This plan should utilize appropriate tracking tools to address CDC’s requirements as follows: target population demographics, venues/locations, total number of condoms distributed to high-risk negative individuals and individuals with unknown HIV status, total number of condoms distributed to HIV-positive individuals and total number of condoms distributed overall.

22. Applicants must have a quality improvement plan that focuses on who, what, when and how evaluations will be conducted in order to examine areas for improvement. The quality improvement plan should utilize appropriate assessment tools to address site productivity, client satisfaction surveys, staff development and training needs, record review, referral tracking and data collection process.
23. Applicants must accurately complete required medical records, lab records and risk assessments. Applicants must develop a mechanism to collect, track and report required HIV testing data in accordance with the guidelines established by the state and CDC data requirements. All records related to the performance of the contract will be maintained according to the contract guidelines.
24. Applicants must maintain all programmatic and fiscal records pertaining to the performance of the agency and contract guidelines. Applicants will be required to submit annual projection reports, quarterly progress reports, monthly activity calendars and other required documents to the Branch by stated guidelines.
25. Applicants must adopt a written confidentiality policy and ensure all staff are trained and support the policies. They must also have a data release policy and ensure physical security of patient information.
26. Applicants must have a testing policy and procedure manual in place by the end of the first quarter of the funding cycle to address the areas listed in **Appendix 6: Testing Policy and Procedure Manual.**

PROGRAM AREA TWO

Counseling, Testing and Referral in Substance Abuse Centers (SAC)

The CTR in Substance Abuse Centers project was developed in response to a mandate from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to support HIV prevention activities among substance abusers. As one of the partners with CDC, all applicants should be pursuing a High-Impact Prevention approach to advance the goals of the NHAS and maximize the effectiveness of current HIV prevention methods. This approach centers on using combinations of scientifically proven, cost effective and scalable interventions/activities targeted to substance abusers; this approach promises to increase the impact of HIV prevention efforts.

The purpose of the SAC project is to provide HIV/STD counseling, testing, and referral services for substance abusers at the locations where they are receiving their substance abuse treatment services. This initiative is aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing HIV prevention services for those with a diagnosis of HIV infection.

Applicants of Program Area TWO, CTR in Substance Abuse Centers (SAC), must adhere to the following requirements:

1. Applicants must offer HIV and syphilis counseling, testing and referral services in substance abuse centers at accessible hours and to persons undergoing substance abuse treatment. Applicants are strongly

- encouraged to offer hepatitis C testing to people who inject drugs or have a history of injecting drugs. Applicants are also encouraged to test for gonorrhea and chlamydia, when appropriate.
2. Applicants must review CDC's Planning and Implementing HIV Testing and Linkage Programs in Non-Clinical Settings: A Guide for Program Managers at www.effectiveinterventions.org to support planning, implementation, and evaluation of HIV testing and linkage services in non-clinical settings.
 3. Applicants must offer testing services and identify testing venues that are supported by local and statewide epidemiologic data and Disease Intervention Specialist (DIS).
 4. Applicants must complete the Projection Report in **Appendix 25: Projection Report** to establish their annual testing objectives.
 5. Applicants must have a Letter of Support from each local health department where services will be offered. All HIV/STD counseling and testing should be conducted with the approval of the local health department in the county where the activities are to occur.
 6. Applicants must have a Memorandum of Agreement (MOA) from each established site in which agency/ies intend to conduct testing, condom distribution and linkage activities. Each MOA should describe the specific collaborative activities and commitment of the agency/ies, **See Appendix 16: Sample Memorandum of Agreement (MOA)**
 7. Applicants must arrange for physician oversight of their testing program and submit a copy of their Physician's Standing Orders.
 8. Applicants must follow the current CDC HIV testing guidelines at <http://www.cdc.gov/hiv/guidelines/testing.html>. Staff providing these services must attend the Branch sponsored HIV CTR Training. Branch staff will be allowed to observe sessions during site visits (with the consent of the client.)
 9. Applicants must offer HIV counseling and testing on a voluntary basis that includes informed consent. Informed consent should include why agency is offering HIV testing; agency's commitment to confidentiality and how it will be maintained; how specimens will be handled and processed; and how and when clients will receive their test results. In addition, clients should be required to sign an Informed Patient Consent Form to do HIV testing. A general consent form may be used if HIV testing is offered as part of routine laboratory testing panels as long as the patient is notified that they are being tested for HIV and are given the opportunity to refuse.
 10. Applicants must have a plan for post-test counseling. NC law mandates that post-test counseling for persons infected with HIV is required, must be individualized, and shall include referrals for medical and psychosocial services and N.C. Communicable Disease Control Measures. A physician can delegate the post-test counseling responsibility to agency staff that have attended the Branch approved Counseling, Testing and Referral (CTR) training.
 11. Applicants must have a plan in place for ensuring that confirmed positive laboratory results for HIV and other STDs are reported to the local health department. They must have a system for follow-up of positive HIV or syphilis clients to Disease Intervention Specialists (DIS) listed in **Appendix 5: NC Branch Regional Offices** for partner notification, referrals, and linkage to HIV care and treatment, and review of Communicable Disease Control Measures.
 12. Applicants must have a system in place to collect, document and track referral activities that will include the number of HIV-positive clients

- “actively” referred and the number of clients that complete an initial visit with a HIV care provider. If State bridge counselors facilitate these activities, agency must have a plan by which they will work with Bridge Counselors to ensure that newly diagnosed HIV-positive clients will be bridged to their first medical appointment. MOAs must be established with HIV Regional Network of Care and Prevention providers.
13. Applicants offering hepatitis C screening must have a system for active referral and follow up of newly identified hepatitis C positive individuals. They must document and track referral activities that include the number of hepatitis C clients “actively” referred. They must have a plan in which they will work with their local/regional providers to bridge newly identified hepatitis C clients to their first medical appointment. MOAs with applicant’s local/regional provider will be required.
 14. Applicants must have a current resource list that includes information about available services in the community. Referral services should include HIV care, comprehensive risk reduction services, STD screening and treatment, viral hepatitis testing, treatment and vaccination, tuberculosis testing and treatment, substance abuse counseling and treatment, mental health and addiction treatment services, family planning, and domestic abuse services.
 15. Applicants must have a Pre-Exposure Prophylaxis (PrEP) plan. This plan should include the referral process of HIV-negative clients for HIV antiretroviral (ARV) drugs to reduce their risk of becoming infected with HIV, appropriate referral tracking tools and a list of PrEP providers.
 16. Applicants must develop a Condom Distribution Program. This plan should utilize appropriate tracking tools to address CDC’s requirements as follows: target population demographics, venues/locations, total number of condoms distributed to high-risk negative individuals and individuals with unknown HIV status, total number of condoms distributed to HIV-positive individuals and total number of condoms distributed overall.
 17. Applicants must have a quality improvement plan that focuses on who, what, when and how evaluations will be conducted in order to examine areas for improvement. The quality improvement plan should utilize appropriate assessment tools to address site productivity, client satisfaction surveys, staff development and training needs, record review, referral tracking and data collection process.
 18. Applicants must accurately complete required medical records, lab records and risk assessments. Applicants must develop a mechanism to collect, track and report required HIV testing data in accordance with the guidelines established by the state and CDC data requirements. All records related to the performance of the contract will be maintained according to the contract guidelines.
 19. Applicants must maintain all programmatic and fiscal records pertaining to the performance of the agency and contract guidelines. Applicants will be required to submit annual projection reports, quarterly progress reports, monthly activity calendars and other required documents to the Branch by stated guidelines.
 20. Applicants must adopt a written confidentiality policy and ensure all staff are trained and support the policies. They must also have a data release policy and ensure physical security of patient information.
 21. Applicants must have a testing policy and procedure manual in place by the end of the first quarter of the funding cycle to address the areas listed in **Appendix 6: Testing Policy and Procedure Manual.**

PROGRAM AREA THREE

Prevention with Positives (PWP)

The goal of Prevention with Positives is to increase access to care and improve health outcomes for people living with HIV (PLWH.) Activities should be directed to persons living with HIV. As noted in CDC's High-Impact HIV Prevention, PLWH should be a priority population. The Branch will fund Prevention with Positive activities conducted by community-based organizations (CBOs) and local health departments (LHDs). Preference will be given to applicants that include evidence based interventions or public health strategies listed in **Appendix 4: Diffusion of Effective Behavioral Interventions (DEBI) and Public Health Strategies** (www.effectiveinterventions.org). Specific interventions or strategies should be identified and thoroughly described for these populations. Applicants may also propose other public health strategies that reach the priority target populations. Applicants may implement multiple programs or interventions; however, the application must clearly demonstrate which intervention is the primary focus. In order for HIV prevention efforts to work, people who are living with HIV need to have access to effective prevention tools. In particular, research has shown that increasing the availability of condoms is associated with reductions in HIV risk. Applicants should integrate targeted condom distribution activities into prevention with positive program for PLWH.

All proposed programs must be culturally, linguistically, and developmentally appropriate for the target population. These funds are not intended for one-time activities or events, but to provide on-going risk reduction interventions with specific target populations, as described in this RFA.

Applicants of Program Area THREE (Prevention with Positives), must adhere to the following requirements:

1. Prevention with Positive services must be offered at accessible hours and locations to Persons Living with HIV (PLWH).
2. Applicants conducting Effective Behavioral Interventions (EBIs) and other public health strategies must maintain the fidelity of the intervention and follow CDC guidelines and protocols. Staff providing CDC Diffusion of Effective Behavioral Interventions must attend the official trainings offered by a CDC designated capacity building agency. Branch staff will be allowed to observe intervention sessions during site visits (with the consent of the client.)
3. Applicants must have a current resource list that includes information about available services in the community. Referral services may also be provided directly by the applicant. Referral services should include HIV care; comprehensive risk reduction services; STD screening and treatment; viral hepatitis testing, treatment and vaccination; tuberculosis testing and treatment; substance abuse counseling and treatment; mental health services; family planning; and domestic/sexual abuse services. If they are unavailable from the applicant, clients must be "actively" referred to other area organizations with which the agency has established relationships. These relationships must be defined in a Memorandum of Agreement

(MOA). Any such MOA becomes a part of the contractual agreement with the Branch. Referrals must make all efforts to preserve client confidentiality as provided in North Carolina General Statutes 130A-143.

4. Applicants must have a Memorandum of Agreement (MOA) from each established site in which agency/ies intend to conduct PWP, condom distribution and linkage activities. Each MOA should describe the specific collaborative activities and commitment of the agency/ies,
5. Applicants are encouraged to integrate STD testing activities into PWP programs.
6. Applicants must recruit clients from locations where PLWH frequent, such as ID clinics, AIDS Service Organizations (ASOs), Federally Qualified Health Centers (FQHCs), health department clinics, etc.
7. Applicants must ensure clients are in care. A plan must be developed for clients that are not in care and included in the intervention protocols. Applicants must document and link clients that are not in care. Linkage activities must include the name of the provider, date client received medical services and any follow-up activities.
8. Applicants must develop a Condom Distribution Program. The plan should utilize appropriate tracking tools to address CDC's requirements as follows: target population, demographics, venues/locations, total number of condoms distributed to high-risk negative individuals and individuals with unknown HIV status, total number of condoms distributed to HIV-positive individuals and total number of condoms distributed overall.
9. Applicants must submit required reports (annual projection report, quarterly reports and monthly activity calendars) to the Branch by stated guidelines. Branch staff will provide technical assistance.
10. Applicants must accurately complete required records and provide timely input of client data in the WebBased Evaluation System.
11. Applicants must include a quality improvement plan that focuses on who, what, when and how evaluations will be conducted in order to examine areas for improvement. The quality improvement plan should utilize appropriate assessment tools to address site productivity, client satisfaction surveys, staff development and training needs, record review, referral tracking and data collection process.
12. Applicants must maintain all programmatic and fiscal records pertaining to the performance of the agency and contract guidelines. Applicants will be required to submit annual projection reports, quarterly progress reports, monthly activity calendars and other required documents to the Branch by stated guidelines.
13. Applicants must adopt a written confidentiality policy and ensure all staff are trained and support the policies. They must also have a data release policy and ensure physical security of patient information.
14. Applicants must have an intervention manual in place by the end of the first quarter of the funding cycle.

PROGRAM AREA FOUR

Ryan White Part B

Currently the Ryan White HIV/AIDS Program (RW) provides services to an estimated 536,000 people in the United States each year. The grant awards made under the Ryan White Program legislation are the “payer of last resort.” This means that the Ryan White HIV/AIDS Program grant funds may not be used for any item or service for which payment has been made, or can reasonably be expected to be made by any other payer.

Ryan White Part B is the state and territorial funding that is a part of the Ryan White legislation administered by the Health Resources and Services Administration. This legislation targets identifying people infected with HIV and linking them to HIV primary care with initiation and long-term maintenance of life-saving antiretroviral treatment (ART). These are important public health steps toward the elimination of HIV in the United States. The Continuum of HIV Care is a continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression. The Continuum of HIV Care includes the diagnosis of HIV, linkage to HIV medical care, lifelong retention in HIV medical care, appropriate prescription of ART, and ultimately HIV viral load suppression. Once this is accomplished those living with HIV are less likely to spread the virus. Services that are administered with RW Part B funds are necessary to those who are HIV positive and assist them in acquiring HIV viral load suppression that concludes the Continuum of HIV Care.

Applicants must describe how they will provide the following required services:

Core Medical Services:

- Outpatient/Ambulatory Health Services (including Treatment Adherence Counseling)
- Oral Health Care
- Mental Health Services
- Medical Case Management (including Treatment Adherence)
- Substance Abuse Services-outpatient
- Health Insurance Premium and Cost-Sharing Assistance

Support Services:

- Case Management (non-Medical)
- Medical Transportation Services

The above-listed Ryan White Part B Services do not have to be funded by Ryan White Part B funds. Other resources available within the network region can be utilized to provide these services, however all of the above must be available

Networks can provide the optional services (without an asterisk) listed in **Appendix 22: Ryan White and HOPWA Services List** based on the needs of clients and available resources in the geographic area covered by the network.

Definitions of Ryan White Part B Services are located in the HIV/AIDS Bureau, Division of State HIV/AIDS Programs National Monitoring Standards for Ryan White Part B Grantees:

<http://hab.hrsa.gov/manageyourgrant/files/programmonitoringpartb.pdf>.

Applicants should be prepared to comply with any subsequent revisions of this document released by HRSA/HAB.

Applicants of Program Area FOUR, Ryan White Part B, must adhere to the following requirements:

1. Core Medical and Support services shall be provided in accordance with:
 - a. Federal and State rules, regulations, and guidance for the Ryan White Part B HIV Care Program.
 - b. HIV/AIDS Bureau National Monitoring Standards: Universal, Program and Fiscal, posted at:
<http://hab.hrsa.gov/manageyourgrant/granteebasics.html>
 - c. The North Carolina Ryan White Part B Performance Requirements/Standards.
 - d. Policy Clarification Notices (PCNs) posted at:
<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>
2. At least 75% of all client service funds must be used for Core Medical Services. Up to 25% of client service funds can be used for Support Services. This does not mean that each of the Network agencies funded with Ryan White Part B funds must individually meet this requirement. The Network as a whole must meet this requirement.
3. Ensure that HIV-related health care and support services delivered with Ryan White Part B assistance are provided in a manner that makes them accessible to low-income individuals with HIV disease, without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual with HIV disease. Where individuals can afford to contribute, such contribution shall be in accord with applicable federal and/or state guidelines. Per The Ryan White HIV/AIDS Treatment Extension Act of 2009, the Contractor may not impose charges for service on any individual whose income is less than or equal to 100% of Federal Poverty Level (FPL). For all clients whose income exceeds 100% of FPL, the Contractor must impose charges on the client according to a schedule that is made available to the public. Limitations on such charges are as follows: for individuals whose income above 100% FPL but does not exceed 200% of FPL, calendar year charges may not exceed 5% of the individual's annual gross income; for individuals whose income is above 200% FPL but does not exceed 300% of FPL, calendar year charges may not exceed 7% of the individual's annual gross income; and for individuals whose income exceeds 300% of FPL, calendar year charges may not exceed 10% of the individual's annual gross income. The financial eligibility

cap for RW Part B participation is 300% FPL. Individuals between 301% and 500% FPL who were enrolled as of April 1, 2015 and do not miss subsequent reauthorizations every six months will remain eligible for Ryan White Part B services. Individuals with incomes above 500% FPL may not be served by the RW Part B program.

4. Ensure that HIV-related health care and support services are provided in a facility that meets the Americans with Disabilities Act (ADA) requirements and is accessible by public transportation. Ensure the provision of transportation assistance when the facility is not accessible by public transportation
5. Reach out assertively to underserved populations, especially low-income, minority, and non-English speaking persons, inform them of the services available under Ryan White Part B, and address the special care and service needs of the populations and subpopulations within the Network region including PWID and their partners, homeless people, women, children, youth, and men who have sex with men (MSM).
6. Up to 10% of the total amount of Ryan White Part B funds allocated to the Network can be budgeted for Administrative expenses. Note: Ryan White administrative expenses are based on total expenditures, not on allocated funds. For example, if an agency receives a total allocation of \$100,000, then 10% of that total can be budgeted for administrative costs. However, if the agency then expends only \$90,000 of the allocated funds, only 10% of the \$90,000 expended can be charged to administrative expenses (\$9,000). These costs include:
 - a. CAREWare data collection and data entry for the Ryan White Part B Program, and submission of the Ryan White HIV/AIDS Program Services Report (RSR) and Client Level Data (CLD).
 - b. Monitoring subcontracted providers.
 - c. Assuring the network adheres to all applicable federal and state regulations, policies and guidance and that all Ryan White Part B contractual obligations are fulfilled.
 - d. Compilation and submission of required Ryan White Part B fiscal and program reports.
 - e. Development, implementation, updating and maintenance of a Quality Management Plan and collecting/reporting quality management performance indicators.
7. Up to 10% of the Ryan White Part B allocation to the Network can be budgeted for Planning and Evaluation costs which is a required component. These costs include:
 - a. Coordinating the network, including convening and facilitating (at minimum) quarterly network meetings.
 - b. Conducting a network-wide needs assessment. This will need to be completed within the first year of the three-year funding cycle and updated the second and third year.
 - c. Coordinating network services throughout the region.
 - d. Developing and implementing/updating annually an evaluation plan for the network.

- e. Developing and annually reviewing/updating a grievance policy and procedures for the network.
 - f. Conducting an annual client satisfaction survey.
8. Obtain prior approval from HRSA through the AIDS Care Program (ACP) in order to use Ryan White Part B funds for purchase of vehicles.
 9. Ensure that Ryan White Part B funds will not be used for any of the following unallowable costs:
 - a. Purchase or improve land, or to purchase, construct, or permanently improve any building or other facility
 - b. Make cash payments to recipients of services
 - c. Fund programs or develop materials designed to directly promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual
 - d. Support Syringe Services programs inclusive of syringe exchange, access and disposal
 - e. Purchase clothing
 - f. Pay for employment readiness assistance
 - g. Pay for funeral, burial, cremation or related expenses
 - h. Legal services related to criminal defense and class action suits not related to HIV-related purposes
 - i. Maintenance or any other costs associated with a privately owned vehicle (except those of an organizational entity whose purpose is to transport HIV-infected individuals)
 - j. Payment of local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied)
 - k. Purchase of household appliances
 - l. Purchase of pet foods or other non-essential products
 - m. Payment for off-premise social/recreational activities or payments for a client's gym membership
 - n. Pre and post-exposure prophylaxis
 - o. Outreach programs which have HIV prevention education as their exclusive purpose
 - p. Broad-scope awareness activities about HIV services that target the general public
 - q. Payments for any item or service to the extent that payment has been made or could reasonably be expected to be made for that item or service under any State compensation program, under an insurance policy, or under any Federal or State health benefits program (or by an entity that provides health services on a prepaid basis except for a program administered by or providing the services of the Indian Health Service)
 - r. Payment of inpatient hospital services, nursing home or other long-term care facilities
 - s. Costs associated with creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools) or to

- pay any amount expended by the State under the Title XIX of the Social Security Act (Medicaid)
- t. Lobbying activities for the purpose of influencing or attempting to influence members of Congress and other Federal personnel
 - u. Foreign Travel
10. Assure that Ryan White funds are used as “funds of last resort” in supporting HIV-related outpatient services and that all other funding sources are vigorously pursued and utilized before Ryan White, including, but not limited to, Medicaid, Medicare, (including the Part D prescription benefit), pre-paid health plans, private insurance (including medical, drug, dental, and vision benefits), State Children’s Health Insurance Programs (SCHIP), Affordable Care Act Insurance plans, and all other types of public and private assistance. Establish and consistently implement billing and collection policies and procedures, electronic or manual systems to bill third party payers and an accounts receivable system for tracking charges and payments for third party payers. Document participation in Medicaid and provider certification to receive Medicaid payments, or if Medicaid certification does not exist, document current efforts to obtain certification. Maintain a file of contracts with Medicaid insurance companies. Document billing and collection of program income and report program income documented by charges, collections, and adjustment reports or by the application of a revenue collection formula. Any program income received shall be used within the Part B program only. For those clients who are veterans, all efforts should be made to encourage their participation in the Veteran’s Administration (VA) system; however, Ryan White Part B assistance cannot be denied if that individual chooses not to receive services from the VA. For those clients who are American Indians or Alaska Natives, all efforts should be made to encourage their participation in the Indian Health Service (IHS) system; however, Ryan White Part B assistance cannot be denied if that individual chooses not to receive services from the IHS.
 11. Maintain relationships with entities in the Network region that constitute key points of access to the health care system for individuals with HIV/AIDS (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, STD clinics, HIV counseling and testing sites, mental health programs, homeless shelters, HIV prevention providers, MSM task forces, Federally Qualified Health Centers, Ryan White Part A, C, D and F grantees), for the purpose of facilitating early intervention for individuals newly diagnosed with HIV/AIDS and individuals knowledgeable of their HIV status but not in care.
 12. Cooperate with any federal and/or state investigations regarding the Part B program when necessary.
 13. Implement all HRSA/HAB Quality Improvement Performance measures required by the State Ryan White Part B Program.
 14. Utilize performance measures data in the development and implementation of Network-wide quality improvement projects.

15. Actively participate in the NC Regional Quality Council and conduct agreed-upon quality projects within the Network.
16. Utilize health outcome data to facilitate improved health outcomes of clients served by the Network.
17. Provide updates of Network Quality Improvement activities in quarterly reports and other reports as required to the ACP.
18. Include information of consumer involvement in the Quality Improvement activities of the Network.
19. Provide all medical and/or dental care services in accordance with applicable Federal guidelines found at: <http://aidsinfo.nih.gov/guidelines>.

PROGRAM AREA FIVE

Housing Opportunities for Persons with AIDS (HOPWA)

The goals of the North Carolina HOPWA program are to provide decent and affordable housing, suitable living environment and to expand economic opportunity. The North Carolina HOPWA program's intent is to also assist clients in achieving and maintaining housing stability in order to avoid/reduce homelessness and improve access to, and engagement in, HIV care and treatment. HOPWA is designed to promote client housing stability and to bridge participants to long-term assistance programs, such as Section 8, or to self-sufficiency (when a client's health and financial situation allows him/her to maintain suitable housing without HOPWA or other financial assistance.) The HOPWA program is needs-based and is not an entitlement program. Participation in HOPWA is voluntary and conditional.

HOPWA funding is provided annually through the Department of Housing and Urban Development (HUD). Client assistance is subject to continued availability of funds.

All 10 Regional Networks of Care are required to provide the following NC HOPWA Eligible Activities:

- Tenant-Based Rental Assistance (TBRA), and
- Short-Term Rent, Mortgage, and Utility Assistance (STRMU).

In addition to TBRA and STRMU, many of our HOPWA Project Sponsors also provide the following optional NC HOPWA Eligible Activities based upon regional need and resources:

- Permanent Housing Placement (PHP)
- Supportive Services (SS),
- Housing Information (HI),
- Resource Identification (RI), and
- Operating Costs for Licensed Facilities (OC-LF).

HOPWA and Fair Housing Laws and Affirmatively Furthering Fair Housing

The State of North Carolina's HOPWA Program ensures access to the HOPWA program by maintaining full compliance with The Fair Housing Laws: Fair Housing Act Title VIII of the Civil Rights Act of 1968 (Fair Housing Act), as amended, which

prohibits discrimination in the sale, rental, and financing of dwellings, and in other housing-related transactions, based on race, color, national origin, religion, sex, familial status (including children under the age of 18 living with parents or legal custodians, pregnant women, and people securing custody of children under the age of 18), and disability.

Fair housing laws are civil rights laws that apply to housing. All housing providers, whether they are in the private, public or nonprofit housing sector, are required to follow fair housing laws. These laws cover the entire relationship between a housing provider and an applicant/resident/tenant from the time of the initial inquiry, through application and residency, to termination and move-out. During that time, any transaction or interaction can give rise to a claim of discrimination. Additionally, housing providers have an affirmative responsibility under the Fair Housing Act to help their disabled applicants or residents overcome barriers to obtaining or maintaining housing.

The NC HOPWA Grantee and its Sub-recipients shall Affirmatively Further Fair Housing by taking meaningful actions, in addition to combating discrimination, that overcome patterns of segregation and foster inclusive communities free from barriers that restrict access to opportunity based on protected characteristics. Specifically, affirmatively furthering fair housing means to take meaningful actions that, taken together, address significant disparities in housing needs and in access to opportunity, replacing segregated living patterns with truly integrated and balanced living patterns, transforming racially and ethnically concentrated areas of poverty into areas of opportunity, and fostering and maintaining compliance with civil rights and fair housing laws.

Applicants of Program Area FIVE, Housing Opportunities for Persons with AIDS, must adhere to the following requirements:

1. HOPWA services shall be provided in accordance with:
 - a. HUD Code of Federal Regulations, 24 CFR, Part 574 for Housing Opportunities for Persons with AIDS posted at: www.hudexchange.info/resource/2936/24-cfr-part-574
 - b. State rules, regulations and guidance for the HOPWA program.
2. Ensure that HOPWA funds are used to leverage other housing related programs including, but not limited to, Section 811, HOME Investment Funds, and other housing resources identified by local Continuums of Care, Ryan White and all other types of public and private assistance.
3. Ensure that under totally favorable conditions, housing is made available within two weeks of client eligibility determination to all eligible clients seeking stable housing. In the event that housing cannot be made available within two weeks, clients shall be placed on a waiting list and receive help identifying other potential housing resources.
4. Ensure that all eligible clients receiving HOPWA services have access to a case manager.
5. Ensure that all eligible clients receiving Tenant Based Rental Assistance (TBRA), Short-Term Rent, Mortgage and Utility Assistance (STRMU) and

Supportive Services have a Housing Care Plan documenting goals and activities to maintain stable housing.

6. Up to 7% of the total amount of HOPWA funds allocated to the Network can be budgeted for Administrative expenses. These costs include:
 - a. CAREWare data collection and data entry for the HOPWA program.
 - b. Monitoring subcontracted providers.
 - c. Assuring the Network adheres to all applicable federal and state regulations, policies and guidance and that all HOPWA contractual obligations are met.
 - d. Participation in the creation and maintenance of the Network Quality Management Plan.
 - e. Compilation and submission of required HOPWA fiscal and program reports.
7. Ensure delineation of Program Costs for all HOPWA eligible activities. Program Costs shall be reflected as staff time spent delivering the service.

IV. GENERAL INFORMATION ON SUBMITTING APPLICATIONS

1. Award or Rejection

All qualified applications will be evaluated and an award will be made to that agency or organization whose combination of budget and service capabilities are deemed to be in the best interest of the funding agency (Communicable Disease Branch). The funding agency reserves the unqualified right to approve all final plans and funded agencies, and reject any or all offers if determined to be in its best interest. Successful applicants will be notified by **November 17, 2016**.

2. Decline to Offer – Not Applicable

Any agency or organization that receives a copy of the RFA but declines to make an offer is requested to send a written “Decline to Offer” to the funding agency. Failure to respond as requested may subject the agency or organization to removal from consideration of future RFAs. Email Decline is acceptable.

3. Cost of Application Preparation

Any cost incurred by an agency or organization in preparing or submitting an application is the agency's or organization's sole responsibility; the funding agency will not reimburse any agency or organization for any pre-award costs incurred.

4. Elaborate Applications

Elaborate applications in the form of brochures or other presentations beyond that necessary to present a complete and effective application are not desired.

5. Oral Explanations

Funding agency will not be bound by oral explanations or instructions given at any time during the competitive process or after awarding the

grant.

6. Reference to Other Data

Only information that is received in response to this RFA will be evaluated; reference to information previously submitted will not suffice.

7. Titles

Titles and headings in this RFA and any subsequent RFA are for convenience only and shall have no binding force or effect.

8. Form of Application

Each application must be submitted on the form provided by the funding agency, and will be incorporated into the funding agency's Performance Agreement (contract).

9. Exceptions

All applications are subject to the terms and conditions outlined herein. All responses will be controlled by such terms and conditions. The attachment of other terms and conditions by any agency and organization may be grounds for rejection of that agency or organization's application. Contractors specifically agree to the conditions set forth in the Performance Agreement (contract).

10. Advertising

In submitting its application, applicants agree not to use the results from or as part of any news release or commercial advertising without prior written approval of the funding agency.

11. Right to Submitted Material

All responses, inquiries, or correspondence relating to or in reference to the RFA, and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by the agency or organization will become the property of the funding agency when received.

12. Competitive Offer

Pursuant to the provision of G.S. 143-54, and under penalty of perjury, the signer of any application submitted in response to this RFA thereby certifies that this application has not been arrived at collusively or otherwise in violation of either Federal or North Carolina antitrust laws.

13. Agency and Organization's Representative

Each agency or organization shall submit with its application the name, address, and telephone number of the person(s) with authority to bind the agency or organization and answer questions or provide clarification concerning the application.

14. Subcontracting

Applicants may propose to subcontract portions of work provided that their applications clearly indicate the scope of the work to be subcontracted, and to whom. All information required about the prime grantee is also required for each proposed subcontractor.

15. Proprietary Information

Trade secrets or similar proprietary data which the agency or organization does not wish disclosed to other than personnel involved in the evaluation will be kept confidential to the extent permitted by NCAC TO1: 05B.1501 and G.S. 132-1.3 if identified as follows: Each page shall be identified in boldface at the top and bottom as "CONFIDENTIAL." Any section of the application that is to remain confidential shall also be so marked in boldface on the title page of that section.

16. Participation Encouraged

Pursuant to Article 3 and 3C, Chapter 143 of the North Carolina General Statutes and Executive Order No. 77, the funding agency invites and encourages participation in this RFA by businesses owned by minorities, women and the disabled including utilization as subcontractor(s) to perform functions under this Request for Applications.

17. Contract

The Division will issue a contract to the recipient of the RFA funding. Expenditures can begin immediately upon receipt of a completely signed contract.

V. APPLICATION PROCUREMENT PROCESS AND APPLICATION REVIEW

The following is a general description of the process by which applicants will be selected for funding for this project.

1. Announcement and Distribution of the Request for Applications (RFA)

The announcement of the RFA and instructions for receiving the RFA are being sent to prospective and interested applicants via email and will be posted on the HIV/STD Prevention and Care website on **August 2, 2016**: <http://epi.publichealth.nc.gov/cd/stds/program.html>.

2. Bidders' Conference/Teleconference/Question & Answer Period

All prospective applicants are encouraged to attend a Bidders Conference on **August 17, 2016** from 9:30 am – 1:00 pm in the McKimmon Conference and Training Center, Raleigh, North Carolina. The purpose of the conference is to provide an overview of the RFA and to answer any questions that are raised by potential applicants. Attendance at the RFA Bidders Conference is not required, but is highly encouraged.

Pre-registration is required and should be faxed to 919-733-2054 or e-mailed to Prevention.Care.RFA@dhhs.nc.gov by **August 10, 2016**. Please limit attendance to two (2) representatives per program area. Registration forms should be e-mailed to the address above or faxed to 919-733-2054. Please note: lunch is not included.

All questions regarding preparation of the application must be submitted by e-mail to Prevention.Care.RFA@dhhs.nc.gov by the close of business (5:00 pm) on **August 24, 2016**. Answers will be provided to the inquiring agency and posted on the Branch website at: <http://epi.publichealth.nc.gov/cd/stds/program.html> on **September 8, 2016**. Questions received after the specified deadline will be disregarded. No phone calls will be accepted.

3. Applications

Applicants shall submit one original unbound application and two unbound copies. All three copies shall include the required attachments. Documents may be secured with binder clips or rubber bands. In addition, applicants shall submit an electronic version of the application, line item budget(s) and budget narrative(s) as e-mail attachments to Prevention.Care.RFA@dhhs.nc.gov. Electronic submission of an application will not be accepted in lieu of an original. Faxed applications will not be accepted. Both hard copies and email submission must be submitted by **October 3, 2016** at 5:00 pm. The original application must contain original documents and all signatures in the original application must be original. Mechanical, copied, or stamped signatures are not acceptable. The original application should be clearly marked "Original" on the application face sheet.

4. Format

Applications must be typed, double-spaced using 12 point Times New Roman font on 8 ½ x 11" paper with 1" margins.

5. Space Allowance

Pages must be numbered throughout not to exceed 125 pages. This page limit does not include required attachments.

6. Application Deadline

All applications must be received by the HIV/STD Prevention and AIDS Care Programs by the date and time on the cover sheet of this RFA by **5:00 pm on October 3, 2016**. Faxed or e-mailed applications **will not** be accepted in lieu of the original and required number of hard copies. Late applications will be removed from consideration. Original signatures are required. Note: If the US Postal Service is used, allow sufficient time for delivery to the Branch **by 5:00 pm on October 3, 2016**.

7. Receipt of Applications

Applications from each responding agency and organization will be stamped with the date received on the cover sheet.

8. Review of Applications

Applications will be evaluated by a committee according to completeness, content, experience with similar projects, ability of the agency's or organization's staff, cost, etc. The award of a grant to one agency and organization does not mean that the other applications lacked merit, but that, all facts considered, the selected applications were deemed capable to provide the best services to the State.

Applications submitted in response to this notice will be reviewed in two steps: first, to determine whether the necessary requirements have been included and second, to determine the technical merit of the applications and the extent to which they meet the goals and intent of the RFA. Applicants will be advised of selection decisions by **November 17, 2016**.

Applicants are cautioned that this is a request for applications, and the funding agency reserves the unqualified right to reject any and all applications when such rejections are deemed to be in the best interest of the funding agency.

9. Request of Additional Information

At their option, the application reviewers may request additional information from any or all applicants for the purpose of clarification or to amplify the materials presented in any part of the application. However, applicants are cautioned that the reviewers are not required to request clarification: therefore, all applications should be complete and reflect the most favorable terms available from the agency or organization.

10. Audit

Please be advised that successful applicants may be required to have an audit in accordance with G.S. 143C-6-22 and G.S. 143C-6-23 as applicable to the agency's status.

11. Assurances

The contract may include assurances that the successful applicant would be required to execute prior to receiving a contract as well as when signing the contract.

12. Additional Documentation Required with Application

All applicants are required to include documentation of their tax identification number.

Those applicants which are private non-profit agencies are to include a copy of an IRS determination letter regarding the agency's 501(c)(3) tax-

exempt status. (This letter normally includes the agency's tax identification number, so it would also satisfy that documentation requirement.)

In addition, those private non-profit agencies are to provide a completed, signed, and notarized page verifying continued existence of the agency's 501(c)(3) status. See **Appendix 12: Notarized Statement of Continued 501 (c) (3) Status.**

13. Federal Certifications

Applicants receiving Federal funds through this RFA are required to execute Federal Certifications regarding Non-discrimination, Drug-Free Workplace, Environmental Tobacco Smoke, Debarment, Lobbying, and Lobbying Activities. A copy of the Federal Certifications is included in this RFA for your reference in **Appendix 8: Federal Certifications.** Federal Certifications should NOT be signed or returned with application.

14. Additional Documentation Prior to Contract Execution

Contracts require more documentation prior to contract execution. After the award announcement, contractors will be contacted about providing the following documentation:

- a. A completed and signed letter from the agency's Board President/Chairperson identifying individuals as authorized to sign contracts. **A reference version appears in Appendix 9: Letter to Identify Individuals to Sign Contracts.**
- b. A completed and signed letter from the agency's Board President/Chairperson identifying individuals as authorized to sign expenditure reports. **A reference version appears in Appendix 10: Letter to Identify Individuals to Sign Expenditure Reports.**
- c. Documentation of the agency's DUNS number. Documentation consists of a copy of communication (such as a letter or email correspondence) from Dun & Bradstreet (D&B) which indicates the agency or organization's legal name, address, and DUNS number. In lieu of a document from D&B, a copy of the agency or organization's CCR record is acceptable.

If your agency does not have a DUNS number, please use the D&B online registration (<http://fedgov.dnb.com/webform>) to receive one free of charge (DUNS is the acronym for the Data Universal Numbering System developed and regulated by D&B).

Contracts with private non-profit agencies require additional documentation prior to contract execution. After the award announcement, private non-profit agencies will be contacted about providing the following documentation:

- a. A completed, signed, and notarized statement which includes the agency's Conflict of Interest Policy. **A reference version appears in Appendix 11: Notarized Statement and Conflict of Interest Policy.**

- b. A completed, signed, and notarized page certifying that the agency has no overdue tax debts. A reference version appears in **Appendix 13: No Overdue Tax Debts Certification.**

All grantees receiving funds through the State of North Carolina are required to execute Contractor Certifications Required by North Carolina Law. A copy of the certifications is included in this RFA for your reference. **See Appendix 14 Contractor Certifications.** Contractor Certifications should NOT be signed or returned with application.

Note: At the start of each calendar year, all contractors with current DPH contracts are required to update their contract documentation. These contractors will be contacted a few weeks prior to the due date and will be provided the necessary forms and instructions.

15. Registration with the Secretary of State

Private non-profit applicants must also be registered with the North Carolina Secretary of State to do business in North Carolina, or be willing to complete the registration process in conjunction with the execution of the contract documents. (See www.secretary.state.nc.us/corporations.)

16. Federal Funding Accountability and Transparency Act (FFATA) Data Reporting Requirement

The Contractor shall complete and submit to the Division, the Federal Funding Accountability and Transparency Act (FFATA) Data Reporting Requirement form within 10 State Business Days upon request by the Division when awarded \$25,000 or more in federal funds. **A reference version appears in Appendix 15: FFATA Form.**

17. Iran Divestment Act Certification of Eligibility

Pursuant to G.S. 147-86.59, any person identified as engaging in investment activities in Iran, determined by appearing on the Final Divestment List created by the State Treasurer pursuant to G.S. 147-86.58, is ineligible to contract with the State of North Carolina or any political subdivision of the State. The Iran Divestment Act of 2015, G.S. 147-86.55 et seq.* requires that each vendor, prior to contracting with the State certify that the vendor is not identified on the Final Divestment List of entities that the State Treasurer has determined engages in investment activities in Iran and that the vendor shall not utilize on any contract with the State agency any subcontractor that is identified on the Final Divestment List. The vendor must complete, sign, and return the under the Act for every contract and contract amendment. **A reference version appears in Appendix 26: Certification of Eligibility.**

18. System for Award Management Database (SAM)

All grantees receiving federal funds must have an active SAM record, or be willing to complete the registration process in conjunction with the award. [SAM](#)

[is the System for Award Management](#) database for the federal government, formerly known as Central Contractor Registration (CCR).

19. Application Process Summary Dates

8/2/16	Request for Applications distributed
8/10/16	Bidders Conference Pre-registration Deadline
8/17/16	Bidders Conference
8/24/16	Written inquiries due to Branch staff (via email)
9/8/16	Answers to Questions released to all applicants
10/3/16	Applications due to the HIV/STD Prevention and AIDS Care Programs by close of business (5:00 pm)
11/17/16	Awards announced
4/1/17 – 10/1/17	Contracts and Agreement Addenda begin

VI. APPLICATION EVALUATION CRITERIA

Applications can receive a maximum score of 18 and will be evaluated and scored based on the following criteria:

1. Description of the proposed Regional Network of Care and Prevention; and
2. Description of how activities of each of the five (5) Program Areas will be provided in the Network region.

Requirements for what must be included in the description of the Regional Network of Care and Prevention and the five (5) Program Areas can be found in **Section 3. APPLICANT'S RESPONSE.**

The description of the Regional Network of Care and Prevention and each of the five (5) Program Areas will be scored on a scale of 1 to 3 based on the scale below:

- 1 = Descriptions partially addressed (only some of the elements required for the Network description and five (5) Program Areas were addressed with minimal response).
- 2 = Descriptions were addressed (each element of the Network description and five (5) Program Areas were addressed with minimal response).
- 3 = Descriptions were addressed (each element of the Network description and five (5) Program Areas were addressed with detailed response).

Each budget and budget narrative will be reviewed to ensure compliance with applicable program requirements, but will not be scored.

a. Preliminary Screening

Applications will be screened for completeness and compliance with the requirements specified in the RFA Application Checklist. **See Section VII. 1. Application Checklist.** Applicants who fail to follow instructions or to include all essential elements will be deemed incomplete and removed from further review. In addition, applicants with long-standing, significant unresolved issues in current or prior year contracts with the State of North Carolina may be removed from consideration for additional funding.

b. Review and Selection Process

The HIV/STD Prevention and AIDS Care programs will facilitate an independent review panel of appropriate staff and experts including HIV-related providers, government staff, and other professionals in the field of community and minority health education. All reviewers will demonstrate their lack of conflicts of interest and adherence to confidentiality of information shared in the review sessions. Completed applications will be reviewed for technical merit.

Recommendations concerning the selection of applications for funding will be made by the RFA Review Panel and shared with appropriate Branch staff for consideration.

With the recommendations from the independent review panel, the Branch will conduct pre-decisional site visits with selected Prevention applicants. Pre-decisional site visits will generally be limited to Prevention applicants that do not have an existing funding relationship with the Branch. The purpose of the pre-decisional site visit is to ensure that the applicant has accurately characterized its administrative and technical ability to perform the proposed activities. Pre-decisional site visits will only be to those Prevention applications that scored high enough to be considered for funding. This is the second tier of the selection process. The following areas will be evaluated:

- Proposed Program
- Organizational Infrastructure
- Programmatic Capacity
- Fiscal Management

Pre-decisional site visits are scheduled at the sole discretion of the Branch. Applicant requests for Branch staff to conduct a pre-decisional site visit will not be honored. Pre-decisional site visits should not in any way be considered as an offer for funding.

Following the final selection, a contractual agreement will be developed between the applicant and Division of Public Health that details services to be provided, budget and reporting requirements. No financial obligation against the state can be incurred until a contract is fully executed. A minimum of one site visit will be conducted with all contracted agencies each contract year.

Applications meeting the following conditions will be given preferred consideration:

- Applications that propose to conduct targeted testing and linkage to care to priority populations.
- Applications that propose to have a standard linkage and re-engagement protocol that applies across the entire network.

- Applications from areas with high prevalence, incidence, and morbidity rates of HIV/AIDS as well as areas that have limited access to and/or the availability of resources.
- Applications that reach out assertively to underserved populations, especially low income, minority, and non-English speaking persons.
- Applications reflecting services to racial and ethnic minorities, Men who have Sex with Men and/or Persons Living with HIV and AIDs.
- Applications that demonstrate consumer involvement in the Network.
- Applications that utilize health outcome data to facilitate improved health outcomes of consumers served by the network.
- Minority-owned and minority-operated establishments that meet all other application requirements.
- Applications demonstrating collaborations and partnerships with other community based organizations that focus on the same or similar issues of HIV/STD in the targeted community. Appropriate Memorandums of Agreement forms should be signed and included in the application packet as **Attachment E. See Appendix 16: Sample Memorandum of Agreement (MOA).**

VII. APPLICATION

1. Application Checklist

Please be sure that all of the following items are included in your application. Assemble the application in the following order. Use a binder clip at the top left corner on each copy of the application. Number each page consecutively. Applications must be typed in 12 point font, double-spaced with one inch margins, single sided.

___Cover Letter: The application must include a cover letter, on agency letterhead (if available), signed and dated by an individual authorized to legally bind the Applicant. Include in the cover letter:

- The legal name of the Applicant agency
- The RFA number
- The Applicant agency's federal tax identification number
- The Applicant agency's DUNS number
- The closing date for applications.

___Application Face Sheet

___Completed Application (125 page maximum)

___**Attachment A:** Matrix of Services Table (applies to RNCP only; does not apply to TGA) (**See Appendix 23: Sample Matrix of Services Table**)

___**Attachment B:** Projection Reports (**See Appendix 25: Projection Report**)

___**Attachment C:** Standing Orders: This form applies only to those applicants conducting testing.

___**Attachment D:** Verification 501(c)(3) Status Form:

IRS Letter Documenting your Organization's Tax Identification Number (public agencies)

OR

IRS Determination Letter Regarding Your Organization's 501(c)(3) Tax Exempt Status (private non-profit agencies)

Verification of 501(c)(3) Status Form (private non-profits) (**See Appendix 12: Notarized Statement of Continued 501 (c) (3) Status**)

___**Attachment E:** Memorandum of Agreement (MOA)/Letters of Support: MOAs from each provider, documenting which required and/or optional services each member of the network has agreed to be responsible and how health outcomes and services data will be shared among appropriate network providers. Include MOAs for all agencies providing administration, planning and evaluation. (**See Appendix 16: Sample Memorandum of Agreement (MOA)**)

___**Attachment F:** Diagram of Network

___ **Attachment G:** Agency Boards of Directors

___ **Attachment H:** Client Grievance Policy and Procedures

___ **Attachment I:** Client Satisfaction Assessment Tools

___ **Attachment J:** Resumes of Staff Providing Services

___ **Attachment K:** Budgets and Budget Narratives: Only submit the Budget Breakdown Page and Budget Justification Pages for the first 12 month periods in the format provided. Budget Summary Instructions, Estimated Budget Breakdown Page and Estimated Budget Justification examples and blank budget page are included. Indirect costs are allowed. Reference each program area for contract year. **(See Appendix 17: Budget Guidelines and Sample Budgets)**

___ **Attachment L:** Sexual Harassment Policy

___ **Attachment M:** Confidentiality Policy

___ **Attachment N:** Indirect Cost Rate Approval Letter (if applicable)

___ **Attachment O:** Organizational Chart **(See Appendix 24: Organizational Charts for sample O-Charts and instructions for completing O-Charts)**

2. Application Face Sheet

This form provides basic information about the applicant and the proposed project with DPH, HIV/STD Prevention Program, including the signature of the individual authorized to sign "official documents" for the agency. This form is the application's cover page. Signature affirms that the facts contained in the applicant's response to **RFA # A-328** are truthful and that the applicant is in compliance with the assurances and certifications that follow this form and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below.

1. Legal Name of Agency:	
2. Name of individual with Signature Authority:	
3. Mailing Address (include zip code+4):	
4. Address to which checks will be mailed:	
5. Street Address:	
6. Contract Administrator:	Telephone Number:
▪ Name:	▪ Fax Number:
▪ Title:	▪ E-mail Address
7. Agency Status (check all that apply):	
<input type="checkbox"/> Public <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Local Health Department	
8. Agency Federal Tax ID Number:	9. Agency DUNS Number:
10. Agency's URL (website):	
11. Agency's Financial Reporting Year:	
12. Current Service Delivery Areas (county(ies) and communities):	
13. Proposed Area(s) To Be Served with Funding (county(ies) and communities):	
14. Amount of Funding Requested	
15. Projected Expenditures: Does applicant's state and/or federal expenditures exceed \$500,000 for applicant's current fiscal year (excluding amount requested in #14) Yes <input type="checkbox"/> No <input type="checkbox"/>	
The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in NC DHHS/DPH Assurances Certifications. I understand that the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. The governing body of the applicant has duly authorized this document and I am authorized to represent the applicant.	
16. Signature of Authorized Representative:	17. Date

3. APPLICANT'S RESPONSE

Each Network will submit at least one application. Applications should not exceed 125 pages and must be clear and concise. Applicants should not feel compelled to submit the maximum number of pages, especially if the proposed project is limited in scope. Each applicant should clearly describe the Program Areas, what they propose to do and how they propose to demonstrate these activities. Applicants must determine if any Program Areas are not applicable and address how these services will be provided in their region. Applicants must adhere to the program requirements listed under each Program Area. **In addition, applications must include the following:**

I. Regional Network of Care and Prevention

- a. Provide a brief overview of the proposed Network. Identify services and all agencies, organizations, stakeholders provided by providers in the region and how their feedback was incorporated in the development of the application. Identify all agencies that will be directly funded and subcontracted by the HIV/STD Prevention and AIDS Care programs.
- b. Describe how non funded HIV Prevention service providers in the region will be linked to the Network. Identify these providers and the specific linkages. Identify how the Network will ensure Care and HOPWA services are provided for clients in all counties of the region. Prevention services do not have to be provided in all counties but in every region. If the Network is not providing the Prevention service(s) directly, describe how services will or will not be rendered in the region.
- c. Describe how the Network will ensure that services provided by these providers are coordinated and not duplicated. Provide an explanation on why these providers were excluded from the application and the criteria utilized for exclusion.
- d. Attach signed Memoranda of Agreement (MOA) documenting services(s) each member of the Network has agreed to be responsible in how health outcomes and services data will be shared among appropriate network providers as Attachment E. **See Appendix 16: Sample Memorandum of Agreement (MOA).** Complete and attach the Matrix of Services Table as **Attachment A** showing all Ryan White Part B, C and D, HOPWA, MAI and Prevention services to be provided by the Network. Identify which services will be supported by the various funding streams. **See Appendix 23: Sample Matrix of Services Table.**
- e. Attach a diagram of the Network model. Include diagram as Attachment F.
- f. Describe which agency or agencies will be responsible for providing the administrative and planning/evaluation responsibilities of coordinating the network, data collection, meeting reporting requirements, assessing client needs, etc. Attach a list of the Board of Directors for every agency for which the Network is requesting direct funding from the HIV/STD Prevention, RW Part B, and HOPWA programs. Include as **Attachment G.**
- g. Describe who will develop, implement/update and oversee the overall quality management program. Describe the quality management plan that will be

- utilized by the Network.
- h. Include how the network will ensure Prevention, Ryan White Part B, C, and D, and HOPWA services are coordinated to avoid duplication and non-supplanting of funds.
 - i. Describe how the Network will ensure that all funds are leveraged with other federal, state, county, local and other funding resources to most efficiently utilize these limited funds. Describe how the Network will assure that all funds are payers of last resort; i.e., all other possible funding sources should be exhausted prior to billing to any programs covered under this RFA.
 - j. Describe how the Network will ensure that no other sources of funds are supplanted; i.e., that existing services provided by other resources (i.e., local government funds, private funds, etc.) do not have those resources replaced by Prevention, Ryan White Part B or HOPWA funds.
 - k. Explain how the Network will ensure client confidentiality.
 - l. Describe how the Network will provide culturally and linguistically appropriate services.
 - m. Explain how PLWHA will be involved in guiding the development, implementation and evaluation of the network operations and services.
 - n. Each Network will be expected to have a network client grievance policy and procedures and to assure all clients are aware of the grievance policy/procedures and are provided a copy of it. Explain how clients will be made aware of the grievance policy/procedures. Submit a copy of the client grievance policy that will be used by the network. Include the Client Grievance Policy/Procedures as **Attachment H**. If the Network grievance policy and procedures are not yet developed, include a timeline for development of the policy during the first year of funding.
 - o. Each Network will be expected to assess client satisfaction with Network services on a routine basis, at minimum annually. Explain how client satisfaction will be assessed. Submit a copy of any client satisfaction survey tool that will be used by the Network. Include the Client Satisfaction Assessment Tools as **Attachment I**. If the tools to be used by the Network to assess client satisfaction are not yet developed, include a timeline for development of these tools during the first year of funding.
 - p. Describe how clients will access the Network and identify the agencies, positions, staff persons that will serve as access points for clients.
 - q. Explain how providers of counseling and testing services in the region will relate to the Network. Identify the providers and the specific linkages.

II. Program Areas

A. Program Area One

Integrated Targeted Testing Services (ITTS)

- a. Describe the need for Integrated Targeted Testing Services in the region. Utilizing the NC Epidemiologic Profile, the agency/ies should describe the burden of the epidemic addressing health inequities in the region. Determine the anticipated benefit and how these activities would fulfill an unmet need in the region. Data can be located on the Branch's website: <http://epi.publichealth.nc.gov/cd/stds/epiprofile.html>.

- b. Provide a brief overview of the proposed program(s), including new program components or the continuation of existing services. For existing services, state how long you have provided these services and describe major accomplishments.
- c. Complete and attach Physician's Standing Orders as **Attachment C**.
- d. Describe specific goals, objectives and activities for the number of HIV/STD tests conducted, number of new positives identified reaching a 1% positivity rate and linked to care within 30 days. All testing services should describe how they will be offered at hours and locations that are accessible to persons at highest risk. Complete and attach Projection Report as **Attachment B**. Use **Appendix 25: Projection Report** to establish the annual testing objectives. Identify testing services that will be offered i.e., rapid vs. traditional HIV testing, syphilis, hepatitis C, gonorrhea and chlamydia testing. Programs are strongly encouraged to offer hepatitis C testing to people who inject drugs or have a history of injecting drugs. See **Appendix 25: Projection Report**
- e. Describe how the agency/ies will recruit key priority groups for testing. Note: 25% of total tests should be among African American MSM. Include a MSM plan that utilizes appropriate interventions and/or strategies with consideration given to potential testing venues/locations frequented.
- f. Describe a plan by which the agency/ies will work with needle exchange programs to ensure that HIV/STD and HCV counseling, testing and linkage to care/treatment will occur. Agencies should develop MOAs with any needle exchange programs that they work with outlining the services that the HIV/STD prevention agency will provide.
- g. Describe a plan by which the agency/ies will work with the Network to ensure that newly diagnosed HIV clients will be bridged to their first medical appointment. Describe how the agency/ies plan to work together, including how HIV positive clients will be linked to their first HIV medical care appointment and how client data and analysis will be shared.
- h. Describe how clients will be referred to treatment for syphilis, hepatitis C, gonorrhea and chlamydia.
- i. Describe the plan for post-test counseling. Ensure the plan includes that confirmed positive laboratory results for HIV and other STDs are reported to the local health department. Agency/ies must describe the system for follow-up of positive HIV or syphilis clients to Disease Intervention Specialists (DIS) listed in **Appendix 5: NC Branch Regional Offices** for partner notification, referrals, and linkage to HIV care and treatment.
- j. Describe the Pre-Exposure Prophylaxis (PrEP) plan for the referral process of HIV-negative clients for HIV antiretroviral (ARV) drugs that includes appropriate referral tracking tools and a list of PrEP providers.
- k. Describe how the agency/ies will implement a social marketing program to enhance testing services and increase awareness of and access to services by key priority groups. Note: 70% of social marketing funds and activities should focus on young African American men who have sex with men (ages 13-24). Review www.effectiveinterventions.org for examples as follows: a. integrating social media into health campaigns utilizing trends in social media; b. expanding mobile health to include information on mobile websites, downloadable applications and SMS text messaging; and c. utilizing Facebook, YouTube, Twitter and/or other social media tools to disseminate health messages..
- l. Describe how agency/ies will integrate condom distribution activities into the program(s).

- m. Provide a signed copy of each Memorandum of Agreement (MOA) as **Attachment E** from each established site in which agency/ies intend to conduct testing, condom distribution and linkage activities. Each MOA should describe the specific collaborative activities and commitment of the agencies. Refer to sample MOA in **Appendix 16: Sample Memorandum of Agreement (MOA)** (MOAs do not count toward the page limit.)
- n. Provide a Letter of Support as Attachment E from each local health department where services will be offered. All HIV/STD counseling and testing should be conducted with the approval of the local health department in the county where the activities are to occur. (Letters of Support do not count toward the page limit).
- o. Provide an organizational chart of all program-related staff including volunteers involved in implementing programmatic goals and objectives as **Attachment O**. A sample organizational chart is provided in **Appendix 24: Organizational Charts**. If you need to create an organizational chart, Microsoft Excel has a template that is relatively easy to use.
- p. Include a quality assurance and program monitoring plan that describes how your organization will maintain the integrity of the HIV prevention program. A description of how observations will be documented and feedback given on the observations to the staff. Observation and feedback forms should be attached to the Quality Assurance Plan. Observation documentation should focus on:
 - Attainment of program objectives;
 - Quality of interaction with clients;
 - Staff's responsiveness to clients;
 - How staff can improve performance as well as feedback on areas of particular strength.
- q. Submit an itemized budget as **Attachment K** for your agency's proposal with a budget justification for each line item under budget forms. See **Appendix 17: Budget Guidelines and Sample Budgets**. The first year budget should run from **June 1, 2017 – May 31, 2018**.
 - List each proposed position by name, title, percentage of time/effort on the project and a brief job description for that position. If the identity of any individual is unknown, list it as "To be Determined (TBD)".
 - List costs for prevention supplies, travel, condoms, printing, office supplies, etc.
 - List in-kind or donated services.

Note: The amount of the requested budget may not be increased after the application is submitted. All cost estimates will be considered as "not to exceed" quotations against which time and expenses will be charged. In addition, the proposed budget is subject to change during contract award negotiations.

B. Program Area Two

Counseling, Testing and Referral in Substance Abuse Centers (SAC)

- a. Describe the need for Counseling, Testing and Referral in Substance Abuse Centers in the region. Utilizing the NC Epidemiologic Profile, the agency/ies should describe the burden of the epidemic addressing health inequities in the region. Determine the anticipated benefit and how these activities would fulfill an unmet need in the region. Data can be located on the Branch's website: <http://epi.publichealth.nc.gov/cd/stds/epiprofile.html>.

- b. Provide a brief overview of the proposed program(s), including new program components or the continuation of existing services. For existing services, state how long you have provided these services and describe major accomplishments.
- c. Complete and attach Physician's Standing Orders as **Attachment C**.
- d. Describe specific goals, objectives and activities for the number of HIV/STD tests conducted, number of new positives identified and linked to care within 30 days. Complete and attach Projection Report as **Attachment B**. Use **Appendix 25: Projection Report** to establish the annual testing objectives. Identify testing services that will be offered i.e., rapid vs. traditional HIV testing, syphilis, hepatitis C, gonorrhea and chlamydia testing. Programs are strongly encouraged to offer hepatitis C testing to people who inject drugs or have a history of injecting drugs.
- e. Describe a plan by which the agency/ies will work with the Network to ensure that newly diagnosed HIV clients will be bridged to their first medical appointment. Describe how the agency/ies plan to work together, including how HIV positive clients will be linked to their first HIV medical care appointment and how client data and analysis will be shared.
- f. Describe how clients will be referred to treatment for syphilis, hepatitis C, gonorrhea and chlamydia.
- g. Describe the plan for post-test counseling. Ensure the plan includes that confirmed positive laboratory results for HIV and other STDs are reported to the local health department. Agency/ies must describe the system for follow-up of positive HIV or syphilis clients to Disease Intervention Specialists (DIS) listed in **Appendix 5: NC Branch Regional Offices** for partner notification, referrals, and linkage to HIV care and treatment.
- h. Describe the Pre-Exposure Prophylaxis (PrEP) plan for the referral process of HIV-negative clients for HIV antiretroviral (ARV) drugs that includes appropriate referral tracking tools and a list of PrEP providers.
- i. Describe how agency/ies will integrate condom distribution activities into your program.
- j. Provide a signed copy of each Memorandum of Agreement (MOA) as **Attachment E** from each established site in which agency/ies intend to conduct testing, condom distribution and linkage activities. Each MOA should describe the specific collaborative activities and commitment of the agency/ies, Refer to sample MOA in **Appendix 16: Sample Memorandum of Agreement (MOA)**. (MOAs do not count toward the page limit.)
- k. Provide a Letter of Support as **Attachment E** from each local health department where services will be offered. All HIV/STD counseling and testing should be conducted with the approval of the local health department in the county where the activities are to occur. Provide at least two additional letters from agency/ies that have knowledge and capacity to support agency/ies description of experience in providing the prevention services (Letters of Support do not count toward the page limit).
- l. Provide an organizational chart of all program-related staff including volunteers involved in implementing programmatic goals and objectives as **Attachment O**. A sample organizational chart is provided in **Appendix 24: Organizational Charts**. If you need to create an organizational chart, Microsoft Excel has a template that is relatively easy to use.
- m. Include a quality assurance and program monitoring plan that describes how your organization will maintain the integrity of the HIV prevention program. A description of how observations will be documented and feedback given on

the observations to the staff. Observation and feedback forms should be attached to the Quality Assurance Plan. Observation documentation should focus on:

- Attainment of program objectives;
 - Quality of interaction with clients;
 - Staff's responsiveness to clients;
 - How staff can improve performance as well as feedback on areas of particular strength.
- n. Submit an itemized budget as **Attachment K** for your agency's proposal with a budget justification for each line item under budget forms. **See Appendix 17: Budget Guidelines and Sample Budgets.** The first year budget should run from June 1, 2017 – May 31, 2018.
- List each proposed position by name, title, percentage of time/effort on the project and a brief job description for that position. If the identity of any individual is unknown, list it as "To be Determined (TBD)".
 - List costs for prevention supplies, travel, condoms, printing, office supplies, etc.
 - List in-kind or donated services.

Note: The amount of the requested budget may not be increased after the application is submitted. All cost estimates will be considered as "not to exceed" quotations against which time and expenses will be charged. In addition, the proposed budget is subject to change during contract award negotiations.

C. Program Area Three

Prevention with Positives (PWP)

- a. Describe the need for Prevention with Positives in the region. Utilizing the NC Epidemiologic Profile, the agency/ies should describe the burden of the epidemic addressing health inequities in the region. Determine the anticipated benefit and how these activities would fulfill an unmet need in the region. Data can be located on the Branch's website: <http://epi.publichealth.nc.gov/cd/stds/epiprofile.html>.
- b. Provide a brief overview of the proposed program, including new program components or the continuation of existing services. For existing services, state how long you have provided these services and describe major accomplishments.
- c. Identify the Prevention with Positives evidence based interventions and/or public health strategies that agency/ies will implement. Select only from the approved list provided in **Appendix 4: Diffusion of Effective Behavioral Interventions (DEBI) and Public Health Strategies (www.effectiveinterventions.org)**. Describe specific goals, objectives and activities that will demonstrate how services will be rendered in the region.
- d. Describe how the agency/ies will recruit, retain and reengage PLWH into their activities, e.g., ID clinics, AIDS Service organizations (ASOs), Federally Qualified Health Centers (FQHCs), health department clinics.
- e. Describe how the agency/ies plan to work together to ensure clients remain in care and how client data and analysis will be shared.
- f. Describe how agency/ies will integrate condom distribution activities into the program.
- g. Provide a signed copy of each Memorandum of Agreement (MOA) as **Attachment E** from each established site in which agency/ies intend to

conduct PWP, condom distribution and linkage activities. Each MOA should describe the specific collaborative activities and commitment of the agency/ies. Refer to sample MOAs in **Appendix 16: Sample Memorandum of Agreement (MOA)** (MOAs do not count toward the page limit.)

- h. Provide an organizational chart of all program-related staff including volunteers involved in implementing programmatic goals and objectives as **Attachment O**. A sample organizational chart is provided in **Appendix 24: Organizational Charts**. If you need to create an organizational chart, Microsoft Excel has a template that is relatively easy to use.
- i. Include a quality assurance and program monitoring plan that describes how your organization will maintain the integrity of the HIV prevention program. A description of how observations will be documented and feedback given on the observations to the staff. Observation and feedback forms should be attached to the Quality Assurance Plan. Observation documentation should focus on:
 - Attainment of program objectives;
 - Quality of interaction with clients;
 - Staff's responsiveness to clients;
 - How staff can improve performance as well as feedback on areas of particular strength.
- j. Submit an itemized budget as **Attachment K** for your agency's proposal with a budget justification for each line item under budget forms. **See Appendix 17: Budget Guidelines and Sample Budgets**. The first year budget should run from June 1, 2017 – May 31, 2018.
 - List each proposed position by name, title, percentage of time/effort on the project and a brief job description for that position. If the identity of any individual is unknown, list it as "To be Determined (TBD)".
 - List costs for prevention supplies, travel, condoms, printing, office supplies, etc.
 - List in-kind or donated services.

Note: The amount of the requested budget may not be increased after the application is submitted. All cost estimates will be considered as "not to exceed" quotations against which time and expenses will be charged. In addition, the proposed budget is subject to change during contract award negotiations.

D. Program Area Four Ryan White Part B

- a. Identify and describe the most pressing needs of PLWH in the region and explain how the Network will address those needs.
- b. Explain how PLWH were involved in planning the Network and helping to identify services to be provided by the Network.
- c. Describe how the Network will "bridge" newly diagnosed and/or newly referred or self-referred individuals into the network. This description should include the following:
 - Who (agency, position, identified staff) will be responsible for identifying newly diagnosed PLWHA and work with them to get them into care.

- Who (agency, position, identified staff) will be responsible for tracking clients who have dropped out of care and “bridging” them back into care.
- How the Network will coordinate bridge counseling services with State Bridge Counselors and Patient Navigators using the State Bridge Counselor map in **Appendix 1: Branch Regional Map**.

(Note: The Branch views bridge counseling activities as critical to engaging clients in care and to re-engaging those who have fallen out of care, an activity that is increasingly important to reduce the HIV epidemic. The Ryan White services that may be used to facilitate “bridging” activities include Health Education/Risk Reduction, Outreach, Psychosocial Support and Referral for Health Care/Supportive Services).

- d. Explain how HIV positive clients released from jails, prisons, mental health facilities, substance abuse facilities or other facilities in the region will be identified and identify who will work with them to get them re-engaged into care.
- e. Explain how the Network will assure that persons identified as HIV positive are provided medical care as quickly as possible.
- f. Explain how long it will take for newly diagnosed clients to access their first medical care appointment within the Network.
- g. Identify the number of RW Part B clients the Network proposes to serve.
- h. Explain how the Network plans to assure clients are “navigated” into the new Affordable Care Act Insurance Marketplace.
- i. Explain who (agency, position, identified staff) will track clients in the Network, following them through the system of care, to be sure they are going to appointments, receiving services, and being referred for other services as necessary.
- j. Explain how the following required Ryan White Core Medical Services will be provided in the Network and identify the agency/agencies that will be responsible for providing each service: Outpatient/Ambulatory Health Services, Health Insurance Premium and Cost-Sharing Assistance, Oral Health Care, Mental Health Services, Medical Case Management (including Treatment Adherence) and Substance Abuse Services-outpatient.
- k. Explain how the following required Ryan White Support Services will be provided in the Network and identify the agency/agencies that will be responsible for providing each service: Medical Transportation Services and Case Management (non-medical).
- l. Explain which optional Ryan White services will be provided in the Network and identify which agency/agencies will provide each service. See **Appendix 22: Ryan White and HOPWA Services List** for a list of optional Ryan White services.
- m. Explain who (agency, position, identified staff) in the Network will be responsible for the following required Administrative activities:

- CAREWare data collection and data entry for the Ryan White Part B Program, and submission of the Ryan White HIV/AIDS Program Services Report (RSR) and Client Level Data (CLD).
 - Monitoring subcontracted providers.
 - Assuring the network adheres to all applicable federal and state regulations, policies and guidance and that all Ryan White Part B contractual obligations are fulfilled.
 - Compilation and submission of required Ryan White Part B fiscal and program reports.
 - Development, implementation, updating and maintenance of a Quality Management Plan and collecting/reporting quality management performance indicators.
- n. Explain who (agency, position, identified staff) in the Network will be responsible for the following required Planning and Evaluation activities:
- Coordinating the network, including convening and facilitating (at minimum) quarterly network meetings.
 - Conducting a network-wide needs assessment. Note: This will need to be completed within the first year of the three-year funding cycle and updated the second and third year.
 - Coordinating network services throughout the region.
 - Developing and implementing/updating annually an evaluation plan for the network.
 - Developing and annually reviewing/updating a grievance policy and procedures for the network.
 - Conducting an annual client satisfaction survey.
- o. Explain who (agency, position, identified staff) will assist clients with ADAP enrollment and reauthorization processes and help them with any questions they have about the ADAP Program.
- p. Explain who (agency, position, identified staff) will provide HIV Infectious Disease care for clients in the Network and how those individuals are qualified to provide HIV Infectious Disease care. Include resumes as **Attachment J** for all of the Infectious Disease staff that is included in the Network budgets.
- q. While not required, every network is strongly encouraged to provide (or assure access to Prevention With Positives (PWP) activities for clients served by the network. The Ryan White services that include prevention with positives activities include (but are not limited to) Health Education/Risk Reduction, Referral for Health Care/Supportive Services, and Psychosocial Support Services. If your Network plan includes the provision of PWP activities, explain who (agency, position, identified staff) will be responsible for providing these activities, how these activities will be provided, and a description of the specific activities that will be provided. PWP activities provided by the network or by other providers in the region should be marketed to all clients served by the network. If applicable, explain how PWP activities will be marketed within the Network.

- r. Explain who (agency, position, identified staff) in the Network will be responsible for referring clients to Disease Intervention Specialists (DIS) for partner notification and the process to be followed for referring clients to DIS.
- s. Explain who (agency, position, identified staff) will collect, report and monitor health outcomes of clients served by the Network and explain how the Network will utilize health outcomes data to facilitate improved health outcomes.
- t. Explain how Network providers will assure that data on clients, services and health outcomes are appropriately shared across the Network for tracking, monitoring and reporting purposes.
- u. Provide a signed copy of each Memorandum of Agreement (MOA) as **Attachment E** outlining RW Part B and MAI activities. Each MOA should describe the specific collaborative activities and commitment of the agency/ies. Refer to sample MOA in **Appendix 16: Sample Memorandum of Agreement (MOA)** (MOAs do not count toward the page limit.)
- v. Provide a Letter of Support as **Attachment E** from each agency where services will be offered. All RW Part B and MAI activities should be conducted with the approval of the Network in the region where the activities are to occur. Provide at least two additional letters from agency/ies that have knowledge and capacity to support agency/ies description of experience in providing the RW Part B and MAI services (Letters of Support do not count toward the page limit).
- w. Provide an organizational chart of all program-related staff at each agency including volunteers involved in implementing programmatic goals and objectives as **Attachment O**. A sample organizational chart is provided in **Appendix 24: Organizational Charts**. If you need to create an organizational chart, Microsoft Excel has a template that is relatively easy to use.
- x. Include a quality assurance and program monitoring plan that describes how your organization will maintain the integrity of the RW Part B and MAI program. A description of how observations will be documented and feedback given on the observations to the staff. Observation and feedback forms should be attached to the Quality Assurance Plan. Observation documentation should focus on:
 - Attainment of program objectives
 - Quality of interaction with clients
 - Staff's responsiveness to clients
 - How staff can improve performance as well as feedback on areas of particular strength.
- y. Submit an itemized budget as **Attachment K** for your agency's proposal with a budget justification for each line item under budget forms. **See Appendix 17: Budget Guidelines and Sample Budgets**). The first year budget should run from April 1, 2017 – March 31, 2018.
 - List each proposed position by name, title, percentage of time/effort on the project and a brief job description for that position. If the identity of any individual is unknown, list it as "To be Determined (TBD)".
 - List costs for supplies, travel, printing, office supplies, etc.
 - List in-kind or donated services.

Note: The amount of the requested budget may not be increased after the application is submitted. All cost estimates will be considered as “not to exceed” quotations against which time and expenses will be charged. In addition, the proposed budget is subject to change during contract award negotiations.

E. Program Area Five

Housing Opportunities for Persons with AIDS Program (HOPWA)

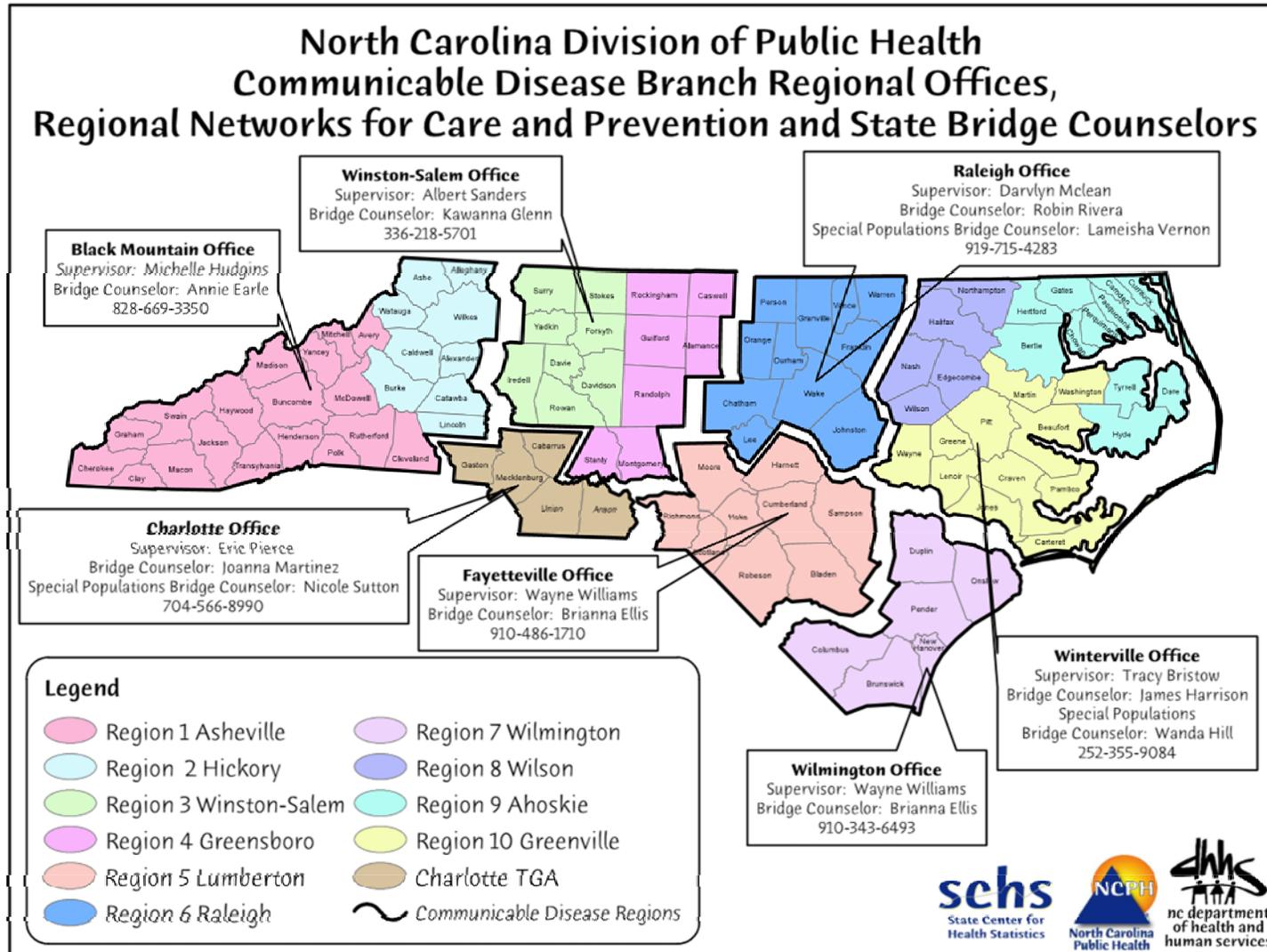
- a. Explain who (agency, position, identified staff) will provide the following required HOPWA services in the Network: Tenant-based Rental Assistance and Short-Term Rent, Mortgage and Utilities.
- b. Explain which optional HOPWA services will be provided by the Network and identify which agency/agencies will provide each service. (See **Appendix 22: Ryan White and HOPWA Services List** for a list of optional HOPWA services)
- c. Describe how HOPWA funds will be leveraged with other housing programs such as Section 811, HOME Investment FUNDS, and other housing resources, Ryan White and all other types of public and private assistance.
- d. Describe the anticipated timeline for securing housing for an individual once eligibility for assistance has been determined.
- e. Explain your wait list policy for clients.
- f. Explain how clients will access case management services.
- g. Describe how all HOPWA services provided will comply with Fair Housing Laws, Fair Housing Counseling requirements and HOPWA provider training requirements.
- h. Describe specific meaningful actions that will be completed (e.g., outreach activities, fair housing counseling and fair housing training) to Affirmatively Further Fair Housing.
- i. Provide a signed copy of each Memorandum of Agreement (MOA) as **Attachment E** from each established site in which agency/ies intend to conduct HOPWA activities. Each MOA should describe the specific collaborative activities and commitment of the agency/ies, Refer to sample MOA in **Appendix 16: Sample Memorandum of Agreement (MOA)**. (MOAs do not count toward the page limit.)
- j. Provide a Letter of Support as **Attachment E** from each agency where services will be offered. All HOPWA activities should be conducted with the approval of the Network in the region where the activities are to occur. Provide at least two additional letters from agency/ies that have knowledge and capacity to support agency/ies description of experience in providing the HOPWA services (Letters of Support do not count toward the page limit).
- k. Provide an organizational chart of all program-related staff at each agency including volunteers involved in implementing programmatic goals and objectives as **Attachment O**. A sample organizational chart is provided in **Appendix 24: Organizational Charts**. If you need to create an organizational chart, Microsoft Excel has a template that is relatively easy to use.
- l. Include a quality assurance and program monitoring plan that describes how your organization will maintain the integrity of the HOPWA program. A

description of how observations will be documented and feedback given on the observations to the staff. Observation and feedback forms should be attached to the Quality Assurance Plan. Observation documentation should focus on:

- Attainment of program objectives;
 - Quality of interaction with clients;
 - Staff's responsiveness to clients;
 - How staff can improve performance as well as feedback on areas of particular strength.
- m. Submit an itemized budget as **Attachment K** for your agency's proposal with a budget justification for each line item under budget forms. See **Appendix 17: Budget Guidelines and Sample Budgets** for sample budget. The first year budget should run from October 1, 2017 – September 30, 2018.
- List each proposed position by name, title, percentage of time/effort on the project and a brief job description for that position. If the identity of any individual is unknown, list it as "To be Determined (TBD)".
 - List costs for supplies, travel, printing, office supplies, etc.
 - List in-kind or donated services.

Note: The amount of the requested budget may not be increased after the application is submitted. All cost estimates will be considered as "not to exceed" quotations against which time and expenses will be charged. In addition, the proposed budget is subject to change during contract award negotiations.

Appendix 1: Branch Regional Map



Appendix 2: List of Counties per Network Region

Region 1

Avery, Buncombe, Cherokee, Clay, Cleveland, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Region 2

Alexander, Alleghany, Ashe, Burke, Caldwell, Catawba, Lincoln, Watauga, Wilkes

Region 3

Davidson, Davie, Forsyth, Iredell, Rowan, Stokes, Surry, Yadkin

Region 4

Alamance, Caswell, Guilford, Montgomery, Randolph, Rockingham, Stanly

Region 5

Bladen, Cumberland, Harnett, Hoke, Moore, Richmond, Robeson, Sampson, Scotland

Region 6

Chatham, Durham, Franklin, Granville, Johnston, Lee, Orange, Person, Vance, Wake, Warren

Region 7

Brunswick, Columbus, Duplin, New Hanover, Onslow, Pender

Region 8

Edgecombe, Halifax, Nash, Northampton, Wilson

Region 9

Bertie, Camden, Chowan, Currituck, Dare, Gates, Hertford, Hyde, Pasquotank, Perquimans, Tyrrell

Region 10

Beaufort, Carteret, Craven, Greene, Jones, Lenoir, Martin, Pamlico, Pitt, Washington, Wayne

Charlotte TGA

Anson, Cabarrus, Gaston, Mecklenburg, Union

Appendix 3: High-Impact HIV Prevention (HIHP) & National HIV/AIDS Strategy (NHAS) Overview

<https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>

NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES: UPDATED TO 2020 JULY 2015

EXECUTIVE SUMMARY

The Nation's first comprehensive National HIV/AIDS Strategy for the United States (Strategy) was released in 2010, and in the subsequent five years, people and organizations have joined together around its vision and goals. The Strategy has changed the way the American people talk about HIV, prioritize and organize prevention and care services locally, and deliver clinical and non-clinical services that support people living with HIV to remain engaged in care, and has helped achieve the following:

- Implementation of the Affordable Care Act. Millions of Americans can access preventive services like HIV testing without a co-pay or deductible. People living with HIV can no longer be discriminated against because of their HIV status, and thousands more people living with HIV have new coverage options through Medicaid expansion or the Health Insurance Marketplace.
- Groundbreaking work by the National Institutes of Health (NIH), including the HIV Prevention Trials Network (HPTN) 052 study, which Science magazine called the scientific breakthrough of 2011, and which demonstrated that early treatment for HIV reduces the risk of onward transmission by 96 percent while simultaneously improving health outcomes. NIH also supported the Strategic Timing of Antiretroviral Therapy (START) trial, which demonstrated that those with HIV who received immediate treatment significantly reduced their risk of serious, adverse health outcomes.
- The introduction of PrEP (Pre-Exposure Prophylaxis), a much-needed new biomedical prevention tool that helps people reduce their risk of HIV infection by taking a daily pill. Based on evidence from multiple clinical trials released from 2011 to 2013, the Food and Drug Administration approved PrEP in 2012, and in 2014 the U.S. Public Health Service issued clinical practice guidelines for PrEP.
- Vital work by the Centers for Disease Control and Prevention (CDC), including key guidance for the adoption of new testing technologies that enhance the ability to diagnose HIV soon after infection. These technologies broaden the window of opportunity for effective interventions during the acute phase of infection—a time when HIV is most likely to be transmitted to others.
- Critical funding increases for the AIDS Drug Assistance Program (ADAP) of the Health Resources and Services Administration (HRSA), which ensured access to lifesaving treatment by helping to eliminate ADAP waiting lists, and for additional services that support a system of care necessary for those with HIV to maintain health.

- Major strides in collaboration across the Federal government, establishing cross-agency partnerships, formulating recommendations for the HIV Care Continuum Initiative, and developing and implementing a core set of HIV program indicators to support data sharing and increased transparency in progress made. For example: 2 NATIONAL HIV/AIDS STRATEGY: UPDATED TO 2020.
- A Federal interagency workgroup was established to investigate the intersection of HIV and violence against women and it resulted in more than 15 new initiatives within two years.
- The Department of Justice (DOJ) collaborated with CDC to publish a comprehensive examination of HIV-specific criminal laws. As a result, DOJ issued a best practices guide to reform these laws that help states ensure their policies do not place unnecessary burdens on individuals living with HIV/ AIDS and that they reflect an accurate understanding of HIV transmission routes and associated benefits of treatment.
- Demonstration projects funded through the Secretary's Minority AIDS Initiative Fund (SMAIF) have engaged multiple HHS agencies—including CDC, HRSA, and the Substance Abuse and Mental Health Services Administration (SAMHSA)—to foster coordination and collaboration across agencies and evaluate agency policies that may act as barriers to coordinated planning, implementation, delivery, and evaluation of HIV/AIDS services at the state and local levels.

These and other accomplishments have resulted in important gains toward targets for increasing the percentage of persons living with HIV who know their status, are linked to care, and have achieved viral suppression, as well as reducing death rates. Despite this progress, the level of infection is stable overall. While declines in diagnoses have occurred for women, persons who inject drugs, and heterosexuals, the epidemic among gay and bisexual men remains severe, with increases in new diagnoses. Achieving the goals of the Strategy will require intensified efforts for this population in order to realize the greatest impact. The Nation has the tools to slow, and eventually end, the epidemic in the United States. With ongoing leadership, sustained funding commitments, strategic action, and emerging digital tools and technologies to help inform and educate, the American people are closer than ever to the day when the Strategy's vision will be attained. Together, people living with HIV and those affected, state, Tribal, and local governments, health providers, government and industry scientists, faith leaders, and community partners have fundamentally transformed the response to HIV/AIDS in the United States. The Strategy has truly become the roadmap for collective action and has brought new energy and commitment in States and local communities across the country. This is the first update of the Strategy (Update), which is designed to look ahead to 2020. The Update reflects the hard work accomplished and the lessons learned since 2010. Moreover, it incorporates the scientific advances that could one day bring the United States, and the world, closer to virtually eliminating new HIV infections, effectively supporting all people living with HIV to lead long and healthy lives and eliminating the disparities that

persist among some populations. The Strategy remains a steady foundation on which to build future efforts. As such, this Update retains its vision and four main goals through 2020. At the same time, the Strategy is also a living document, designed to be updated. The Update includes the following changes:

- The Steps and Recommended Actions under each of the goals have been revised to reflect past progress and activities to meet the Strategy goals (see “At-A-Glance” summaries on pages 8-11).
- The Update has 10 quantitative indicators—some of which are new additions, and some of which are revised—to better monitor progress and ensure that the Nation is constantly moving in the right direction to achieve its goals (see list on page 12 and detailed information in the Indicator Development and Progress Appendix).
- In addition, three areas have been identified as priorities for developing indicators: PrEP, stigma, and HIV among transgender persons.

EXECUTIVE SUMMARY 3

- The objectives and recommendations of both the HIV Care Continuum Initiative and the Federal Interagency Working Group on the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities have been fully integrated into the Steps and Recommended Actions (see Tables on pages 13 and 14). As a guiding document, the Update is a National plan, not just a Federal plan. Federal efforts are vitally important but the goals of the Strategy can only be achieved by engagement at the national, state, Tribal, and local levels and across all sectors. It is especially important that people who work in communities play an active role in implementing this Strategy. It is on the ground that the work is accomplished, and it is on the ground where the Strategy’s implementation has improved the lives of Americans impacted by HIV. The Update looks toward 2020 with the following statements in mind:
 - There is still an HIV epidemic and it remains a major health issue for the United States.
 - Most people can live long, healthy lives with HIV if they are diagnosed and get treatment.
 - For a variety of reasons, certain populations bear a disproportionate burden of HIV. People across the Nation deserve access to tools and education to prevent HIV transmission.
 - Every person diagnosed with HIV deserves immediate access to treatment and care that is non-stigmatizing, competent, and responsive to the needs of the diverse populations impacted by HIV. The Update allows for opportunities to refresh the ongoing work in HIV prevention, care, and research.

Advances in four key areas are of critical focus for the next five years:

- Widespread testing and linkage to care, enabling people living with HIV to access treatment early.
- Broad support for people living with HIV to remain engaged in comprehensive care, including support for treatment adherence.

- Universal viral suppression among people living with HIV.
- Full access to comprehensive PrEP services for those whom it is appropriate and desired, with support for medication adherence for those using PrEP.

A COLLABORATIVE NATIONAL RESPONSE

By working in the direction of shared national goals and aligning efforts across sectors with the principles and priorities of the updated Strategy, the Nation can advance toward the life-saving HIV goals.

4 NATIONAL HIV/AIDS STRATEGY: UPDATED TO 2020

GOAL 1: REDUCING NEW HIV INFECTIONS HIV does not impact all Americans equally. While anyone can become infected, the HIV epidemic is concentrated in key populations and geographic areas. In 2010, the Strategy called for a path that followed epidemiological data. This Update continues along that path by calling for Federal agencies to ensure that funding is allocated according to the current epidemiological profile of each jurisdiction, and that cost-effective, scalable interventions are prioritized in the communities where HIV is most concentrated for the following groups:

- Gay, bisexual, and other men who have sex with men of all races and ethnicities (noting the particularly high burden of HIV among Black gay and bisexual men)
- Black women and men
- Latino men and women
- People who inject drugs
- Youth aged 13 to 24 years (noting the particularly high burden of HIV among young Black gay and bisexual men)
- People in the Southern United States
- Transgender women (noting the particularly high burden of HIV among Black transgender women)

Over the next five years, the Nation must ensure that programmatic funding is appropriately allocated and supports the most effective interventions, including research into innovative ways to prevent new infections. The HIV prevention toolbox has grown. Based on scientific and technological advances in the past five years, new guidelines and recommendations have expanded the number of options for prevention. CDC has issued guidance to providers recommending PrEP be considered for those at substantial risk for HIV. In addition, guidelines from the U.S. Department of Health and Human Services (HHS) now recommend that all persons with HIV be offered treatment not only for their own health, but also because antiretroviral treatment significantly reduces the risk of HIV transmission to others. Additionally, the U.S. Preventive Services Task Force (USPSTF) recommends that all people aged 15 to 65 years, and all pregnant women, be screened for HIV. CDC has also provided guidance for the adoption of new testing technologies that enhance the ability to diagnose HIV soon after infection, broadening the window of opportunity for effective interventions during

the acute phase of infection—a time when HIV is most likely to be transmitted to others. Over the next five years sustained effort is required to realize the promise of these and other scientific advances, and to adopt and embrace emerging beneficial research findings. These may include the availability of sustained release antiretroviral agents either for PrEP or for treatment, new developments in microbicides or vaccines, or more effective delivery of HIV care services. HIV information should be universally integrated into appropriate educational access points. All Americans deserve scientifically accurate, easy-to-access information about HIV transmission and prevention. This entails providing clear, specific, consistent, and scientifically up-to-date messages about risk and prevention strategies—followed by active deployment of this information to develop and disseminate education campaigns, prevention programs, and risk assessment tools. These interventions should leverage digital strategies and new technologies to reach the broadest number of people at relevant access points.

EXECUTIVE SUMMARY 5

GOAL 2: INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV

Health care coverage matters for people living with HIV. Due to the Affordable Care Act, people living with HIV can no longer be discriminated against on the basis of their HIV status or other pre-existing health conditions when seeking health care coverage. In addition, thousands more people living with HIV have new access to Medicaid or a Marketplace health insurance plan. And for people who already have health care coverage, there are new limits on out-of-pocket spending and other protections to make coverage more secure. Additionally, the Administration, with strong bipartisan support from Congress, has been unwavering in its commitment to sustaining the Ryan White HIV/AIDS Program, administered by HRSA. Critical funding increases for the ADAP have been provided to ensure access to lifesaving treatment and support for the clinics and additional services necessary for those with HIV to maintain health. Finally, successful access to care is often precluded by unmet basic needs such as housing. Supplementing care services with robust policies in support of basic needs is crucial for timely linkage to and retention in HIV care. Improving outcomes at every step of the HIV care continuum must remain a priority. In 2013, President Obama issued an Executive Order establishing the HIV Care Continuum Initiative, calling for coordinated action among Federal agencies to mobilize efforts in line with the recent advances in HIV treatment. These efforts are expected to yield longer lives and fewer new infections. Going forward, efforts must be directed toward improving outcomes at every step of the continuum, from testing to diagnosis, linkage and engagement in care, treatment, and ultimately, viral suppression. Key to this effort will be the identification and re-engagement of people who have been lost to care. Promising initiatives in several cities and States across the country have already demonstrated successful strategies, using HIV surveillance data and clinical care data. An essential next step is to enhance capacity in all states to systematically identify and re-engage people living with HIV. This will also allow more rigorous monitoring of the continuum at all stages of

care. Developing models of competent care that treat the whole person, as well as the virus, is crucial. People living with HIV—after being diagnosed, entering the healthcare system, and being prescribed treatment — require supports to remain engaged in care. A culturally competent and skilled workforce is vital to this effort, and includes a range of providers such as peer navigators, nurses, doctors, case managers, pharmacists, and social workers. Key priorities for improving outcomes along the care continuum include expanding the workforce by engaging and training non-traditional providers and expanding proven models of team-based, patient-centered care that facilitate ongoing engagement in care. Implementation science research is also essential to develop evidence-based models of care that are proven to deliver life-enhancing services.

SCIENTIFIC DISCOVERY REQUIRES A LONG-TERM COMMITMENT

The scientific advances that have led to current treatment and prevention interventions are the result of ongoing Federal investments in basic, biomedical, behavioral, and social science research. In 2013, President Obama announced that NIH would redirect \$100 million to launch an HIV Cure Initiative to further advance HIV/AIDS research with the hope of catalyzing a new generation of therapies aimed at curing HIV or inducing lifelong remission. Today, the science directly points to the benefit of getting all people living with HIV on treatment as soon as possible. The NIH has supported groundbreaking work, including the HPTN 052 study, called the scientific breakthrough of 2011 by Science magazine, which demonstrated that early treatment for HIV reduces the risk of onward transmission by 96 percent while simultaneously improving health outcomes, and the START trial demonstrated that those with HIV who received immediate treatment significantly reduced their risk of illness and death. Combined with the treatment-as-prevention benefit previously demonstrated by the HPTN 052 study, the emphasis on optimizing the continuum of care and making access to lifesaving antiretroviral therapy a right, not a privilege, becomes a core tenet of the Strategy.

6 NATIONAL HIV/AIDS STRATEGY: UPDATED TO 2020

GOAL 3: REDUCING HIV-RELATED DISPARITIES AND HEALTH INEQUITIES

The Nation cannot meet the Strategy goals without reducing disparities. Poor social and environmental conditions, coupled with high rates of HIV among specific populations and in geographic areas, contribute to stubbornly persistent—and in some cases, growing—HIV-related health disparities. These disparities include higher rates of HIV infection, lower rates of access to HIV care, lower HIV viral suppression rates and higher HIV-related complications, and higher HIV-related death rates; and they affect Black, Latino, and American Indian/ Alaska Native people, transgender people, and young people. Structural approaches can reduce risk of HIV transmission at community and societal levels. It is imperative that the conditions in which people live, learn, work, play, and pray facilitate—rather than detract from—their ability to lead healthy lives. Such conditions include the background prevalence of HIV in sexual and drug networks as well as housing, education, employment, and family and social support systems. It has become abundantly clear that these social determinants of health are significant factors in

the ability to meet the goals of the Strategy. More work is needed to test new models that advance health in a variety of settings. Work is underway to develop models for trauma-informed primary care that offer promises to change the health care environment in ways that reduce stress on patients and providers alike, and improve HIV and other health outcomes. Stigma and discrimination must be eliminated in order to diminish barriers to HIV prevention, testing, and care. HIV-related stigma can be confounded by or complicated with stigma related to substance use, mental health, sexual orientation, gender identity, race/ethnicity, or sex work. Stigma can lead to many negative consequences for people living with HIV. It is imperative that all levels of government recognize that these various biases exist and work to combat stigma and discrimination in order to reduce new infections and improve health outcomes for people living with HIV. In the legal arena, this requires ensuring that all Federal and state criminal laws regarding HIV transmission and prevention are scientifically based, and that prosecutors and others in law enforcement have an accurate understanding of transmission risks.

GOAL 4: ACHIEVING A MORE COORDINATED NATIONAL RESPONSE TO THE HIV EPIDEMIC

Recognizing that improved coordination has occurred since the release of the Strategy in 2010, even greater coordination is possible and essential. Further effort should be directed toward identifying, learning from and replicating international, state, Tribal, and local successes. Federal leadership is critical in identifying overarching national priorities, as well as supporting research to evaluate which activities are most effective and ensure that Federal resources deployed will have maximum effect. The White House Office of National AIDS Policy (ONAP) will work collaboratively with the Office of National Drug Control Policy and other White House offices, as well as other Federal agencies, to further the goals of the Strategy. As with the 2010 Strategy, this Update provides specific recommendations to help us meet the goals as well as indicators to measure progress. A system of regular public reporting will help to sustain nationwide public attention and support for the Strategy. Working together, ONAP, the Office of the Assistant Secretary for Health at HHS, and other Federal agencies will develop a Federal Action Plan during 2015 that outlines the specific steps to be taken by Federal agencies to implement the priorities set by the Update. In addition, an action plan framework, similar to the Federal Action Plan structure, will be created to assist non-Federal partners such as state and local health departments, Tribal governments, community-based organizations, coalitions of persons living with HIV, and other stakeholders to identify specific actions that they can take—tailored to their own specific missions and priorities—to ensure that the Nation is working to meet the goals of the Strategy. Shared priorities, streamlined grantee requirements, evidence-based strategies, and data-informed resource allocation will help get us there.

CALL TO ACTION

The Obama Administration demonstrated its commitment to reinvigorating the collective domestic response to HIV when the Strategy was released in 2010. Since then, the Nation has aligned its efforts to move closer toward achieving the goals of the Strategy and the national dialogue around HIV/AIDS has evolved to imagining a future free of new HIV infections in the United States and healthier, longer lives for people living with HIV. However, major challenges remain. Working together with renewed focus and vigor will advance that vision. Key focus areas for the Update include HIV testing with linkage to care for those with HIV infection, along with support for retention in care and treatment adherence to ensure that persons living with HIV remain virally suppressed, and for those testing negative but at substantial risk, linkage to PrEP and support for medication adherence. This Update is a call to action to myriad systems: everyone is needed to put this Strategy; the Nation can advance toward the life-saving HIV goals.

High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States

The Status of HIV Prevention in the United States

In the United States, prevention has already averted more than 350,000* HIV infections.¹ Now, we have the potential to go much further. The nation's HIV prevention efforts are guided by a single, ambitious strategy for combating the epidemic: the National HIV/AIDS Strategy (NHAS).² Recent scientific breakthroughs have equipped us with an unprecedented number of effective tools to prevent infection.³⁻⁶ And in many of the communities hardest hit by HIV, there is growing leadership and momentum for change.

Yet the challenges remain daunting. By CDC's latest estimates, approximately 50,000 Americans become infected with HIV annually, and 16,000 people with AIDS died in 2008.^{7,8} As a result, the number of people living with HIV in the United States, now at nearly 1.2 million, continues to grow by tens of thousands each year, creating more opportunities for HIV transmission.⁹ And a range of social, economic, and demographic factors affect some Americans' risk for HIV, such as stigma, discrimination, income, education, and geographic region. While current prevention efforts have helped to keep the number of new infections stable in recent years, continued growth in the population living with HIV will ultimately lead to more new infections if prevention, care, and treatment efforts are not intensified.¹⁰

To address these challenges, CDC and its partners are pursuing a High-Impact Prevention approach to reducing new HIV infections.¹¹ By using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, this approach promises to increase the impact of HIV prevention efforts – an essential step in achieving the goals of NHAS.

This approach is designed to maximize the impact of prevention efforts for all Americans at risk for HIV infection, including gay and bisexual men, communities of color, women, injection drug users, transgender women and men and youth.

**A conservative estimate examining the period 1991 to 2006.*

High-Impact Prevention: CDC's Approach to Reducing New HIV Infections

To advance the prevention of goals of NHAS and maximize the effectiveness of current HIV prevention methods, CDC pursues a High-Impact Prevention approach.¹¹ By using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, this approach promises to greatly increase the impact of HIV prevention efforts.

Appendix 4: Diffusion of Effective Behavioral Interventions (DEBI) and Public Health Strategies (www.effectiveinterventions.org)

Funding priority will be given to the following Diffusion of Effective Behavioral Interventions (DEBI) and Public Health Strategies

The DEBI project was designed to bring science-based, community, group, and individual-level HIV prevention interventions to community-based service providers and state and local health departments. The goal is to enhance the capacity to implement effective interventions at the state and local levels, to reduce the spread of HIV and STDs, and to promote healthy behaviors. Under the guidance of CDC DHAP, the Center on AIDS & Community Health (COACH) at the Academy for Educational Development (AED) coordinates training on a variety of science-based, effective interventions for HIV prevention. Staff of CDC DHAP Capacity Building Branch, STD/HIV Prevention Training Centers, AED, health departments, and Capacity Building Assistance providers offers training and TA for the interventions.

Evidence Based Interventions for Persons Living with HIV

Choosing Life! Empowerment! Action! Results! (CLEAR) is an evidence-based, health promotion intervention for males and females ages 16 and older living with HIV/AIDS and high-risk HIV-negative individuals. CLEAR is a client-centered program delivered in one-on-one sessions using cognitive behavioral techniques to change behavior, enables prevention counselors to individually tailor the intervention to address the unique needs of each client.

Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.

WILLOW (Women Involved in Life Learning from Other Women) is a social-skills building and educational intervention for adult women living with HIV. It consists of 4 four-hour sessions which are delivered by two trained adult female facilitators, one of whom is a woman living with HIV. The small group sessions consist of 8-10 women living with HIV and are conducted in a community-based setting. An adaptation of the SISTA intervention, WILLOW emphasizes gender pride, informs women how to identify and maintain supportive social networks, teaches coping strategies to reduce life stressors, enhances awareness of STD transmission and HIV reinfection risk behaviors, teaches communication skills for negotiating safe sex, reinforces proper and consistent condom use, distinguishes between healthy and unhealthy relationships, and defines types of abusive relationships and their effect on a woman's ability to negotiate safer sex practices.

Partnership for Health (PfH) is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention. It uses message framing, repetition, and reinforcement during patient visits to increase HIV positive patients' knowledge, skills, and motivations to practice safer sex. Implementation of PfH includes development of clinic and staff "buy-in" and training.

Public Health Strategies aim to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment, and ongoing prevention services for HIV-positive persons, their partners, and those at high risk of contracting the infection. This is achieved by routine HIV testing as a part of medical care and preventing new infections by working with people living with HIV or with populations of high risk.

Public Health Strategy for Persons Living with HIV

Anti-Retroviral Treatment and Access to Services (ARTAS) is an individual-level, multi-session, time-limited intervention with the goal of linking recently diagnosed persons with HIV to medical care soon after receiving their positive test result. ARTAS is based on the Strengths-based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (particularly self-efficacy) and Humanistic Psychology. SBCM is a model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator (LC).

Appendix 5: NC Branch Regional Offices

Regional Disease Intervention Specialist (DIS) Offices

<p>Field Services Co-Manager (Policy, Procedures & Quality Assurance) Todd Vanhoy 3904 West Wendover Avenue, Suite G Greensboro, NC 27407 336-218-5701 todd.vanhoy@dhhs.nc.gov</p>	<p>Field Services Co-Manager (Training & Personnel Coordinator) Constance Jones 225 Green Street, Suite 905 Fayetteville, NC 28301 910-486-1710 constance.jones@dhhs.nc.gov</p>
<p><u>Region I - Black Mountain</u> Michelle Hudgins - Supervisor 952 Old US Hwy 70 Black Mountain, NC 28711 828-669-3350 michelle.hudgins@dhhs.nc.gov</p>	<p><u>Region V - Fayetteville</u> Wayne Williams- Supervisor 225 Green Street, Suite 905 Fayetteville, NC 28301 910-486-1710 wayne.d.williams@dhhs.nc.gov</p>
<p><u>Region II – Charlotte</u> Mediah Lewis – Acting Supervisor 5501 Executive Center Drive, Suite 225 Charlotte, NC 28212 704-566-8990 mediah.lewis@dhhs.nc.gov</p>	<p><u>Region VI – Winterville</u> Tracy Bristow - Supervisor 2561-C Mill Street Winterville, NC 28590 252-355-9084 tracy.bristow@dhhs.nc.gov</p>
<p><u>Region III – Greensboro</u> Albert Sanders- Supervisor 3904 West Wendover Avenue, Suite G Greensboro, NC 27407 336-218-5701 albert.sanders@dhhs.nc.gov</p>	<p><u>Region VII – Wilmington</u> Dishonda Taylor- Lead DIS 3240-6 Burnt Mill Drive Wilmington, NC 28403 910-343-6493 dishonda.taylor@dhhs.nc.gov</p>
<p><u>Region IV - Raleigh</u> Robert Guffey - Supervisor 1200 Front Street, Suite 109 Raleigh, NC 27609 919-715-4283 robert.guffey@dhhs.nc.gov</p>	

Appendix 6: Testing Policy and Procedure Manual

1. Current contract
2. Required reports (progress reports, monthly calendars, projection reports)
3. Resumes/training certificates for staff person(s) funded on current contract
4. Standing orders for delivery of services
5. State updates
6. Letters of Support, Memoranda of Agreement with testing and condom distribution sites
7. Schedule of testing sites
8. Agency Request for Access to State Laboratory of Public Health Laboratory Form and instructions
9. Exposure Control Plan to protect employees from exposure to bloodborne pathogens, staff training, staff vaccination against HBV, properly disposing of regulated medical waste, hand washing procedures, containing, transporting and mailing specimens, handling exposure of patients/staff to HIV/hepatitis B, post-exposure evaluation and follow-up, incident report form, physicians evaluation form
10. Pre-test counseling, risk reduction form, testing report form and all instructions, consent for testing form
11. Post-test counseling, providing results for both negative and positive off-site clients, communicable disease report form
12. Referral form, patient tracking and confirmation referral logs, list of community resources/referral agencies
13. PrEP to high-risk negatives referral form
14. Condom distribution plan, condom log (site of distribution, target demographics, number and brand distributed) Utilizing Disease Intervention Specialists (DIS), follow-up of positive individuals for partner notification, regional office contact information
15. Patient confidentiality of records, personnel confidentiality statement, confidentiality of patient information, permission to release patient information form
16. Rapid HIV testing, if applicable, CLIA certificate of waiver, HIV testing license number certificate, training records, quality assurance plan, proficiency testing, method used for confirmatory testing, temperature logs for storage of test kits and controls
17. Quality assurance plan, staff training, professional development and evaluation, client satisfaction surveys, file transport and storage, chart audits, records management protocol
18. Grievance policy, managing patient complaints, employee complaints
19. Community outreach activities, outreach log, field safety, transporting specimens
20. N.C. General Statutes 130A and N.C. Administrative Codes (10A NCAD 41A. 0100)

Appendix 7: Patient Navigation Protocol

Patient Navigation in North Carolina

Patient navigators provide a wide array of services aimed at helping HIVpositive individuals of color navigate and circumvent the social and structural barriers that impede their successful retention in HIV care and adherence to antiretroviral therapy (ART) regimens. The success of patient navigation is hinged upon the ability of each patient navigator to work with their Regional Network of Care to identify gaps in care for their respective region, and work to fill those gaps. Patient navigation begins with clients at their first contact (Health Department, DIS, SBC, MCM, etc.) and it is this immediate assistance that has made patient navigation so successful around the state. Patient navigation serves as a complement to traditional case management services, and can serve to lessen the burden of traditionally heavy caseloads in medical case management (MCM).

Patient navigators should develop and foster relationships with community-based social service agencies to ensure seamless referrals for their clients that help to address the structural barriers and secondary healthcare needs faced by HIV+ individuals of color. These community relationships should allow the patient navigator to help address any or all of the following barriers to care, as needed within each region and for each client:

- Housing
- Transportation
- Substance Abuse
- Mental Health
- Employment
- Clothing Needs
- Health Literacy
- Social Support
- Partner Testing and Prevention
- Food Security

Patient navigators should also have the ability to attend appointments with their clients. Many clients struggle with the volume of information that is presented at their first appointments, and having a patient navigator present can lessen this burden. Patient navigators should be able to assist clients with making it to appointments by providing bus passes, cab fare or rides to and from these appointments. It is essential that patient navigators have the flexibility to address client needs as they arise so as to ensure each client is immediately engaged or reengaged in care and is able to address any and all barriers to their retention in care. Patient navigators must also have the flexibility to work with a client as long as is needed to ensure the client is able to maintain self-care and stay engaged in their medical care without assistance.

Appendix 8: Federal Certifications

The undersigned states that:

1. He or she is the duly authorized representative of the Contractor named below;
2. He or she is authorized to make, and does hereby make, the following certifications on behalf of the Contractor, as set out herein:
 - a. The Certification Regarding Nondiscrimination;
 - b. The Certification Regarding Drug-Free Workplace Requirements;
 - c. The Certification Regarding Environmental Tobacco Smoke;
 - d. The Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions; and
 - e. The Certification Regarding Lobbying;
3. He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;
4. [Check the applicable statement]
 He or she **has completed** the attached **Disclosure of Lobbying Activities** because the Contractor **has made, or has an agreement to make**, a payment to a lobbying entity for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action;
OR
 He or she **has not completed** the attached **Disclosure of Lobbying Activities** because the Contractor **has not made, and has no agreement to make**, any payment to any lobbying entity for influencing or attempting to influence any officer or employee of any agency, any Member of Congress, any officer or employee of Congress, or any employee of a Member of Congress in connection with a covered Federal action.
5. The Contractor shall require its subcontractors, if any, to make the same certifications and disclosure.

Signature

Title

Contractor [Organization's] Legal Name

Date

[This Certification must be signed by a representative of the Contractor who is authorized to sign contracts.]

I. Certification Regarding Nondiscrimination

The Contractor certifies that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to

nondiscrimination on the basis of alcohol abuse or alcoholism; (g) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (h) the Food Stamp Act and USDA policy, which prohibit discrimination on the basis of religion and political beliefs; and (i) the requirements of any other nondiscrimination statutes which may apply to this Agreement.

II. Certification Regarding Drug-Free Workplace Requirements

1. **The Contractor certifies** that it will provide a drug-free workplace by:
 - a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
 - b. Establishing a drug-free awareness program to inform employees about:
 - (1) The dangers of drug abuse in the workplace;
 - (2) The Contractor's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
 - c. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);
 - d. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;
 - e. **Notifying the Department within ten days after receiving notice under subparagraph (d)(2) from an employee or** otherwise receiving actual notice of such conviction;
 - f. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted:
 - (1) taking appropriate personnel action against such an employee, up to and including termination; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and
 - g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

2. The sites for the performance of work done in connection with the specific agreement are listed below (list all sites; add additional pages if necessary):

Street Address No. 1: _____

City, State, Zip Code: _____

Street Address No. 2: _____

City, State, Zip Code: _____

3. Contractor will inform the Department of any additional sites for performance of work under this agreement.
4. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. 45 C.F.R. 82.510.

III. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

IV. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions Instructions

[The phrase "prospective lower tier participant" means the Contractor.]

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

- a. **The prospective lower tier participant certifies**, by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
- b. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

V. Certification Regarding Lobbying

The Contractor certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of \$100,000.00 or more and that all subrecipients shall certify and disclose accordingly.
4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000.00 and not more than \$100,000.00 for each such failure.

VI. Disclosure of Lobbying Activities

Instructions

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal Identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, grant announcement number, the contract grant, or loan award number, the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate boxes. Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate boxes. Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

**Disclosure of Lobbying Activities
(Approved by OMB 0348-0046)**

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

<p>1. Type of Federal Action:</p> <p><input type="checkbox"/> a. contract</p> <p><input type="checkbox"/> b. grant</p> <p><input type="checkbox"/> c. cooperative agreement</p> <p><input type="checkbox"/> d. loan</p> <p><input type="checkbox"/> e. loan guarantee</p> <p><input type="checkbox"/> f. loan insurance</p>	<p>2. Status of Federal Action:</p> <p><input type="checkbox"/> a. Bid/offer/application</p> <p><input type="checkbox"/> b. Initial Award</p> <p><input type="checkbox"/> c. Post-Award</p>	<p>3. Report Type:</p> <p><input type="checkbox"/> a. initial filing</p> <p><input type="checkbox"/> b. material change</p> <p>For Material Change Only:</p> <p>Year _____ Quarter _____</p> <p>Date of Last Report: _____</p>
<p>4. Name and Address of Reporting Entity:</p> <p><input type="checkbox"/> Prime</p> <p><input type="checkbox"/> Subawardee Tier _____, (if known)</p> <p>Congressional District (if known) _____</p>	<p>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</p> <p>Congressional District (if known) _____</p>	
<p>6. Federal Department/Agency:</p>	<p>7. Federal Program Name/Description:</p> <p>CFDA Number (if applicable) _____</p>	
<p>8. Federal Action Number (if known)</p>	<p>9. Award Amount (if known) :</p> <p>\$ _____</p>	
<p>10. a. Name and Address of Lobbying Registrant (if individual, last name, first name, MI):</p> <p>(attach Continuation Sheet(s) SF-LLL-A, if necessary)</p>	<p>b. Individuals Performing Services (including address if different from No. 10a.) (last name, first name, MI):</p> <p>(attach Continuation Sheet(s) SF-LLL-A, if necessary)</p>	
<p>11. Amount of Payment (check all that apply):</p> <p>\$ _____ actual</p> <p>planned</p>	<p>13. Type of Payment (check all that apply):</p> <p><input type="checkbox"/> a. retainer</p> <p><input type="checkbox"/> b. one-time fee</p> <p><input type="checkbox"/> c. commission</p> <p><input type="checkbox"/> d. contingent fee</p> <p><input type="checkbox"/> e. deferred</p> <p><input type="checkbox"/> f. other; specify: _____</p>	
<p>12. Form of Payment (check all that apply):</p> <p><input type="checkbox"/> a. cash</p> <p><input type="checkbox"/> b. In-kind; specify: Nature _____</p> <p>Value _____</p>		
<p>14. Brief Description of Services Performed or to be Performed and Date(s) of Services, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11 (attach Continuation Sheet(s) SF-LLL-A, if necessary):</p>		
<p>15. Continuation Sheet(s) SF-LLL-A attached: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		

16. Information requested through this form is authorized by title 31 U. S. C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U. S. C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Signature: _____

Print Name: _____

Title: _____

Telephone No: _____ Date: _____

Federal Use Only

Authorized for Local Reproduction
Standard Form - LLL

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D. C. 20503

Appendix 10: Letter to Identify Individuals to Sign Expenditure Reports

**Letter from Board President/Chairperson
Identifying Individuals as Authorized to Sign
Contract Expenditure Reports**

I, _____, Board President/Chairperson
of _____ [Organization's legal name]
hereby identify the following individual(s) who is (are) authorized to sign **Contract
Expenditure Reports** for the organization/agency named above:

Printed Name	Title	Signature
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Reference only — Not for signature

Signature	* Title	Date
-----------	---------	------

** Indicate if you are the Board President or Chairperson*

Appendix 11: Notarized Statement and Conflict of Interest Policy

Notarization of Conflict of Interest Policy

State of North Carolina, County of _____
I, _____, Notary Public for said County and State,
certify that _____ personally appeared
before me this day and acknowledged that he/she is

_____ [title]
of _____

_____ [name of organization]
and by that authority duly given and as the act of the Organization, affirmed that the
foregoing Conflict of Interest Policy was adopted by the Board of Directors/Trustees or
other governing body in a meeting held on the ____ day of _____, _____.
Sworn to and subscribed before me this ____ day of _____, 20 ____.

Notary Signature and Seal
Notary's commission expires _____, 20 ____.

Instruction for the Organization:
Sign below and **attach the organization's Conflict of Interest Policy** which is referenced
above.

Reference only — Not for signature

Signature of above named Organization Official

Conflict of Interest Policy

The Board of Directors/Trustees or other governing persons, officers, employees or agents are to avoid any conflict of interest, even the appearance of a conflict of interest. The Organization's Board of Directors/Trustees or other governing body, officers, staff and agents are obligated to always act in the best interest of the organization. This obligation requires that any Board member or other governing person, officer, employee or agent, in the performance of Organization duties, seek only the furtherance of the Organization mission. At all times, Board members or other governing persons, officers, employees or agents, are prohibited from using their job title, the Organization's name or property, for private profit or benefit.

A. The Board members or other governing persons, officers, employees, or agents of the Organization should neither solicit nor accept gratuities, favors, or anything of monetary value from current or potential contractors/vendors, persons receiving benefits from the Organization or persons who may benefit from the actions of any Board member or other governing person, officer, employee or agent. This is not intended to preclude bona-fide Organization fund raising-activities.

B. A Board or other governing body member may, with the approval of Board or other governing body, receive honoraria for lectures and other such activities while not acting in any official capacity for the Organization. Officers may, with the approval of the Board or other governing body, receive honoraria for lectures and other such activities while on personal days, compensatory time, annual leave, or leave without pay. Employees may, with the prior written approval of their supervisor, receive honoraria for lectures and other such activities while on personal days, compensatory time, annual leave, or leave without pay. If a Board or other governing body member, officer, employee or agent is acting in any official capacity, honoraria received in connection with activities relating to the Organization are to be paid to the Organization.

C. No Board member or other governing person, officer, employee, or agent of the Organization shall participate in the selection, award, or administration of a purchase or contract with a vendor where, to his knowledge, any of the following has a financial interest in that purchase or contract:

1. The Board member or other governing person, officer, employee, or agent;
2. Any member of their family by whole or half blood, step or personal relationship or relative-in-law;
3. An organization in which any of the above is an officer, director, or employee;
4. A person or organization with whom any of the above individuals is negotiating or has any arrangement concerning prospective employment or contracts.

D. **Duty to Disclosure** — Any conflict of interest, potential conflict of interest, or the appearance of a conflict of interest is to be reported to the Board or other governing body or one's supervisor immediately.

E. **Board Action** — When a conflict of interest is relevant to a matter requiring action by the Board of Directors/Trustees or other governing body, the Board member or other governing person, officer, employee, or agent (person(s)) must disclose the existence of the conflict of interest and be given the opportunity to disclose all material facts to the Board and members of committees with governing board delegated powers considering the possible conflict of interest. After disclosure of all material facts, and after any discussion with the person, he/she shall leave the governing board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

In addition, the person(s) shall not participate in the final deliberation or decision regarding the matter under consideration and shall leave the meeting during the discussion of and vote of the Board of Directors/Trustees or other governing body.

F. **Violations of the Conflicts of Interest Policy** — If the Board of Directors/Trustees or other governing body has reasonable cause to believe a member, officer, employee or agent has failed to disclose actual or possible conflicts of interest, it shall inform the person of the basis for such belief and afford the person an opportunity to explain the alleged failure to disclose. If, after hearing the person's response and after making further investigation as warranted by the circumstances, the Board of Directors/Trustees or other governing body determines the member, officer, employee or agent has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

G. **Record of Conflict** — The minutes of the governing board and all committees with board delegated powers shall contain:

1. The names of the persons who disclosed or otherwise were found to have an actual or possible conflict of interest, the nature of the conflict of interest, any action taken to determine whether a conflict of interest was present, and the governing board's or committee's decision as to whether a conflict of interest in fact existed.
2. The names of the persons who were present for discussions and votes relating to the transaction or arrangement that presents a possible conflict of interest, the content of the discussion, including any alternatives to the transaction or arrangement, and a record of any votes taken in connection with the proceedings.

Approved by:

Reference only — Not for signature

Legal Name of Organization

Signature of Organization Official

Title of Organization Official

Date

Appendix 12: Notarized Statement of Continued 501 (c) (3) Status

Verification of 501(c)(3) Status Form

Verification of 501 (c) (3) Status

We, the undersigned entity, hereby testify that the undersigned entity’s 501 (c)(3) status, on file with the North Carolina Department of Health and Human Services is still in effect.

Name of Agency

Signature of Chairman, Executive Director, or other authorized official

Title of above signed authorized official

Sworn to and subscribed before me this _____ day of _____, 20__.

Notary Signature and Seal

Notary’s commission expires _____, 20 ____.

Appendix 13: No Overdue Tax Debts Certification

State Grant Certification – No Overdue Tax Debts¹

To: State Agency Head and Chief Fiscal Officer

Certification:

We certify that the _____ [Organization’s full legal name] does not have any overdue tax debts, as defined by **N.C.G.S. 105-243.1**, at the federal, State, or local level. We further understand that any person who makes a false statement in violation of **N.C.G.S. 143C-6-23(c)** is guilty of a criminal offense punishable as provided by **N.C.G.S. 143C-101(b)**.

Sworn Statement:

_____ [Name of Board Chair] and _____ [Name of Second Authorizing Official] being duly sworn, say that we are the Board Chair and _____ [Title of Second Authorizing Official], respectively, of _____ [Agency/Organization’s full legal name] of _____ [City] in the State of _____ [State]; and that the foregoing certification is true, accurate and complete to the best of our knowledge and was made and subscribed by us. We also acknowledge and understand that any misuse of State funds will be reported to the appropriate authorities for further action.

Reference only — Not for signature

Board Chair
Title

Date

Reference only — Not for signature

Signature

Title of Second Authorizing Official

Date

Sworn to and subscribed before me this _____ day of _____, 20__.

Reference only — Not for signature

Notary Signature and Seal

Notary’s commission expires _____, 20__.

¹ G.S. 105-243.1 defines: Overdue tax debt – Any part of a tax debt that remains unpaid 90 days or more after the notice of final assessment was mailed to the taxpayer. The term does not include a tax debt, however, if the taxpayer entered into an installment agreement for the tax debt under G.S. 105-237 within 90 days after the notice of final assessment was mailed and has not failed to make any payments due under the installment agreement.”

Appendix 14 Contractor Certifications

Contractor Certifications Required by North Carolina Law

Instructions

The person who signs this document should read the text of the statutes listed below and consult with counsel and other knowledgeable persons before signing.

- The text of Article 2 of Chapter 64 of the North Carolina General Statutes can be found online at: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf
- The text of G.S. 105-164.8(b) can be found online at: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf
- The text of G.S. 143-48.5 (S.L. 2013-418, s. 2.(d)) can be found online at: <http://www.ncga.state.nc.us/Sessions/2013/Bills/House/PDF/H786v6.pdf>
- The text of G.S. 143-59.1 can be found online at: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf
- The text of G.S. 143-59.2 can be found online at: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf
- The text of G.S. 147-33.95(g) (S.L. 2013-418, s. 2.(e)) can be found online at: <http://www.ncga.state.nc.us/Sessions/2013/Bills/House/PDF/H786v6.pdf>

Certifications

- (1) Pursuant to **G.S. 143-48.5 and G.S. 147-33.95(g)**, the undersigned hereby certifies that the Contractor named below, and the Contractor's subcontractors, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system." E-Verify System Link: www.uscis.gov
- (2) Pursuant to **G.S. 143-59.1(b)**, the undersigned hereby certifies that the Contractor named below is not an "ineligible Contractor" as set forth in G.S. 143-59.1(a) because:
 - (a) Neither the Contractor nor any of its affiliates has refused to collect the use tax levied under Article 5 of Chapter 105 of the General Statutes on its sales delivered to North Carolina when the sales met one or more of the conditions of G.S. 105-164.8(b); **and**
 - (b) [check **one** of the following boxes]
 - Neither the Contractor nor any of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001; **or**
 - The Contractor or one of its affiliates **has** incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001 **but** the United States is not the principal market for the public trading of the stock of the corporation incorporated in the tax haven country.
- (3) Pursuant to **G.S. 143-59.2(b)**, the undersigned hereby certifies that none of the Contractor's officers,

directors, or owners (if the Contractor is an unincorporated business entity) has been convicted of any violation of Chapter 78A of the General Statutes or the Securities Act of 1933 or the Securities Exchange Act of 1934 within 10 years immediately prior to the date of the bid solicitation.

(4) The undersigned hereby certifies further that:

6. He or she is a duly authorized representative of the Contractor named below;
7. He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and
8. He or she understands that any person who knowingly submits a false certification in response to the requirements of G.S. 143-59.1 and -59.2 shall be guilty of a Class I felony.

Contractor's Name

Reference only — Not for signature

Signature of Contractor's Authorized Agent

Date

Printed Name of Contractor's Authorized Agent

Title

Reference only — Not for signature

Signature of Witness

Title

Printed Name of Witness

Date

The witness should be present when the Contractor's Authorized Agent signs this certification and should sign and date this document immediately thereafter.

Appendix 15: FFATA Form

Federal Funding Accountability and Transparency Act (FFATA) Data Reporting Requirement
 NC DHHS, Division of Public Health Subawardee Information

A. Exemptions from Reporting

1. Entities are **exempted** from the entire FFATA reporting requirement if **any** of the following are true:
 - The entity has a gross income, from all sources, of less than \$300,000 in the previous tax year
 - The entity is an individual
 - If the required reporting would disclose classified information
2. Entities who are not exempted for the FFATA reporting requirement may be exempted from the requirement to provide executive compensation data. This executive compensation data is required only if both are true:
 - More than 80% of the entity’s gross revenues are from the federal government **and** those revenues are more than \$25 million in the preceding fiscal year
 - Compensation information is not already available through reporting to the U.S. Securities and Exchange Commission.

By signing below, I state that the entity listed below is exempt from:

The entire FFATA reporting requirement:

- as the entity’s gross income is less than \$300,000 in the previous tax year.
- as the entity is an individual.
- as the reporting would disclose classified information.

Only executive compensation data reporting:

- as at least one of the bulleted items in item number 2 above is not true.

Reference only — Not for signature

Signature _____ Name _____ Title _____

Entity _____ Date _____

B. Reporting

1. **FFATA Data** required by all entities which receive federal funding (except those exempted above) per the reporting requirements of the *Federal Funding Accountability and Transparency Act (FFATA)*.

Entity’s Legal Name _____ Contract Number _____

Active SAM registration record is attached _____
 An active registration with SAM is required _____ Entity’s DUNS Number _____ Entity’s Parent’s DUNS Nbr (if applicable) _____

Entity’s Location

street address _____
 city/st/zip+4 _____
 county _____

Primary Place of Performance for specified contract

Check here if address is the **same** as Entity’s Location

street address _____
 city/st/zip+4 _____
 county _____

2. **Executive Compensation Data** for the entity’s five most highly compensated officers (unless exempted above):

Title	Name	Total Compensation
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Appendix 16: Sample Memorandum of Agreement (MOA)
Sample Memorandum of Agreement (MOA) for ITTS and SAC

Apple County Health Department
and
North Carolina Ends HIV/STD Program

This Memorandum of Agreement (MOA) is entered by and between Apple County Health Department and North Carolina End AIDS Program (hereinafter referred to as "Contractor"), for the purpose of participating in the Integrated HIV/STD Targeted Testing Sites Project. This MOA is subject to the provisions of all applicable Federal and State laws, regulations, policies and standards.

The administrator for the Apple County Health Department will be Joe Blow, Health Director, 123 Main Street, Anytown, North Carolina 12345 (919) 555-5555. The administrator for the Contractor will be Sally Mae, Executive Director, 321 Prevention Street, Anywhere, North Carolina 54321, (919) 555-5556.

This MOA may be terminated by either party upon at least 30 days written notice or immediately upon notice for cause. This MOA may be amended, if mutually agreed upon, to change scope and terms of the MOA. Such changes shall be incorporated as a written amendment to this MOA.

The Apple County Health Department agrees to provide the following:

- Certified HIV counselor for free pre- and post-test counseling (trained in the State approved CTR Training)
- Trained staff for venipuncture testing and rapid HIV testing
- Laboratory and testing supplies, condoms and literature
- Paperwork and data entry required by the State HIV/STD Prevention and Care Branch and the State Laboratory
- Continuous quality improvement in accordance with laboratory and procedural guidelines for labeling and processing samples
- Linkages and referrals to HIV/STD treatment and community service organizations serving targeted population

The Contractor agrees to provide the following:

- A secure free space, which allows for privacy and is in close proximity to a telephone and water source, for counseling and testing activities twice per month
- Social marketing strategies to actively market the program in efforts to raise community awareness about counseling and testing activities (i.e., distribute brochures and flyers)
- Recruit and refer clients for counseling and testing

This MOA shall begin on June 1, 2017 and end on May 31, 2018.

Apple County Health Department

North Carolina End AIDS Program

BY: Joe Jenkins

BY: Sally Mae

TITLE: Health Director

TITLE: Executive Director

DATE: June 1, 2017

DATE: June 1, 2017

Leroy Jones **Witness**

Sample Memorandum of Agreement (MOA) for Ryan White Part B Services

Community Care Services
and
The Counseling Center

This Memorandum of Agreement (MOA) is entered by and between Community Care Services (hereinafter referred to as Program) and The Counseling Center (hereinafter referred to as Sub-Recipient), for the purpose of participating in the Ryan White Part B HIV Care Services program. Through this MOA, The Counseling Center will provide mental health services for persons living with HIV referred by Community Care Services. This MOA is subject to the provisions of all applicable Federal and State laws, regulations, policies and standards.

The administrator for the Program will be Joe Blow, HIV Services Director, 123 Main Street, Anytown, North Carolina 12345 (919) 555-5555. The administrator for the Sub-Recipient will be Sally Mae, Executive Director, 321 Prevention Street, Anywhere, North Carolina 54321, (919) 555-5556.

This MOA may be terminated by either party upon at least 30 days written notice or immediately upon notice for cause. This MOA may be amended, if mutually agreed upon, to change scope and terms of the MOA. Such changes shall be incorporated as a written amendment to this MOA.

The Counseling Center (Sub-Recipient) agrees to provide the following:

- Work with Community Care Services (Program) to establish a client referral and tracking system in order to have a Counselor available to meet with clients at designated times.
- Provide outpatient, individual, mental health counseling services for four hours per week. Client appointments will be made within two weeks of referral from the Program to the Sub-Recipient.
- Maintain record keeping for the provision of mental health services as outlined in the Ryan White Part B National Monitoring Standards.
- Allow for client record and fiscal review by the Program as required to ensure that all Federal and State laws, regulations, policies and standards are being met.
- Not refer clients to another mental health provider outside of the Sub-Recipient's agency without prior notification to and approval from the Program.
- Invoice the Program monthly in a mutually agreed upon format.

Community Care Services (Program) agrees to provide the following:

- Work with The Counseling Center (Sub-Recipient) to establish a client referral and tracking system in order to ensure a Counselor is available to meet with clients at designated times.
- Refer patients with mental health conditions that are beyond the expertise of the Program's staff.
- Review client and fiscal records for client services provided by the Sub-Recipient to ensure that all Federal and State laws, regulations, policies and standards are being met.
- Provide reimbursement at \$65 per hour (not to exceed Medicaid rates) for payment of services rendered in keeping with the policies of the Ryan White Part B program.
- Review this agreement with the Sub-Recipient quarterly and make written modifications as necessary.

This MOA shall begin on June 1, 2017 and end on May 31, 2018.

Community Care Services

BY: Joe Jenkins

TITLE: HIV Services Director

DATE: April 1, 2017

Leroy Jones **Witness**

The Counseling Center

BY: Sally Mae

TITLE: Executive Director

DATE: April 1, 2017

Sample Memorandum of Agreement (MOA) for HOPWA Services

Housing Coalition, Inc.
and
Clifton Housing Services

This Memorandum of Agreement (MOA) is entered by and between Housing Coalition, Inc. (hereinafter referred to as Program) and Clifton Housing Services (hereinafter referred to as Sub-Recipient), for the purpose of participating in the Housing Opportunities for Persons with AIDS (HOPWA) program. Through this MOA, Clifton Housing Services will provide Tenant Based Rental Assistance (TBRA) for persons living with HIV/AIDS as referred by Housing Coalition, Inc. This MOA is subject to the provisions of all applicable Federal and State laws, regulations, policies and standards.

The administrator for the Program will be Joe Blow, HIV Services Director, 123 Main Street, Anytown, North Carolina 12345 (919) 555-5555. The administrator for the Sub-Recipient will be Sally Mae, Executive Director, 321 Prevention Street, Anywhere, North Carolina 54321, (919) 555-5556.

This MOA may be terminated by either party upon at least 30 days written notice or immediately upon notice for cause. This MOA may be amended, if mutually agreed upon, to change scope and terms of the MOA. Such changes shall be incorporated as a written amendment to this MOA.

Clifton Housing Services (Sub-Recipient) agrees to provide the following:

- Administer the TBRA program to referred clients through a voucher system.
- Conduct all inspections or rental units in accordance with HUD guidelines.
- Maintain record keeping for the provision of TBRA services as outlined in the North Carolina HOPWA Manual.
- Allow for client record and fiscal review by the Program as required to ensure that all Federal and State laws, regulations, policies and standards are being met.
- Notify the program anytime a client wait list has to be implemented and provide a plan for how the wait list will be managed and clients will be referred to other available housing resources.
- Invoice the Program monthly in a mutually agreed upon format.

Housing Coalition Inc. (Program) agrees to provide the following:

- Screen clients for HOPWA eligibility and refer clients needing TBRA services to the Sub-Recipient.
- Provide TBRA programmatic training and technical assistance as needed to Sub-Recipient staff.
- Review client and fiscal records for client services provided by the Sub-Recipient to ensure that all Federal and State laws, regulations, policies and standards are being met.
- Provide reimbursement for TBRA services rendered in keeping with the policies of the HOPWA program.
- Review this agreement with the Sub-Recipient quarterly and make written modifications as necessary. Any modification will be dated and signed by all parties prior to any changes being performed.

This MOA shall begin on June 1, 2017 and end on May 31, 2018.

Housing Coalition, Inc.

BY: Joe Jenkins

TITLE: HIV Services Director

DATE: October 1, 2017

Leroy Jones **Witness**

The Counseling Center

BY: Sally Mae

TITLE: Executive Director

DATE: October 1, 2017

Appendix 17: Budget Guidelines and Sample Budgets
Travel Reimbursement

Mileage reimbursement rates must be based on rates determined by the North Carolina Office of State Budget and Management (OSBM). Because mileage rates fluctuate with the price of fuel, the OSBM will release the “Change in IRS Mileage Rate” memorandum to be found on [OSBM’s website](#) when there is a change in this rate. The current state mileage reimbursement rate is \$.54 cents per mile.

For other travel related expenses, please refer to the current rates for travel and lodging reimbursement, presented in the chart below. However, please be advised that reimbursement rates periodically change. The Division of Public Health will only reimburse for rates authorized in OSBM’s North Carolina Budget Manual¹ or adopted by means of an OSBM Budget Memo².

Current Rates for Travel and Lodging

Meals			In State	Out of State
	Breakfast		\$8.30	
	Lunch		\$10.90	
	Dinner		\$18.70	
	Per Diem		\$37.90	
Lodging		(Maximum)	\$67.30	\$79.50
Total			\$105.20	\$120.00
Mileage		\$0.54 cents per mile		

State rules and guidelines shall take precedence over federal guidelines governing the use of federal grant funds, unless specifically exempted by OSBM in advance.

¹ Office of State Budget and Management Budget Manual. Current travel rates can be found in this document: <https://ncosbm.s3.amazonaws.com/s3fs-public/documents/files/BudgetManual.pdf>

² Office of State Budget and Management Budget Memos are published in the Library section of OSBM’s website and categorized by State Fiscal year: <https://www.osbm.nc.gov/library>

Housing Opportunities for Persons with AIDS (HOPWA)

Administrative Costs

Spend no more than 7% of total HOPWA expenditures on administration, and submit documentation of administrative expenditures to the ACP each month.

Incentives

N/A

Indirect Cost

The HOPWA grant limits administrative cost to 7 percent of total HOPWA expenditures. Where the applicant has a Federal Negotiated Indirect Cost Rate (FNICR), the indirect cost rate requested may not exceed the grant limits, regardless of the applicant's recognized rate.

Ryan White Part B

Administrative Costs

Spend no more than 10% of total Ryan White expenditures on administration, and submit documentation of administrative expenditures to the ACP each month.

Incentives

N/A

Indirect Cost

The Ryan White grant limits administrative cost to 10 percent of total Ryan White expenditures. Where the applicant has a Federal Negotiated Indirect Cost Rate (FNICR), the indirect cost rate requested may not exceed the award's limits regardless of the applicant's recognized rate.

Counseling, Testing and Referral in Substance Abuse Centers (SAC)

Administrative Costs

N/A

Incentives

N/A

Indirect Cost

The Substance Abuse Treatment and Block Grant does not restrict indirect cost. Where the applicant has a Federal Negotiated Indirect Cost Rate (FNICR) letter, the indirect cost rate defined in the letter can be taken on the Modified Total Direct Cost (MTDC). A copy of the FNICR must be included with the applicant's budget.

If the applicant has no FNICR, a 10% indirect cost rate (known as the *de minimus* rate), can be taken on the MTDC with no additional documentation required, per the U.S. Office of

Management and Budget (OMB) Omni-Circular. Applicants must indicate in the budget narrative that they wish to use the de minimus rate, or some part thereof. Applicants who do not wish to claim any indirect cost should enter “No indirect cost requested” in the budget narrative.

**Federally Funded Integrated Targeted Testing Services (ITTS)
Prevention With Positives (PWP)**

Administrative Costs

N/A

Incentives

N/A

Indirect Cost

The Comprehensive HIV Prevention Projects for Health Departments Grant does not restrict indirect cost. Where the applicant has a Federal Negotiated Indirect Cost Rate (FNICR) letter, the indirect cost rate defined in the letter can be taken on the Modified Total Direct Cost (MTDC). A copy of the FNICR must be included with the applicant’s budget.

If the applicant has no FNICR, a 10% indirect cost rate (known as the *de minimus* rate), can be taken on the MTDC with no additional documentation required, per the U.S. Office of Management and Budget (OMB) Omni-Circular. Applicants must indicate in the budget narrative that they wish to use the de minimus rate, or some part thereof. Applicants who do not wish to claim any indirect cost should enter “No indirect cost requested” in the budget narrative.

State Funded Integrated Targeted Testing Services (ITTS)

Administrative Costs

N/A

Incentives

N/A

Indirect Cost

NC Division of Public Health policy limits indirect cost to 10 percent. Where the applicant has a FNICR, the total modified direct cost identified in the applicant’s FNICR shall be applied up to 10 percent. A copy of the FNICR must be included with the applicant’s budget.

If the applicant has no FNICR, an indirect cost rate may be established by an independent Certified Public Accountant (CPA) using criteria and cost principles outlined in the applicable codes of federal regulations (CFRs):

State, Local and Indian Tribal Governments	2 CFR Part 225 & ASMB C-10
Educational Institutions	2 CFR Part 220
Hospitals	2 CFR Part 215
Private Non-Profit Organizations	2 CFR Part 230
For Profit Organizations (other than hospitals)	48 CFR Part 31

Under these conditions, a person or firm, preferably one knowledgeable of this subject should establish the rate. This person or firm should not be associated with the audit firm that conducts an audit of the entity's records. Once a rate has been established, this person or firm should certify in writing to the entity that the rate has been established in accordance with the applicable federal circular and that the documentation should be maintained and made available to any auditor requesting such information. Per NC Division of Public Health policy, the total modified direct cost identified in the applicant's indirect cost rate letter shall be applied up to 10 percent.

If the applicant has no FNICR and no indirect cost rate established by a CPA, person or firm, then the applicant may *not* claim indirect cost in the budget.

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Sample Budgets - HOPWA

Housing Coalition, Inc. HOPWA Budget Narrative October 1, 2017 - September 30, 2018

Administration **\$30,646**
Salary/Fringe **\$28,426**

Director of Housing (Keith Collins - Annual Salary \$50,000) \$12,500

Direct salary cost of 0.25 FTE. The Director of Housing coordinates all of the Network housing-related activities including updating the Network needs assessment and resource directory; assuring Network housing providers adhere to all applicable Federal and state regulations; assuring all HOPWA contractual obligations are fulfilled; monitoring of sub-contractors; and compiling the quarterly HOPWA Data Report and annual CAPER. He also develops and maintains excellent working relationships with more than 100 private market landlords to maintain an adequate supply of housing units that meet both Housing Quality Standards (HQS) and Fair Market Rent (FMR) throughout the Network service area. In the absence of the Housing Specialist (e.g., vacations and illness), the Director of Housing performs all of her tasks.

Fringe Benefits (at 19.45% of salary expense excluding health insurance)\$3,119

Annual Medical Insurance \$4,131

FICA \$956.25 (7.65%) + SUTA \$262.50 (2.10%) + Workers Comp \$112.50 (.9%) + Dental/L/STD/LTD \$725.00 (5.8%) + 403-b \$375.00 (3%) = \$2,431.25

Medical Insurance \$687.50 (5.5%)

\$2,431.25 + 687.50 = \$3,118.75

Accountant (Phyllis Peele – Annual Salary \$41,000) \$10,250

Direct salary cost of 0.25 FTE. This employee completes rent and utilities calculations on a monthly basis, authorizes amounts to be paid to landlords and subcontractors, prepares the MER and CER, tracks reimbursements from the ACP, and ensures all HOPWA transactions are correctly entered in the accounting records.

Fringe Benefits (at 19.45% of salary expense excluding health insurance)\$2,557

Annual Medical Insurance \$4,131

FICA \$784.13 (7.65%) + SUTA \$215.25 (2.10%) + Workers Comp \$92.25 (.9%) + Dental/L/STD/LTD \$594.50 (5.8%) + 403-b \$307.50 (3%) = \$1,993.63

Medical Insurance \$563.75 (5.5%)

\$1,993.63 + 563.75 = \$2,557.38

Operating Expenses **\$2,220**
Travel Reimbursement \$2,220

The Director of Housing and the Housing Specialist will use their own vehicles to travel throughout the 9 counties of the network service area. This travel is necessary to locate housing units, meet with landlords and clients, conduct outreach, and attend required meetings and trainings. Housing Coalition, Inc. employees are reimbursed for travel at \$0.54 per mile. It is estimated they will be reimbursed for at least 4,111.11 miles per year (4,111.11 x \$0.54 = \$2,220.00).

Housing Information

\$15,619

Salary/Fringe

\$15,619

Director of Housing (Keith Collins – Annual Salary \$50,000) \$12,500

Direct salary cost of .25 FTE. The Director of Housing provides Housing Information, education and counseling, including permanent housing placement, to help persons with HIV/AIDS and their families to identify, locate, obtain, and retain affordable, permanent housing that meets Housing Quality Standards (HQS). He conducts housing intakes, takes clients to look for rental housing, negotiates leases with landlords, and helps clients complete all activities required to obtain housing (e.g., initiating utility service, helping clients resolve pending utility bills, etc.), and coordinates all aspects of the household’s placement in (i.e., move into) permanent housing. He works with Housing Coalition, Inc.’s administrative staff to ensure correct calculation and documentation of the client’s portion of rent and utilities according to HUD guidelines. He ensures all HOPWA-eligible individuals enrolled in HOPWA have a housing plan and helps clients comply with the written lease through regular home visits and telephone contact. He also helps clients and landlords resolve any problems or complaints they have about each other. He ensures that all HOPWA clients are effectively linked to medical care and appropriate support services (e.g., case management, mental health/substance services, etc.). In addition, he conducts outreach to referral sources (i.e., AIDS service organizations, homeless shelters, state prisons, etc.) to promote effective utilization of the rental assistance program, and participates in community-wide homeless coordination activities on behalf of the HOPWA program. At least 115 households receive this service throughout the Network service area.

Fringe Benefits (at 19.45% of salary expense excluding health insurance)\$3,119

Annual Medical Insurance \$4,131

FICA \$956.25 (7.65%) + SUTA \$262.50 (2.10%) + Workers Comp \$112.50 (.9%) + Dental/L/STD/LTD \$725.00 (5.8%) + 403-b \$375.00 (3%) = \$2,431.25

Medical Insurance \$687.50 (5.5%)

\$2,431.25 + 687.50 = \$3,118.75

Short-Term Rental/Mortgage and Utility Assistance (STRMU)

\$46,918

Contracted Services

\$46,918

STRMU Payments - Clifton Case Management Services \$46,918

Based on prior experience, Clifton Case Management Services expects to provide STRMU to at least 55 unduplicated clients (and their household members) per year. The average amount per household per year is \$853.05 X 55 clients = \$46,918.00. No program costs will be charged.

Tenant-Based Rental Assistance (TBRA)

Salary/Fringe (Program Cost)

\$36,164

Housing Specialist (Chris Crisp – Annual Salary \$38,590) \$28,943

Direct salary cost of 0.75 FTE. The Housing Specialist completes client intake and needs assessments; reviews client household income; prepares and maintains TBRA termination documentation; performs initial and annual housing inspections; conducts annual recertification; handles client and/or landlord concerns; and works with the accounting staff to prepare monthly rental assistance checks. He serves at least 160 HOPWA beneficiaries per year which includes both HIV + and non-HIV + individuals in eligible households.

Fringe Benefits (at 19.45% of salary expense excluding health insurance) \$7,221
 Annual Medical Insurance \$4,131
 FICA \$2,214.14 (7.65%) + SUTA \$607.80 (2.10%) + Workers Comp \$260.49 (.9%) +
 Dental/L/STD/LTD \$1,678.69 (5.8%) + 403-b \$868.29 (3%) = \$5,629.41
 Medical Insurance \$1,591.87 (5.5%)
 \$5,629.41 + 1,591.87 = \$7,221.28

Operating Expenses **\$217,475**

TBRA Payments \$217,475
 Housing Coalition, Inc. will provide tenant-based rental assistance to 31 HOPWA-eligible households living throughout the 9 counties of Region 11. Based on experience, the average monthly rent and utilities allowance subsidy per household is \$584.61. Therefore, calculation is \$584.61 X 12 months X 31 households = \$217,475.00.

Contracted Services **\$160,869**

TBRA Program Cost - Luray Housing Authority \$11,260
 At 7.526% of annual TBRA allocation of \$149,609.00 = \$11,260.00. Luray Housing Authority will be reimbursed for the following activities: review and documentation of household income, program termination documentation; annual housing inspections; annual recertification; preparing and issuing monthly rental assistance checks.

TBRA Payments - Luray Housing Authority \$149,609
 Luray Housing Authority will continue its TBRA program for residents of Luray County. Luray Housing Authority estimates it will provide housing to approximately 20 HOPWA-eligible households in Luray County. Based on Luray Housing Authority's experience, the average monthly rent and utilities allowance subsidy per household is \$623.37. Therefore, the calculation is \$623.37 X 12 months X 20 households = \$149,609.00.

Total Request **\$507,691**

Housing Coalition, Inc.					
October 1, 2017 - September 30, 2018					
HOPWA Eligible Activities	Administration	Short Term Rent Mortgage & Billing	TBRA	Housing Information	Total Budget
Salary/Fringe:					
Phyllis Peele, Accountant (.25 FTE of \$41,000 annual salary)	\$10,250.00				\$10,250.00
Keith Collins, Director of Housing (.50 FTE of \$50,000 annual salary)	\$12,500.00			\$12,500.00	\$25,000.00
Chris Crisp, Housing Specialist (.75 FTE of \$38,590 annual salary)			\$28,943.00		\$28,943.00
Fringe Benefits at 24.95%	\$5,676.00		\$7,221.00	\$3,119.00	\$16,016.00
Sub-Total Salary/Fringe	\$28,426.00		\$36,164.00	\$15,619.00	\$80,209.00
Operating Expenses:					
TBRA			\$217,475.00		\$217,475.00
Travel Reimbursement (\$0.54 Mile)	\$2,220.00				\$2,220.00
Sub-Total Operating Expenses	\$2,220.00		\$217,475.00		\$219,695.00
Contracted Services:					
Luray Housing Authority - TBRA			\$149,609.00		\$149,609.00
Luray Housing Authority - TBRA Program Cost			\$11,260.00		\$11,260.00
Clifton Case Management Services - STRMU		\$46,918.00			\$46,918.00
Sub-Total Contracted Svcs		\$46,918.00	\$160,869.00		\$207,787.00
TOTAL	\$30,646.00	\$46,918.00	\$414,508.00	\$15,619.00	\$507,691.00

Sample Budget: Ryan White

**COMMUNITY CARE SERVICES
RYAN WHITE BUDGET NARRATIVE
April 1, 2017- March 31, 2018**

Administration

\$30,731

Medical Case Management (MCM) Supervisor, Frank Smith: \$10,854

Salary – \$72,361, 0.15 FTE

This position will monitor subcontracted providers on an ongoing basis and provide oversight to assure contractual obligations are met and that the Network adheres to all federal and state regulations, policies and guidance. The MCM Supervisor will provide oversight and supervision to all medical case managers at Pathway Case Management. The MCM supervisor will ensure MCM documentation meets the standards required by the AIDS Care Program and will confirm that interactions with clients are documented appropriately. Chart reviews will be completed quarterly as well as individual supervision meetings (minimum two hours) with each medical case manager to ensure current standards are maintained.

Ryan White Program Manager, Kris Kringle: \$7,929

Salary – \$49,557, 0.16 FTE

Position will manage CAREWare data collection and data entry and submission of all Ryan White Part B (RWPB) required reports including the RSR. He will compile and submit required RWPB fiscal and program reports, implement and update a Quality Management Plan, and collect/report quality management performance indicators.

Case Coordinator, Lisa Lee: \$11,948

Salary - \$29,869, 0.40 FTE

Position will assist the Program Manager with CAREWare data collection and data entry and submission of all RWPB required reports including the RSR. This staff person will also assist with the collection and reporting of quality management performance indicators.

Please note: Fringe benefits for administrative salaries are paid by Community Care Services (CCS).

Planning and Evaluation

\$31,721

Medical Case Management (MCM) Supervisor, Frank Smith: \$17,367

Salary – \$72,361, 0.24 FTE

Position will coordinate the Network which includes convening and facilitating network meetings and update a network resource directory. He will also implement and update standards of care for the provision of care services in the region, coordinate Network services, and assist with updating and implementation of the evaluation plan for the Network. The supervisor will include the continuation of a training program transitioning the current case managers from a social case management model to a medical case management model. The training includes mentoring as well as educational courses regarding treatment adherence and bridging activities.

Fringe Benefits: \$4,118

Yearly premium for health insurance = \$8,473

12% fringe and health insurance are paid from RW Part B funding for CCS employees. These benefits are: Pension (\$173.67 or 1%), FICA (\$217.09 or 1.25%), Prescription Coverage (\$43.42 or 0.25%), Dental Insurance (\$43.42 or 0.25%), Disability (\$43.42 or 0.25%), Paid Time Off (\$1,389.36 or 8%), and Employee Assistance Program (\$173.67 or 1%).

Health Insurance calculated at \$8,473. (yearly premium) x 0.24 FTE = \$2,033.52.

\$2,084 + \$2,034 = \$4,118

Ryan White Program Manager, Kris Kringle: \$7,929

Salary – \$49,557, 0.16 FTE

Position will update of a network service delivery plan and network-wide needs assessment. This position will also assist with updating and implementation of the evaluation plan for the Network.

Fringe Benefits: \$2,307

Yearly premium for health insurance = \$8,473

12% fringe and health insurance are paid from RW Part B funding for CCS employees. These benefits are Pension (\$79.29 or 1%), FICA (\$99.11 or 1.25%), Prescription Coverage (\$19.82 or 0.25%), Dental Insurance (\$19.82 or 0.25%), Disability (\$19.82 or 0.25%), Paid Time Off (\$634.32 or 8%), and Employee Assistance Program (\$79.29 or 1%).

Health Insurance calculated at \$8,473. (yearly premium) x 0.16 FTE = \$1,355.68

\$951 + \$1,356 = \$2,307

Note: Community Care Services staff paid through a different funding source are assisting with the update of the Network Client Grievance Policy and conducting the Client Satisfaction survey.

Client Services

Outpatient Ambulatory (Core)

\$72,870

Physician, Megan Kennedy, MD: \$61,329

Salary – \$107,595, 0.57 FTE

Position will provide professional diagnostic and therapeutic medical services in the Ryan White Clinic setting. She will provide primary medical care for the treatment of HIV infection including the provision of care that is consistent with Public Health Service (PHS) guidelines. Care includes access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. 120 clients x 3 visits each = 360 visits.

Fringe Benefits: \$11,541

Yearly premium for health insurance = \$7,336

12% fringe and health insurance are paid from RW Part B funding for CCS employees. These benefits are Pension (\$613.29 or 1%), FICA (\$766.61 or 1.25%), Prescription Coverage (\$153.32 or 0.25%), Dental Insurance (\$153.32 or 0.25%), Disability (\$153.32 or 0.25%), Paid Time Off (\$4,906.32 or 8%), and Employee Assistance Program (\$613.29 or 1%).

Health Insurance calculated at \$7,336 (yearly premium) x 0.57 FTE = \$4,181.52.

\$7,359 + \$4,182 = \$11,541

Medical Case Management (Core)

\$8,056

Medical Case Management (MCM) Supervisor, Frank Smith: \$6,512

Salary – \$72,361, 0.09 FTE

Position will provide medical case management by linking clients with medical care providers and other healthcare services. The MCM Supervisor will conduct intake appointments with clients, which will include the initial assessment of service needs. He will provide treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. The MCM supervisor will ensure timely access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client's needs. He will ensure coordination and follow-up of medical treatments. Key activities include: development of a comprehensive, individualized service plan, coordination of services required to implement the plan, client monitoring to assess the efficacy of the plan, and periodic re-evaluation and adaptation of the plan as necessary.

Fringe Benefits: \$1,544

Yearly premium for health insurance = \$8,473

12% fringe and health insurance are paid from RW Part B funding for CCS employees. These benefits are Pension (\$65.12 or 1%), FICA (\$81.40 or 1.25%), Prescription Coverage (\$16.28 or 0.25%), Dental Insurance (\$16.28 or 0.25%), Disability (\$16.28 or 0.25%), Paid Time Off (\$520.96 or 8%), and Employee Assistance Program (\$65.12 or 1%).

Health Insurance calculated at \$8,473. (yearly premium) x 0.09 FTE = \$762.57.

\$781 + \$763 = 1,544

Psychosocial Support (Support)

\$3,618

Medical Case Management (MCM) Supervisor, Frank Smith: \$3,618

Salary – \$72,361, 0.05 FTE

Position will provide support and counseling activities, HIV support groups, and bereavement counseling to clients and their families. Psychosocial support is a means of providing information concerning coping with chronic illness and gathering educational resources to lessen anxiety about HIV disease. 30 clients x 1 visit = 30 visits.

Please note: Fringe benefits for Psychosocial Support are paid by CCS.

Operating Expenses

Outpatient Ambulatory (Core)

\$59,906

Labs/Diagnostic Tests

Laboratory services, diagnostic testing and immunizations to be provided by CCS and through referral to hospitals and medical practices in the Network to be reimbursed at Medicaid rate on a fee-for-service basis.

100 clients @ 4 lab/diagnostic test/immunization visits = 400 @ \$103.78/visit = \$41,512

Fee for Service

Specialty medical care services to be provided through referral to many medical practices in the Network to be reimbursed at Medicaid rate on a fee-for-service basis.

75 clients @ 2 referral visits = 150 @ \$100/visit = \$15,000

Pharmacy assistance provided by CCS to provide medications to clients. CCS uses a contract 340 B mail-order pharmacy program and a pharmacist will be used to obtain, fill and counsel for medications. This program allows reduction in the overall cost of funding non-covered medications. Medications will be purchased through 340B and other pharmacies as necessary. 78 clients will receive this service

1 HIV/AIDS medication @ \$398/each = \$398

25 non-HIV medications @ \$19.84/each = \$496

Medical Supplies

Partial support for medical supplies including patient sheets, catch kits, bandages, gloves, speculums, syringes, blood collection tubes, and other necessary supplies to be purchased.

500 supply items @ \$5 per supply item = \$2,500

Oral Health (Core)

\$19,200

Fee for Service

Oral health including diagnostic, preventive, and therapeutic services to be provided at Medicaid rates on a fee-for-service basis by Smiles Family Dentistry, Exeter Dental Center, Dr. Page, Dr. Sunshine, Dr. Carol, and other oral health providers.

60 clients @ 2 visits/client = 120 @ \$160/visit = \$19,200

Health Insurance Premium and Cost-Sharing Assistance (Core)

\$10,000

Fee for Service

Funds provided for assistance for eligible individuals to maintain a continuity of health insurance or to receive medical benefits under a health insurance program to be provided through CCS. Services include premium payments, deductibles, and co-payments for medical care and medications.

100 clients @ 4 payments = 400 @ \$25/payment= \$10,000

Mental Health (Core) \$7,000

Fee for Service

Psychological and psychiatric treatment & counseling services will be provided at Medicaid rates on a fee-for-service basis by Carson Psychiatric Services, The Counseling Center, Central Behavioral Health, Glasgow Mental Health, and other mental health providers.

20 clients @ 5 visits/client = 100 @ \$70/visit = \$7,000

Medical Nutrition Therapy (Core) \$1,800

Fee for Service

Therapy provided by a licensed registered dietitian and the provision of appropriate nutritional supplements as required by the plan of care developed by the dietitian to be provided at Medicaid rates on a fee-for-service basis by Celebration Nutrition Services and other providers.

30 clients @ 10 cases/client = 300 @ \$4/case = \$1,200

8 clients @ 1 visit/client @ \$75/visit = \$600

Substance Abuse Outpatient (Core) \$300

Fee for Service

Medical or other treatment and/or counseling to address substance abuse problems in an outpatient setting to be provided by Recovery Connections and other substance abuse providers at Medicaid rates on a fee-for-service basis.

1 clients @ 4 visits/client = 4 @ \$75/visit = \$300

Medical Transportation (Support) \$500

Fee for Service

CCS will provide transportation assistance in the form of mileage reimbursement (at the state rate or below) to volunteers, friends, and family members to transport clients to medical appointments.

10 clients @ 100 miles (3 trips per client) = 1,000 @ \$0.50/mile = \$500

Emergency Financial Assistance (Support) \$3,000

Fee for Service

CCS to provide short-term payments on a fee-for-service basis to assist with emergency expenses related to essential utilities, housing, and food, when other resources are not available. The assistance is provided on a short-term basis and is used as payment of last resort. 30 clients @ \$100/payment = \$3,000

Food Bank (Support) \$300

Fee for Service

CCS to purchase food vouchers to provide to clients on a monthly basis as needed. 10 clients @ 3 vouchers each = 30 vouchers @ \$10/voucher = \$300

Linguistics Services (Support) \$800

Fee for Service

CCS to provide interpretation and translation services (Spanish, Sign Language, and others as needed) at CCS and medical referral agencies on a fee-for-service basis. 60 services will be provided.

8 clients @ 4 hours @ \$25/hour = \$800

Contracted Services

Administration \$8,045

Pathway Lead Medical Case Manager (LMCM), Roberta Rhodes: \$2,854

Salary – \$35,704, 0.08 FTE

Position will process requests for payment of services, assist with contract record keeping, and assist with data collection entry into CAREWare. She will monitor program budget and expenditures to assure that contract guidelines are met and agency adheres to all federal and state regulations.

Pathway Office Manager/Financial Officer, Shirley Shoe: \$5,189

Salary – \$39,914, 0.13 FTE

Position will process and pay check requests from providers, complete and submit monthly billing and reports, monitor budget, and maintain contract records.

Fringe will be paid using other resources.

Planning and Evaluation

\$2,499

Pathway Lead Medical Case Manager (LMCM), Roberta Rhodes: \$2,499

Salary – \$35,704, 0.07 FTE

Position will locate and maintain providers and assist in obtaining Memoranda of Understanding agreements for the region. She will also assist with annual update of the network resource directory and network-wide needs assessment.

Fringe will be paid using other resources.

Note: Pathway staff paid through a different funding source are assisting with the update of the Network Client Grievance Policy and conducting the Client Satisfaction survey.

Medical Case Management (Core)

\$99,153

Pathway Medical Case Managers (MCMs)

Yearly premium for health insurance = \$7,145.52 per staff person

Tonya Claus, Salary \$30,603 @ 0.91 FTE = \$27,849

Roberta Rhodes, Salary \$35,704 @ 0.40 FTE = \$14,282

Tim Tinely, Salary \$15,600 @ .91 FTE = \$14,196

Brandon Mack, Salary \$32,151 @ 0.92 FTE = \$29,579

Positions will link clients with medical care providers and other healthcare services. MCMs will provide treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. They will ensure timely access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client's needs. MCMs will ensure coordination and follow-up of medical treatments. Key activities include: development of a comprehensive, individualized service plan, coordination of services required to implement the plan, client monitoring to assess the efficacy of the plan, and periodic re-evaluation and adaptation of the plan as necessary.

42 clients x 3.5 medical case managers = 147 clients x 6 visits per client = 882 visits/services.

Fringe Benefits \$13,247

CCS allows partial payment of fringe benefits for Pathway MCMs at 8.45% and health insurance at 6.97% (15.40%).

Salary in the amount of \$85,906 is calculated at 8.45% to provide employees with Dental Insurance (\$687.25 or .80%), and FICA (\$6,571.81 or 7.65%).

Health insurance calculated at \$7,146 (yearly premium) x 2.23 FTE (Tim Tinely does not receive benefits) = \$15,935.58 of which \$5,987.94 is being charged to the Ryan White Part B program.

Medical Transportation (Support)

\$9,783

Pathway will provide transportation assistance in the form of bus/van tickets and mileage reimbursement (at the state rate or below) to clients, volunteers, or family members to transport clients to medical appointments. Note: Clients will not be eligible for direct mileage reimbursement. A total of 42 clients will be served.

123.33 trips @ 140 miles @ \$0.54/mile = \$9,324

6 clients @ 34 dial a ride bus/van tickets @ \$2.25/ticket = \$459

<i>Emergency Financial Assistance (Support)</i>	\$15,000
Pathway will provide short-term payments on a fee-for-service basis to assist with emergency expenses related to essential utilities, housing, food, and medication when other resources are not available. The assistance is provided on a short-term basis and is used as payment of last resort.	
150 clients @ \$100/payment = \$15,000	
 <i>Food Bank (Support)</i>	 \$15,618
Pathway will purchase food vouchers for clients on a monthly basis, as needed.	
137 clients @ \$9.50/voucher (1 each month/client for 12 months) = \$15,618	
 <i>Linguistics Services (Support)</i>	 \$100
Pathway will provide interpretation and translation services (Spanish, Sign Language, and others), as needed at Pathway and medical referral agencies, on a fee-for-service basis.	
2 clients @ 2 hours @ \$25/hour = \$100	
 Minority AIDS Initiative (MAI)	 \$29,054
Operating Expense	
Travel	\$2,034
To support the travel of the ADAP Coordinator to various case management agencies, clinics, and community based organizations for the purposes of assisting with completion of ADAP authorizations/reauthorizations. The ADAP coordinator will travel approximately 302.68 miles per month.	
313.89 miles x \$0.54/mile x 12 months = \$2,034	
 Office Supplies	 \$500
General office supplies include cartridges, paper, binders, pens, staples, and copier usage. The total cost of office supplies are based on projected annual costs of \$500 (\$41.67 per month).	
\$41.67 x 12 months = \$500	
 Contracted Services	
ADAP Coordinator, TBD, \$17 per hour	\$26,520
Temporary position will serve as a part-time ADAP Coordinator. Position will assist with ADAP authorizations/reauthorizations for minorities. In addition, this position will provide outreach to clients, especially targeting minorities, about ADAP, viral suppression, medication adherence and the importance of remaining in medical care.	
\$17 per hour x 30 hours per week x 52 weeks = \$26,520	
 Total Contract Budget	 \$429,054

Community Care Services			Core Medical Services							Support Services	
Contract Budget Period 04/01/17-3/31/18			Output.	Oral	Health Ins.	Mental	Med. Nutr.	Med. Case	Sub. Abuse	TOTAL	Medical
Ryan White Part B Eligible Activities	Admin	P&E	Ambul.	Health	Prem. & Cost-Sharing Assis.	Health	Therapy	Mgmt.	Svcs-Outpt.	CORE	Transport.
Salary/Fringe:											
Frank Smith, MCM Supervisor, .53 FTE (\$72,361)	10,854	17,367						6,512		6,512	
Kris Kringle, Ryan White Program Manager, .32 FTE (\$49,557)	7,929	7,929									
Lisa Lee, Case Coordinator, .40 FTE (\$29,869)	11,948										
Megan Kennedy, MD, 0.57 FTE (\$107,595)			61,329							61,329	
Fringe Benefits @ 12% (no fringe for Admin.)		3,035	7,359					781		8,140	
Health Insurance		3,390	4,182					763		4,945	
Sub-Total Salary/Fringe	30,731	31,721	72,870					8,056		80,926	
Operating Expenses:											
Labs/Diagnostic Tests			41,512							41,512	
Fee-for-service			15,894	19,200	10,000	7,000	1,200		300	53,594	500
Medical Supplies			2,500							2,500	
Nutritional Supplements							600			600	
Travel											
Office Supplies											
Sub-Total Operating Expenses			59,906	19,200	10,000	7,000	1,800		300	98,206	500
Contracted Services:											
ADAP Coordinator, Temporary Employee, (\$17/Hr)											
Pathway Case Management	8,045	2,499						99,153		99,153	9,783
Sub-Total Contracted Services	8,045	2,499						99,153		99,153	9,783
TOTAL Part B	38,776	34,220	132,776	19,200	10,000	7,000	1,800	107,209	300	278,285	10,283

Estimated ITTS/SAC Detailed Budget Breakdown Page and Estimated Budget Justification Page Instructions

1. Utilize the forms provided to do the *Estimated Budget Breakdown Page* and *Estimated Budget Justification Page*. Blank forms along with samples are provided.
2. Budget narratives must show calculations for all budget line items and clearly justify/explain the need for these items. Budget costs must be in accordance with State rates, reasonable and justifiable. The budget must support the Scope of Work activities and objectives.
3. All expenses that are shared across multiple programs (e.g., rent, utilities, insurance, etc.) must be prorated for this program and the narrative must include a detailed calculation which demonstrates how the agency prorates the items.

Salary and Fringe:

- a. Salary/Wage – Provide justification of all personnel including staff names, titles and descriptions of job duties as they relate to the program. Note: Narratives for staff in contracts with any State (UNC) Universities MUST include the staff person's university employment status as SPA, EPA, EPA Physician, etc.

Justification Sample for Salary/Wage: HIV/STD Coordinator/Phlebotomist, Rita Cahan, 1.0 FTE - Annual Salary = \$28,100 x 1.0 FTE = **\$28,100** The Coordinator/Phlebotomist will plan, coordinate, and conduct counseling, testing and referrals at targeted sites for high-risk populations using both phlebotomy services and rapid HIV and HCV testing methods. She is also responsible for sending specimens to the State Lab and LabCorp. Conducts post-test counseling and referrals for all clients that receive positive test results.

- b. Fringe – Provide justification narrative for fringe. List each benefit and include percentage for each and show the calculation for each staff person listed.

Justification Sample for Fringe: HIV/STD Coordinator/Phlebotomist, Rita Cahan, 1.0 FTE - Annual Health Insurance Premium = \$4,235 x 1.0 FTE = \$4,235; SUI (\$22,300 x 3.0% = \$669 x 1.0 FTE = \$669); FICA (\$28,100 x 7.65% = \$2,149.65); Retirement (\$28,100 x 3% = \$843); Workers Comp (\$28,100 x 1.0% = \$281). Total = \$8,177.65

Supplies and Materials: There are two main categories under “Supplies and Materials”; *Furniture* and *Other*. The one most commonly used is *Other*. Categories are further described below. Furniture: Desks, Bookshelves, chairs, file cabinets, etc. Other: Additional Supplies and Materials purchased such as Educational items, Curriculums, Videos, Books, Training manuals, Office supplies, Postage, Business cards, etc. Stand

alone, purchased software, under \$500 (such as Peachtree Accounting or similar) is also considered a supply. Disposable (one-time-use) medical supplies are also considered a supply.

Equipment: Equipment is for items that are purchased outright – not rented or leased. Typically, an item considered “Equipment” is a depreciable asset.

Office: Copier Machine, Fax Machine.

IT: Personal Computers, laptops, iPads, scanners, desk printers, PC speakers.

Scientific: Centrifuge, Microscope, Lab equipment.

Travel: Please note: Reimbursements for travel should not exceed current State Rates as defined by the State of North Carolina Office of State Budget and Management.

Contractor Staff: Include any travels, meals, mileage for staff members listed under the salary and fringe section.

Board Members Expense: Includes any travel, meals, mileage for board members

Justification Sample for Contractor Staff Travel: Overnight accommodations for Program Coordinator and Program Assistant to attend required XYZ Training: 2 nights x \$67.30 = \$134.60. 418 miles round trip from Greensboro, NC to Wilmington, NC for training x \$0.54/mile = \$225.72. 2 staff x (1 breakfast at \$8.30 each + 2 lunches at \$10.90 each + 2 dinners at \$18.70 each) = \$135.00. Total travel: \$134.60 + \$225.72 + \$135.00 = \$495.32.

North Carolina Travel Subsistence Rates, *Updated January 1, 2016:*

- In-state meals - \$8.30 breakfast, \$10.90 lunch, \$18.70 dinner.
- In-state lodging (excluding tax) - \$67.30/night.
- Out-of-state meals - \$8.30 breakfast, \$10.90 lunch, \$21.30 dinner.
- Out-of-state lodging (excluding tax) - \$79.50/night.
- Breaks - The state can only reimburse \$4.50 per day for breaks for sponsored events;
20 persons must be in attendance for breaks to be charged to state funds.

Mileage Rate, effective January 1, 2016:

- Mileage rate: \$0.54/mile.

Utilities: (If not included in the rent)

- Gas: Monthly Gas bill prorated for program share
- Electric: Monthly Electricity bill prorated for program share
- Telephone: Monthly Phone or Cell service prorated for program share
- Water: Monthly Water bill prorated for program share
- Other: Use this for any utility item that does not fit in one of the defined categories above, such as internet service (unless it combines with telephone), security monthly monitoring cost, etc.

Justification Sample for Utilities: Prorated share of electric bill: This contract represents 25% of the combined total of all 4 funding sources and therefore is responsible for 25% of the overall cost. 25% of \$100 monthly cost is \$25; 12 months x \$25 = \$300.

Repair and Maintenance: Custodial Services or basic Repairs and Maintenance not billed in the Professional Service area.

Publications: Items that the Contractor is responsible for designing, producing, and/or printing such as brochures, posters, and fact sheets, related to program activities etc.

Reprints: Duplication of an existing publication; photocopies. This is typically done at an office supply business.

Websites and Web Materials: Includes the costs to create a website and/or maintain website, etc. This could also be prorated for program share

Justification Sample for Reprints: Program flyers for community program (1,000 @ \$.10 = \$100); photocopies for use in program sessions (400/month @ \$.05 ea. = \$20 x 12 mos. = \$240); Total = \$340.

Rent: Office Space: Office Space, Program Meeting Space – must include square footage. Calculations must define totals and prorated amounts for the program.

- Equipment: This category is for equipment that is rented or leased, such as a Copier Machine or Phone System.

- Furniture: Rented or Leased office furniture.
- Vehicles: Long-term leases of Cars, Vans or Buses. (Vehicles rented for short-term *staff* travel belong under Contractor Staff travel. Vehicles rented for short-term *participant* travel belong under Incentives and Participants.)

Professional Services: These are services that are purchased to support the overhead of the agency.

- Legal: Legal services retained by the Contractor
- IT: Information Technology or IT-related technical services retained by the Contractor
- Accounting: Accounting, bookkeeping services retained by the Contractor
- Payroll: Payroll services retained by the Contractor
- Security: Security services, in the form of personnel such as a security guard, retained by the Contractor. (Purchase of a security system belongs under Equipment - Other. Monthly security monitoring belongs under Utilities – Other.)

Dues and Subscriptions: Dues for professional associations/affiliations; Subscriptions to related or required periodicals; Subscriptions to web-based applications such as Survey Monkey or Constant Contact that are leased at a rate per month.

Operational Other:

- Audit Services: Cost associated with annual financial audits performed. NOTE: Contractors must be a Level 3 Contractor with the State (i.e., receive more than \$500,000 in State dollars) for audit costs to be allowable in their budget. Audit costs are NOT allowable at all in Purchase of Service (POS) contracts.
- Service Payments: Costs associated with a retained service, or medical activity such as the processing of blood work by a lab, physical examination, or the monitoring of a person's blood pressure where the practitioner is paid for the particular service rendered, rather than receiving a salary.
- Incentives and Participants: Costs associated with: Incentives given to participants or comparison group members (e.g., gift cards, meals, diaper bags, etc.); Participant Costs (field trips, enrichment activities, etc.); Open Houses; Parents' Nights, etc.
- Insurance and Bonding: Liability Insurance to cover staff and participants while field trip or daily activities.
- Other: Use this for any item that does not fit in any other category.

Subcontracting: The Contractor subcontracts work out to another entity. Note: do not include any Professional Services (legal, accounting) as they are captured in the "Professional Services" category listed above.

Example 1:

The Contractor is giving a portion of the funds to another entity that will also render services to participants such as providing testing services.

Example 2:

The contract is for an evaluation and the building of a database to track recipients of service, number of services received, etc. The Contractor hires an IT vendor to build the database. In this instance, the IT vendor is a subcontractor because the work is program-related.

Estimated Detailed ITTS/SAC Budget SAMPLE

Name: No Limits Health Care, Inc.	
<i>Item Description</i>	<i>Contract Amount</i>
Salary and Fringe	
HIV/STD Prevention Program Director, Ruth Chris	\$24,250
Fringe - HIV/STD Prevention Program Director	\$5,277
HIV/STD Coordinator/Phlebotomist, Rita Cahan	\$28,100
Fringe - HIV/STD Coordinator/Phlebotomist	\$8,178
Phlebotomist, Dolby Grey	\$6,460
Fringe – Phlebotomist	\$1,979
Total Salary and Fringe	\$74,244

Operating Expenses	
Supplies and Materials – Office	\$1,092
Supplies and Materials – Medical Supplies	\$4,903
Travel/Contractor Staff	\$3,336
Utilities – Telephone	\$1,260
Rent – Office Space	\$7,749
Professional Services – Payroll	\$1,575
Operational Other – Incentives and Participants	\$1,340
Total Operation Expenses	\$21,256

Subcontracting/Grants	
Operational Other/Service Payments - LabCorp	\$4,500
Total Contractual Services	\$4,500

Total Budget	\$ 100,000
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Estimated Budget ITTS/SAC Narrative -SAMPLE

No Limits Health Care, Inc. - Budget Detail Year 1

Category	Item	Narrative	Amount
Salary/Wages		<p>HIV/STD Prevention Program Director, Ruth Chris, 0.50 FTE - Annual Salary = \$48,500 x 0.50 FTE = \$24,250 The Program Director will be directly responsible for program staff, monitoring the ITTS program budget, and developing and instituting a quality management plan. Also responsible for processing, maintaining, and preparing required reports for the State Communicable Disease Branch.</p> <p>HIV/STD Coordinator/Phlebotomist, Rita Cahan, 1.0 FTE - Annual Salary = \$28,100 x 1.0 FTE = \$28,100 The Coordinator/Phlebotomist will plan, coordinate, and conduct counseling, testing and referrals at targeted sites for high-risk populations using both phlebotomy services and rapid HIV and HCV testing methods. She is also responsible for sending specimens to the State Lab and LabCorp. Conducts post-test counseling and referrals for all clients that receive positive test results.</p> <p>Phlebotomist, Dolby Grey, 0.25 FTE - Annual Salary = \$25,840 x 0.25 FTE = \$6,460 The Phlebotomist will assist in planning, coordinating, and conducting counseling, testing and referrals at targeted sites for high-risk populations using both phlebotomy services and rapid HIV and HCV testing methods. Also responsible for sending specimens to the State Lab and LabCorp. Conducts post-test counseling and referrals for all clients that receive positive test results.</p> <p>Total FTEs: 0.50 + 1.0 + 0.25 = 1.75 FTEs</p> <p>\$24,250 + 28,100 + \$6,460 = \$58,810</p>	\$58,810

Fringe Benefits		<p>HIV/STD Prevention Program Director, Ruth Chris, 0.50 FTE - Annual Health Insurance Premium = \$4,235 x 0.50 FTE = \$2,117.50; SUI (\$22,300 x 3.0% = \$669 x 0.50 FTE = \$334.50); FICA (\$24,250 x 7.65% = \$1,855.13); Retirement (\$24,250 x 3% = \$727.50); Workers Comp (\$24,250 x 1.0% = \$242.50). Total = \$5,277.13 (\$5,277)</p> <p>HIV/STD Coordinator/Phlebotomist, Rita Cahan, 1.0 FTE - Annual Health Insurance Premium = \$4,235 x 1.0 FTE = \$4,235; SUI (\$22,300 x 3.0% = \$669 x 1.0 FTE = \$669); FICA (\$28,100 x 7.65% = \$2,149.65); Retirement (\$28,100 x 3% = \$843); Workers Comp (\$28,100 x 1.0% = \$281). Total = \$8,177.65 (\$8,178)</p> <p>Phlebotomist, Dolby Grey, 0.25 FTE - Annual Health Insurance Premium = \$4,235 x 0.25 FTE = \$1,058.75; SUI (\$22,300 x 3.0% = \$669 x 0.25 FTE = \$167.25); FICA (\$6,460 x 7.65% = \$494.19); Retirement (\$6,460 x 3% = \$193.80); Workers Comp (\$6,460 x 1.0% = \$64.60). Total = \$1,978.59 (\$1,979)</p> <p>\$5,277 + \$8,178+ \$1,979 = \$15,434</p>	\$15,434
Supplies and Materials	Other	<p>Office Supplies: General office supplies needed to support 1.75 FTE ITTS program staff in conducting the day to day program operations:</p> <p>3 - cases of paper x \$35 ea. = \$105; 3 - Desk Calendars x \$6.50 ea. = \$19.50; 8 – Printer toner cartridges x \$32.05 ea. = \$256.40; 1 - pkg. of Sharpie Highlighters at \$6.49; 5 - toner cartridges for the copier x \$68 each = \$340; 20 - boxes of folders x \$12.75 each = \$255; 1 - case of legal pads at \$74.50; 3 – pkg. of pens x \$11.75 ea. = \$35.25.</p> <p>\$105 + \$19.50 + \$256.40 + \$6.49 + \$340 + \$255 + \$74.50 + \$35.25 = \$1,092</p>	\$1,092

Supplies and Materials	Other	<p>Medical Supplies: Medical supplies necessary to conduct the testing requirements of the ITTS Program:</p> <p>100 - syphilis mailers x \$1.76 ea. = \$176; 2 - cases of biohazard bags x \$100 ea. = \$200; 3 - boxes of disposable lab gear x \$135 ea. = \$405; 5 - cases of latex gloves x \$60 ea. = \$300; 15 - bottles of disinfectant x \$3.28 ea. = \$49.20; 4 - Hand Sanitizers x \$3.50 ea. = \$14; 4 - boxes of Lancets at \$20.56 ea. = \$82.24; 3 - packs of Tubes x \$67.23 ea. = \$201.69; 3 - Flexible Fabric Elastic Strips x \$29 ea. = \$87; 176 OraQuick ADVANCE® HCV kits x \$19.25 ea. = \$3,388.</p> <p>\$176 + \$200 + \$405 + \$300 + \$49.20 + \$14 + \$82.24 + \$201.69 + \$87 + \$3,388 = \$4,903</p>	\$4,903
Travel	Contractor Staff	<p>Travel: Reimbursement for staff to travel throughout a five county region to conduct testing and program activities. Also includes mileage to attend HIV/STD Communicable Disease Branch required trainings and meetings. Program staff travels an estimated 515 miles per month. 515 x 12 = 6,180 miles x \$0.54 per mile = \$3,337.20 (\$3,337)</p>	\$3,337
Utilities	Telephone	<p>Telephone: The telephone lines are used to maintain communication with agency staff, community partners, and clients. 3 Cell Phones at \$60 per month each for voice and data package. ITTS Funds are allocated to pay for a portion of the monthly cost, based on 1.75 FTEs. HIV/STD Prevention Program Director 0.50 FTE x \$60 = \$30 per month x 12 = \$360; HIV/STD Coordinator/Phlebotomist, 1.0 FTE x \$60 = \$60 per month x 12 = \$720; Phlebotomist 0.25 FTE x \$60 = \$15 per month x 12 = \$180.</p> <p>\$360 + \$720 + \$180 = \$1,260</p>	\$1,260
Rent	Office Space	<p>Rent: Offices for No Limits Health Care, Inc. are located at 1000 Main St., Suite G, Arrow, NC 28000. The ITTS Program occupies 315 sq. ft. (in a building that is 12,235 sq. ft.). The Rent is based on the rate of \$2.05 per sq.</p>	\$7,749

		ft. x 12 mos. (June 1, 2017 to May 31, 2018). 315 x \$2.05 = \$645.75 per mo. x 12 mos. = \$7,749	
Professional Services	Payroll	Payroll: Automatic Data Processing (ADP) performs payroll and tax filing functions, as well as maintaining 401k accounts. \$75 per month x 1.75 FTE = \$131.25 x 12 months = \$1,575	\$1,575
Operational Other	Incentives and Participants	Incentives: The ITTS Program plans to test 1,000 unduplicated clients. As an incentive to increase test numbers, clients that agree to test will receive a \$5 gift card from various local retail stores. 268 gift cards will be purchased and the remaining 732 gift cards will be requested from the Branch and other sources. 268 x \$5 = \$1,340	\$1,340
Subcontracting/Grants:			
Operational Other	Service Payments	LabCorp: LabCorp is contracted to process Gonorrhea and Chlamydia tests. 150 tests x \$30 ea. = \$4,500	\$4,500
Total Contractual Services:			\$4,500
Total Budget			\$100,000

Appendix 18: AIDS Care Program Funded Projects & HOPWA MSAs

**Patient Management Networks for HIV Care in North Carolina
(Includes AIDS Care Program Funded Projects and HOPWA MSA Projects)
July 7, 2016
Regional HIV Care Networks**

Region/Network Name	Agency Name	Contact Information	Services Provided	Counties Served
One HIV Care Network of WNC	The Western North Carolina Community Health Services, Inc.	Scott Parker (Network Administrator) PO Box 338 Asheville, NC 28802 257 Biltmore Avenue Asheville, NC 28801 Phone: 828-348-2015 Fax: 828-285-9421 wparker@wncchs.org Website: www.hivcarewnc.org Website: www.wncchs.org	Ryan White HOPWA	Avery, Buncombe, Cherokee, Clay, Cleveland, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
	Western North Carolina AIDS Project (WNCAP)	Jeff Bachar P.O. Box 2411 Asheville, NC 28802 554 Fairview Road Asheville, NC 28803 Phone: (828) 252-7489 FAX: (828) 253-8602 jbachar@wncap.org Website: http://wncap.org	Ryan White	Avery, Buncombe, Cherokee, Clay, Cleveland, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
Two Region II Network of Care	Catawba Valley Medical Center	Michelle Lusk (Network Administrator) 810 Fairgrove Church Road, SE Hickory, NC 28602 Phone: 828-326-3467 Fax: 828-326-2922 mmace@catawbavalleycmc.org	Ryan White	Alexander, Alleghany, Ashe, Burke, Caldwell, Catawba, Lincoln, Watauga, Wilkes
	AIDS Leadership-Foothills Area Alliance, Inc.	Hollie Kistler-Black 1120 Fairgrove Church Road, SE, Suite 28 Hickory, NC 28602 Phone: 828-322-1447 Fax: 828-322-8795 alfacms@alfainfo.org	HOPWA	Alexander, Alleghany, Ashe, Burke, Caldwell, Catawba, Watauga, Wilkes *Lincoln – see MSA list on page 6

Region/Network Name	Agency Name	Contact Information	Services Provided	Counties Served
Three Region III Network of Care	Wake Forest University Health Sciences	Michael Case (Network Administrator) Section on Infectious Diseases Medical Center Boulevard Winston-Salem, NC 27157 Phone: (336) 716-4889 Fax: (336) 716-3825 mcase@wakehealth.edu	Ryan White	Davidson, Davie, Forsyth, Iredell, Rowan, Stokes, Surry, Yadkin
	AIDS Care Service, Inc.	Rivkah Meder, Special Programs Case Manager PO Box 21373 Winston-Salem, NC 27120 995 West Northwest Boulevard Winston-Salem, NC 27101 Phone: 336-777-0208 Fax: 336-722-6494 rmeder@acsws.microsoftonline.com	HOPWA	Davidson, Davie, Forsyth, Stokes, Surry, Yadkin *Rowan and Iredell – see MSA list on page 6
	Positive Wellness Alliance	Julie Meyer PO Box 703 Lexington, NC 27293 400 East Center Street Lexington, NC 27292 Phone: 336-248-4646 Fax: 336-248-4059 jmeyer@pwanc.org	HOPWA	Davidson, Davie, Forsyth *Rowan and Iredell – see MSA list on page 6
Four Central Carolina Health Network	Central Carolina Health Network	Kent Gammon (Network Administrator) 1 Centerview Drive Suite 202 Greensboro, NC 27407 Phone: 336-292-0665 Fax: 336-292-6427 Kent.gammon@cchn4.org	Ryan White HOPWA	<u>Ryan White:</u> Alamance, Caswell, Guilford, Montgomery, Randolph, Rockingham, Stanly <u>HOPWA:</u> Alamance, Caswell, Montgomery, Stanly *Guilford, Randolph, Rockingham – see MSA list on page 6
Five Dogwood Healthcare Network	Robeson County Health Department	Sandra Smith (Network Administrator) 460 Country Club Road Lumberton, NC 28360 Phone: 910-737-5010 Fax: 910-737-5011 sandra.smith@hth.co.robeson.nc.us	Ryan White HOPWA	Bladen, Cumberland, Harnett, Hoke, Moore, Richmond, Robeson, Sampson, Scotland, <u>HOPWA</u> Also covers Anson

Region/Network Name	Agency Name	Contact Information	Services Provided	Counties Served
Six Access Network of Care	Duke University Partners In Caring	Artie Hendricks (Network Co-Administrator) Duke University Partners In Caring DUMC 3112 Durham, NC 27710 Phone: 919-684-3211 Fax: 919-684-4971 arthur.hendricks@duke.edu	HOPWA	Granville, Lee, Vance, Warren *Wake, Johnston, Franklin – see MSA list on page 6 *Durham, Orange, Chatham, Person – see MSA list on page 6
	Wake County Human Services	Michael McNeill (Network Co-Administrator) Wake County Human Services 10 Sunnybrook Road Raleigh, NC 27610 Phone: 919-250-4481 Fax: 919-250-4429 michael.mcneill@wakegov.com	Ryan White	Chatham, Durham, Franklin, Granville, Johnston, Lee, Orange, Person, Vance, Wake, Warren
Seven Southeastern Region Network of Care	Duke University Partners In Caring	Artie Hendricks (Network Co-Administrator) Duke University Partners In Caring DUMC 3112 Durham, NC 27710 Phone: 919-684-3211 Fax: 919-684-4971 arthur.hendricks@duke.edu	Ryan White HOPWA	Brunswick, Columbus, Duplin, New Hanover, Onslow, Pender
	New Hanover Regional Medical Center	Susan O'Brien (Network Co-Administrator) 1725 New Hanover Medical Park Dr Wilmington, NC 28403-5345 Phone: 910-662-9349 Fax: 910-662-9380 sobrien@nhrmc.org	Ryan White	Brunswick, Columbus, Duplin, New Hanover, Onslow, Pender
Eight Region 8 Network of Care	Carolina Family Health Centers, Inc.	Corina (Corie) Buzard (Network Administrator) PO Box 99 Wilson, NC 27894 303 East Green Street Wilson, NC 27893 Phone: 252-243-9800 x230 Fax: 252-243-9888 cbuzard@cfhcnc.org Sherita Simmons Ryan White Program Manager Phone: 252-243-9800 x220	Ryan White HOPWA	Edgecombe, Halifax, Nash, Northampton, Wilson

Region/Network Name	Agency Name	Contact Information	Services Provided	Counties Served
Nine Northeastern North Carolina Regional HIV Network of Care	Hertford County Public Health Authority	Cherri Brunson (Network Administrator) PO Box 694 Ahoskie, NC 27910 714 Evans Street Ahoskie, NC 27910 Phone: 252-332-6650 Fax: 252-332-6654 cherri.brunson@hcpha.net	Ryan White HOPWA	<u>Ryan White</u> Bertie, Camden, Chowan, Currituck, Dare, Gates, Hertford, Hyde, Pasquotank, Perquimans, Tyrrell <u>HOPWA:</u> Bertie, Camden, Chowan, Dare, Gates, Hertford, Hyde, Pasquotank, Perquimans, Tyrrell Currituck – see MSA list on page 6
Ten E-CARE Net (Eastern Carolina HIV/AIDS Regional Network)	Brody School of Medicine at East Carolina University	Diane Campbell, M.D. (Network Administrator) Brody School of Medicine at East Carolina University 2300 Beasley Drive, Doctors Park #6A Greenville, NC 27834 ECU Infectious Disease Clinic @ DP6a 600 Moye Blvd., Mailstop 715 Greenville, NC 27834 Phone: 252-744-4500, option 2 Fax: 252-744-3472 campbelldi@ecu.edu Esther Ross Network Coordinator Phone: 252-744-5719 Email: rosse@ecu.edu Website: http://www.ecu.edu/cs-dhs/im/InfectiousDiseases/Ryan-White.cfm	Ryan White	Beaufort, Carteret, Craven, Greene, Jones, Lenoir, Martin, Pamlico, Pitt, Washington, Wayne
	Greenville Housing Authority	Tujuanda Sanders PO Box 1426 Greenville, NC 27834 1103 Broad Street Greenville, NC 27835 Phone: 252-329-4088 Fax: 252-329-4899 sanderstr@ghanc.net	HOPWA	Beaufort, Carteret, Craven, Greene, Jones, Lenoir, Martin, Pamlico, Pitt, Washington, Wayne

ACP Funded Projects (These projects participate in one or more Networks of Care, but are not funded as Networks of Care)

Ryan White Emerging Communities Project

Agency	Contact Information	Counties Served
Wake County Human Services PO Box 14049 Raleigh, NC 27620-4040	Karen Best Phone: 919-212-9575 Fax: 919-250-4429 karen.best@wakegov.com	Franklin, Johnston, Wake *Participates in Region 6

Ryan White Primary Medical Care Project

Agency	Contact Information	Counties Served
UNC Hospitals-ID Clinic 101 Manning Dr. Chapel Hill, NC 27814	Claire Farel Associate Professor Medical Director, UNC Infectious Diseases Clinic Phone: 919-843-3659 Fax: 919-966-8928 cfarel@med.unc.edu Amy Heine, MSN, RN, FNP-BC UNC Department of Medicine Infectious Disease Division Phone: 919-843-5174 Fax: 919-966-6714 Amy_heine@med.unc.edu	Alamance, Caswell, Chatham, Craven, Cumberland, Duplin, Durham, Franklin, Granville, Guilford, Harnett, Hoke, Johnston, Lee, Montgomery, Moore, Orange, Person, Randolph, Richmond, Robeson, Rockingham, Sampson, Scotland, Vance, Wake, Warren *Participates in Regions 4, 5 and 6

HOPWA MSA Providers (Not funded by ACP – Receive direct funding from HUD)

MSA Provider	Counties Served	Contact Information
Wake County MSA	1.Wake 2.Johnston 3.Franklin	Emily Fischbein , Housing Program Manager Emily.fischbein@wakegov.com (919) 508-0781
Durham-Chapel Hill MSA	1. Durham 2. Orange 3. Chatham 4. Person	Reginald Johnson , Esq. Director Reginald.johnson@durhamnc.gov (919) 560-4570 ext. 22223 Esther Wynn , Administrative Assistant to Reginald Johnson. (Copy her on all emails to Mr. Johnson) Esther.wynn@durhamnc.gov (919) 560-4570, ext. 22243

		Lloyd Schmeidler , Project Manager Lloyd.schmeidler@durhamnc.gov (919) 560-4570 ext. 22267
City of Greensboro MSA	1. Guilford 2. Randolph 3. Rockingham	Rhonda Enoch , Housing Program Coordinator Rhonda.enoch@greensboro-nc.gov (336) 373-4147
Carolinas Care Partnership-Charlotte MSA	1. Cabarrus 2. Gaston 3. Iredell 4. Lincoln 5. Mecklenburg 6. Rowan 7. Union	Shannon Warren , Interim Executive Director shannonW@carolinascare.org (704) 531-2467 (704) 531-4414 fax
Virginia Beach, VA MSA	1. Currituck County, North Carolina	AIDS Care Center for Education & Support Services (ACCESS) 222 West 21st Street, Suite F-308 Norfolk, VA 23517 (757) 640-0929 (757) 622-8932 fax www.accessaids.org Stacie Walls-Beegle , Executive Director Stacie@accessaids.org Irma Hinkle , Program Director (757) 640-0929 ext. 216 ihinkle@accessaids.org

Appendix 19: Prevention Projects

Region	Agency Name	Contact Information	Services	Counties Served
Region I	Blue Ridge Community Health Center 2579 Chimney Rock Road Hendersonville, NC 28792	Michelle Hogsed Phone: (828) 692-4289 ext. 2234 Fax: (828) 692-4396 mhogsed@brchs.com	RT ³ only	Henderson
	Buncombe County Health Department 40 Coxe Avenue Asheville, NC 28801	Sue Ellen Morrison, Health Director Phone: (828) 250-5109 sueellen.morrison@buncombecounty.org	RT only	Buncombe
	Carolinas CARE Partnership	Shannon Warren, Executive Director See TGA for contact information.	ITTS SAC RT	Cleveland (See Region III and TGA for additional counties.)
	Western North Carolina AIDS Project 554 Fairview Road Asheville, NC 28803	Jeff Bachar, Executive Director Phone: (828) 252-7489 Fax: (828) 253-8602 jbachar@wncap.org	ITTS RT	Avery, Buncombe, Cherokee, Clay, Cleveland, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
Region II	AIDS Leadership-Foothills Area Alliance 1120 Fairgrove Church Rd. SE Suite 28 Hickory, NC 28602	Chris Kliesch, Executive Director Phone: 828-322-1447 ext. 224 alfadirect@alfainfo.org Linda Sheehan, Dir. Outreach/Education Phone: 828-322-1447 ext. 222 prevention@alfainfo.org	ITTS RT	Alexander, Alleghany, Ashe, Burke, Caldwell, Catawba, Lincoln, Watauga, Wilkes
Region III	Carolinas CARE Partnership	Shannon Warren, Executive Director See TGA for contact information.	ITTS SAC RT	Iredell (See Region I and TGA for additional counties.)
	Forsyth County Department of Public Health 799 North Highland Ave Winston-Salem, NC 27101	Marlon Hunter, Health Director Phone: (336) 703-3100 Fax: (336) 727-8034 huntermb@forsyth.cc Jennifer Nail, HIV/STD Program Spvsr. Phone: (336) 703-3181 nalljl@forsyth.cc	ET ITTS RT	Forsyth
	Livingstone College 701 West Monroe St. Salisbury, NC 28144	Walter Ellis, Professor Phone: (704) 216-6218 Fax: (704) 216-6729 wellis@livingstone.edu	EBIS	Rowan
	NIA Community Action Center 122 N. Elm Street Suite 1000 Greensboro, NC 27401	Sandy Michael Whitaker, Executive Director Phone: (336) 617-7722 sandy051275@yahoo.com	ITTS RT	Forsyth
	Wellness & Education Community Health Action Network	Ricky Duck, Executive Director See Region VI for contact information.	SAC RT ITTS	Davidson, Forsyth, Rowan (See Regions IV, V, VI and TGA for additional counties & services)
Region IV	Alamance Cares 3025 S. Church St Burlington, NC 27215	Jason Greene, Program Director Phone: (336) 538-8111 Fax (336) 538-8634 jasongreene@conehealth.com	ITTS RT	Alamance, Caswell, Rockingham
	Alcohol and Drug Services 119 Chestnut Dr. High Point, NC 27262	Anthony Steele, Dir. of Medical Svcs. Phone: (336) 333-6860 Fax: (336) 822-8153	RT only	Alamance, Guilford, Randolph

³ EBIS – Evidence-Based Intervention Services; ET – Expanded Testing (Jails, FQHCs, Emergency Departments) ITTS – Integrated Targeted Testing Services; SAC – CTR in Substance Abuse Centers; RT – Rapid Testing in conjunction with funded projects; RT only – Receives Rapid Test Kits only

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		astelee@adsyes.org		
	Duke University Partners in Caring	Arthur Hendricks, Director See Region VI for contact information.	SAC RT	Caswell (See Region VI and VII for additional counties.)
	Guilford County Department of Health and Human Services 1203 Maple St. Greensboro, NC 27405 1100 East Wendover Ave Greensboro, NC 27405 (RT)	Merle Green, Health Director Phone: (336) 641-7777 Fax: (336) 641-6971 mgreen@co.guilford.nc.us Anita Ramachandran, Health Education Program Manager Phone: (336) 641-3136 aramach@co.guilford.nc.us Dennis Jenkin, Health Education Unit Sp. Phone: (336) 641-3899 djenkin@co.guilford.nc.us	ITTS ET RT	Guilford
	Piedmont Health Services	Evette Patterson, Dir. of Clinical Svcs. Phone: 919-933-8494 patterse@piedmonthhealth.org Burlington Community Health Center Marielena Castaneda 1214 Vaughn Road, 1 st floor Burlington, NC 27217 Phone: (336) 506-5840 Charles Drew Community Health Center Jennifer Bradsher 221 N. Graham Hopedale Road Burlington, NC 27217-2971 Phone: (336) 570-3739 Prospect Hill Community Health Center Autumn Buckland 322 Main Street Prospect Hill, NC 27314 Phone: (336) 562-3311	RT only	Alamance, Caswell (See Region VI for additional counties.)
	Piedmont Health Services and Sickle Cell Agency Primary - 1102 E. Market St. Greensboro, NC 27401 Satellite - 401 Taylor Ave. High Point, NC 27260	Dr. Gladys Robinson, Executive Director Phone: (336) 274-1507 Fax: (336) 275-7984 grobinson@piedmonthhealthservices.org Kathy Norcott, Asst. Executive Director knorcott@piedmonthhealthservices.org	SAC RT	Guilford
	NIA Community Action Center 122 N. Elm Street, Suite 1000 Greensboro, NC 27401	Sandy Michael Whitaker, Executive Director Phone: (336) 617-7722 sandy051275@yahoo.com	ITTS RT	Forsyth
	Robeson Health Care Corporation	Al Bishop, HIV Program Manager See Region V for contact information	RT only	Montgomery (See Regions V and VII for additional counties)
	Wellness & Education Community Health Action Network	Ricky Duck, Executive Director See Region VI for contact information.	ITTS SAC RT	Alamance, Chatham, Guilford, Montgomery, Stanly, Randolph (See Regions III, V, VI and TGA for additional counties.)
Region V	Cape Fear Regional Bureau for Community Action 2008-F Murchison Road, Fayetteville, NC 28301	Diana Smith, Interim Executive Director Danny Ellis, Interim Deputy Director Phone: (910) 483-9177 Fax: (910) 483-9574 arozier@bureauadvocacy.org	ITTS ET	Cumberland, Hoke, Harnett Scotland
	Community Health Interventions and Sickle Cell Agency 2409 Murchison Rd. Fayetteville, NC 28301	Mary E. McAllister, Executive Director Elazzoa M. McArthur, Project Coordinator Phone: (910) 488-6118 Fax: (910) 488-6810 osc@nc.rr.com	EBIS SAC RT	Cumberland

	CommWell Health (Tri-County Community Health Center) 3331 Easy Street Dunn, NC 28334	Pam Tripp, Executive Director Phone: (910) 567-6194 Fax: (910) 567-5678 ptripp@commwellhealth.org Janet Stroughton, MA, LCAS, CCS VP Behavioral Health Services Phone: 910-567-7167 office JStroughton@commwellhealth.org	SAC RT	Cumberland, Harnett, Hoke, Sampson (See Regions VI and VIII for additional counties.)
	Cumberland County Health Department 1235 Ramsey Street Fayetteville NC 28301	Pat Whitfield, Coordinator Phone: (910) 433-3781 Fax: (910) 433-3659 pwhitfield@co.cumberland.nc.us	RT only	Cumberland
	Harnett County Health Department 307 W. Cornelius Harnett Blvd., Lillington, NC 27546	John Rouse, Jr., Health Director Phone: (910) 893-7550 Fax: (910) 814-4060 jrouse@harnett.org Debra Hawkins, Public Health Admin. Phone: (910) 893-7550 dhawkins@harnett.org	EBIS	Harnett
	Robeson Health Care Corporation 306 North Pine St., Lumberton, NC 28358	Al Bishop, HIV Program Manager Phone: (910) 738-2110 Fax: (910) 738-2988 al_bishop@rhcc1.com	RT only	Hoke, Robeson, Scotland, Montgomery, Columbus (See Regions IV and VII for additional counties)
	Robeson County Health Department 460 Country Club Rd. Lumberton, NC 28360	William J. Smith, Health Director Phone: (910) 671-3404 Fax: (910) 737-096 william.smith@robeson.nc.gov Tracy Jones, Nursing Supervisor Phone: 910-671-3200 tracy.jones@hth.co.robeson.nc.us	ET	Robeson
	Wellness & Education Community Health Action Network	Ricky Duck, Executive Director See Region VI for contact information.	ITTS SAC RT	Cumberland, Harnett, Hoke, Moore, Richmond, Robeson, Scotland (ITTS & RT only) (See Regions III, IV, VI and TGA for additional counties.)
Region VI	Alliance of AIDS Services – Carolina (AAS-C) 1637 Old Louisburg Rd. Raleigh, NC 27604	Hector Salgado, Executive Director Phone: (919) 834-2437 ext. 122 Fax: (919) 896-7441 hector.salgado@aa-c.org Lindsay Holland, Associate Director Phone: (919) 834-2437 ext. 201 lindsay.holland@aa-c.org	EBIS ITTS SAC RT	Durham, Wake, Orange, Person
	CAARE 214 Broadway Street Durham, NC 27701	Virginia Mitchell Phone: 919-687-0791 vmitchell@caare-inc.org	RT only	Durham
	CommWell Health (Tri-County Community Health Center)	Pam Tripp, Executive Director See Region V for contact information.	SAC RT	Johnston (See Regions V and VIII for additional counties.)
	Duke University Partners in Caring Duke University Medical Center DUMC 3112 Durham, NC 27710 2200 West Main Street, Ste 300 Durham, NC 27705	Arthur Hendricks, Director Phone: (919) 684-3211 Fax: (919) 681-8790 arthur.hendricks@duke.edu	SAC RT	Durham, Johnston, Orange, Person, Wake (See Region IV and VII for additional counties.)
	Duke University: Project Know Your Status DUMC, Duke Clinics, Trent Dr., Orange Zone Room	Borna Kassiri and Megan Bader, Co-Directors Overseen by Mehri McKellar mehri.mckellar@duke.edu	RT only	Durham

00369B, Durham, NC 27710			
Durham County Department of Public Health 414 East Main Street Durham, NC 27701-3720	Gayle Harris, Health Director Phone: (919) 560-7650 Fax: (919) 560-7664 gharris@dconnc.gov Annette Carrington Johnson, Manager Phone: (919) 560-7762 acarrington@dconnc.gov	ET ITTS RT	Durham
El Centro Hispano 600 East Main Street Durham, NC 27701	Pilar Rocha-Goldberg, Executive Dir. Phone: (919) 687-4635 ext. 43 Fax: (919) 687-0401 procha@elcentronc.org Maritza Chirinos, Health Program Dir. Phone: (919) 687-4635 ext. 35 mchirinos@elcentronc.org	EBIS	Durham, Orange, Wake
Lincoln Community Health Center 309 Crutchfield St. Durham, NC 27704	Sandra Gomez Phone: (919) 560-7688 sandra.gomez@duke.edu	RT only	Durham
Piedmont Health Services	Evette Patterson, Dir. Clinical Services Phone: (919) 537-7481 patterse@piedmonthhealth.org Carrboro Community Health Center Juanita Akinleye 301 Lloyd Street Carrboro, NC 27510 Phone: (919) 942-8741 Moncure Community Health Center Sharon Williams 7228 Pittsboro-Moncure Road Moncure, NC 27559 Phone: (919) 542-9991 Siler City Community Health Center Niki Homesley 224 South 10th Avenue Siler City, NC 27344 Phone: (919) 663-1744	RT only	Chatham, Orange (See Region IV for additional counties.)
North Carolina Central University 122 Student Health Building 1801 Fayetteville St Durham, NC 27707	Ruth Phillips Gilliam, Executive Director Student Health and Counseling Services Phone: (919)-530-7908 Fax: (919) 530-7969 Ruth.gilliam.phillips@ncsu.edu Osaffo James, Program Coordinator Phone: (919) 530-5427 Fax: (919) 530-6733 ojames1@ncsu.edu	EBIS ITTS	Durham
Samaritan Health Center 507 E Knox St. Durham, NC 27701	Gabriela Magallanes Phone: (919) 407-8223 Fax: (919) 688-3117 alan@samaritanhealthcenter.org	RT only	Durham
Triangle Empowerment 800 N. Mangum St. Ste. 204A Durham, NC 27705	Terry Munn Phone: (919) 423-8902 triangleempowermentcenter@yahoo.com	Sub-contract	Durham, Orange, Wake
UNC Hospital	Lynne Sampson, Principal Investigator lynne_sampson@med.unc.edu	ET	
UNC Infectious Diseases Clinic 1st Floor Memorial Hosp., 101 Manning Drive Chapel Hill, NC 27514	Jonah Pierce, Charge Nurse Phone: (919) 966-4587 Fax: (919) 966-7199 jpierce@unch.unc.edu	RT only	Orange
UNC SHAC	Carly Sherrod, Rapid Testing	RT only	Durham, Orange, Wake

	301 Lloyd Street Carrboro, NC 27510	Coordinator Phone: (205) 533-1162 Fax: (919) 966-6714 carly_sherrod@med.unc.edu		
	Wake County Human Services 220 Swinburne St. Raleigh, NC 27610 Mailing address: 10 Sunnybrook Rd Raleigh, NC 27610	Sue Lynn Ledford, Health Director Phone: (919) 212-7000 Fax: (919) 212-7400 sue.ledford@co.wake.nc.us Yvonne Torres, Program Manager Phone: (919) 250-4479 ytorres@wakegov.com Natasha Bowen, Supervisor Phone: (919) 212-9293 natasha.bowen@wakegov.com	ET ITTS SAC	Wake
	Warren-Vance Community Health Center 511 Ruin Creek Rd, St. 105 Henderson, NC 27536	Michelle Collins Ogle, MD, Clinic Dir. Phone: (252) 572-2610 Fax: (252) 572-2621 mdenise.ogle@gmail.com	RT only	Granville, Warren, Vance
	Wellness & Education Community Health Action Network Siler City, NC 27344 401-B North Ivey Ave. Siler City, NC 27344	Ricky Duck, Executive Director Phone: (919) 742-3762 Fax: (919) 742-3618 ricky@wecahn.org	ITTS SAC RT	Chatham, Durham, Johnston, Lee, Orange, Wake (See Regions III, IV, V and TGA for additional counties.)
Region VII	Coastal Horizons Center 613 Shipyard Blvd., Ste. 106 Wilmington, NC 28412	Tammy Cain, Early Intervention Super. Phone: (910) 202-3860 or (910) 524-1946 Fax: (910) 202-3862 tcain@coastalhorizons.org	RT only	Brunswick, New Hanover, Pender
	Columbus County DREAM Center 403 S. Martin Luther King Jr. Ave., Whiteville, NC 28472	Carol Caldwell, Executive Director Phone: (910) 642-0633 Fax: (910) 642-0712 ccdreamcenter@eastnc.twcbc.com	ITTS RT	Columbus
	Craven County Health Department	Scott Harrelson, Health Director See Region X for contact information.	ET	Onslow (See Region X for additional counties.)
	Duke University Partners in Caring 1209 Market St, Suite B Wilmington, NC 28401 Partners In Caring, Pastoral Service Department Duke University Medical Center 1209 Market St, Suite B Wilmington, NC 28401	Arthur Hendricks, Director Phone: (919) 684-3211 Fax: (919) 681-8790 arthur.hendricks@duke.edu Suzette A. Curry, MRE, P-CAS Associate Director Phone: 910-399-6412 Fax-910-399-6413 suzette.curry@duke.edu	EBIS	Brunswick, Columbus, Duplin, New Hanover, Pender (See Region IV and VI for additional counties.)
	Robeson Health Care Corporation	Al Bishop, HIV Program Manager See Region V for contact information	RT only	Columbus (See Regions IV and V for additional counties)
	New Hanover Community Health Center (MedNorth Health Center) 925 N Fourth Street Wilmington, NC 28401	Althea Johnson Phone: (910) 202-8623 ajohnson@nhchc.net	RT only	New Hanover
	New Hanover County Health Department 2029 South 17th St. Wilmington, NC 28401	David Rice, Health Director Phone: (910) 798-6500 Fax: (910) 341-4146 drice@nhcgov.com Angelia Clinton, Health Supervisor Phone: (910) 798-6548 aclinton@nhcgov.com	ITTS	New Hanover
Region VIII	CommWell Health (Tri-County Community Health	Pam Tripp, Executive Director See Region V for contact information.	SAC RT	Wilson (See Region V and VI for additional counties.)

	Center)			
	Edgecombe County Health Department 122 East St. James St Tarboro, NC 27886	Karen Lachapelle, Health Director Phone: (252) 641-7531 Fax: (252) 641-7565 karen.lachapelle@co.edgecombe.nc.us Meredith Capps, Health Ed. Supervisor Phone: (252) 641-6288 meredith.capps@co.edgecombe.nc.us	ITTS	Edgecombe
	Hertford County Public Health Authority	Ramona Bowser, Health Director See Region IX for contact information.	ET	Halifax (See Region IX and X for additional counties.)
	Nash County Health Department 214 Barnes St. Nashville, NC 27856	William Hill, Jr., Health Director Phone: (252) 459-9819 Fax: (252) 462-2444 william.hill@nashcountync.gov Larissa Mills, Health Ed. Supervisor Phone: (252) 459-1513 larissa.mills@nashcountync.gov Jerome Garner, Health Ed. Specialist Phone: (252) 459-1547 jerome.garner@nashcountync.gov	ITTS RT	Nash
	Northampton County Health Department 9495 NC 305 Highway Jackson, NC 27845	John White, Interim Health Director Phone: (252) 534-5841 Fax: (252) 534-1045 john.white@nhcnc.net Judi Northcott, Nursing Supervisor Phone: (252) 534-5841 judith.northcott@nhcnc.net	ET	Northampton
	Opportunities Industrialization Center (Rocky Mount) 402 East Virginia St. Rocky Mount, NC 27801	Reuben Blackwell, IV, President/CEO Phone: (252) 212-3480 Fax: (252) 212-3492 rblackwell@oicone.org Bridgett Luckey, Program Director Phone: (252) 210-9871 bluckey@oicone.org	ITTS	Edgecombe, Nash, Halifax, Wilson
	Opportunities Industrialization Center of Wilson 801 Reid St. East Wilson, NC 27893	Howard Jones, President/CEO Phone: (252) 291-0038 Fax: (252) 291-7281 hjones@oicwilson.org Cordain Dancy, Health Services Email: cdancy@oicwilson.org	ITTS	Wilson (See Region X for additional counties.)
Region IX	Hertford County Public Health Authority 714 Evans Street Ahoskie, NC 27960	Ramona Bowser, Health Director Phone: (252) 358-7833 ext. 5104 Fax: (252) 358-7869 ramona.bowser@hcpha.net Cherri Brunson, ET Supervisor Phone: (252) 332-6650 ext. 331 cherri.brunson@hcpha.net	ET	Bertie, Camden, Chowan, Currituck, Dare, Gates, Hertford, Hyde, Pasquotank, Perquimans, Tyrell (See Region VIII and X for additional counties.)
Region X	Beaufort County Health Department 1436 Highland Dr. Washington, NC 27889	James Madson, Health Director Phone: (252) 940-6533 Fax: (252) 946-8430 james.madson@bchd.net Janell Lewis, Health Ed. Supervisor (252) 940-5090 janell.lewis@bchd.net Kimberly Matthew, Public Health Spec. (252) 940-6521 kimberly.matthews@bchd.net	EBIS	Beaufort
	Craven County Health Department 2818 Neuse Blvd New Bern, NC 28561	Scott Harrelson, Health Director Phone: (252) 636-4960 Fax: (252) 636-4970 sharrelson@cravencountync.gov	ET	Craven, Carteret, Jones, Lenoir, Pamlico

		Krystal Hargett Phone: 252-636-4920 ext. 2202 khargett@cravencountync.gov		
	Hertford County Public Health Authority	Ramona Bowser, Health Director See Region IX for contact information.	ET	Martin, Washington (See Region VIII and IX for additional counties.)
	Opportunities Industrialization Center of Wilson	Howard Jones, President/CEO See Region VIII for contact information.	ITTS	Greene (See Region VIII for additional counties.)
	Pitt County AIDS Service Organization 1528 Evans St. Suite C-2 Greenville, NC 27834	Aaron Lucier, Board President Phone: (252) 830-1660 Fax: (252) 767-0654 Deborah Savage, ITTS Coordinator dsavage@picaso.org	ITTS RT	Pitt
Transitional Grant Area	Carolinas CARE Partnership 5855 Executive Center Dr. Suite 101 Charlotte, NC 28212	Shannon Warren, Executive Dr. Phone: (704) 496-9581 Fax: (704) 531-4414 Shannonw@carolinascare.org	ITTS SAC RT	Cabarrus, Gaston, Mecklenburg, Union (See Region I and III for additional counties.)
	Gaston County Department of Health and Human Services 991 West Hudson Blvd. Gastonia, NC 28052	Christopher C Dobbins, Health Director Phone: (704) 853-5262 Fax: (704) 853-5252 chris.dobbins@gastongov.com Cynthia Stitt Phone: (704) 853-5013 cynthia.stitt@gastongov.com Joy Armstrong Phone: 704-853-5037 joy.armstrong@gastongov.com	ITTS RT	Gaston
	Mecklenburg County Health Department 249 Billingsley Rd. Charlotte, NC 28211	Dr. Marcus Plescia, Health Director Phone: (980) 314-9020 Fax: (704) 432-0305 marcus.plescia@mecklenburgcountync.gov Linda Flanagan, Health Manager Phone: (980) 314-9307 linda.flanagan@mecklenburgcountync.gov	ITTS SAC ET	Mecklenburg
	Wellness & Education Community Health Action Network	Ricky Duck, Executive Director See Region VI for contact information.	SAC RT	Anson (See Regions III, IV, V and VI for additional counties & services.)

EBIS – Evidence-Based Intervention Services; ET – Expanded Testing (Jails, FQHCs, Emergency Departments) ITTS – Integrated Targeted Testing Services; SAC – CTR in Substance Abuse Centers; RT – Rapid Testing in conjunction with funded projects; RT only – Receives Rapid Test Kits only)
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CORE SERVICES

Service categories:

- a. **Outpatient/Ambulatory medical care (health services)** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing (including lab tests not connected to any other ambulatory care visit), early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy (this may include the cost of transporting medications to an individual who has no other means of actually picking them up), education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under Outpatient/ Ambulatory medical care.

Vision Care - Ryan White HIV/AIDS Program funds may be used for Outpatient/Ambulatory Medical Care (health services), which is a core medical service, that includes specialty ophthalmic and optometric services rendered by licensed providers.

- b. **AIDS Drug Assistance Program (ADAP treatments)** is a State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare. Program funds may also be used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments.
- c. **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding. **(Not available to Part B Sub-grantees).**
- d. **Oral health care** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

- e. **Early intervention services (EIS)** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
- f. **Health Insurance Premium & Cost Sharing Assistance** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Funds awarded under Parts A, B and C of the Ryan White HIV/AIDS Program may be used to support a Health Insurance Premium and Cost-Sharing Assistance Program, a core medical service, for eligible low-income HIV-positive clients.

- *Under this service category, funds may be used as the payer-of-last-resort to cover the cost of public or private health insurance premiums, as well as the insurance deductible and co-payments.*
- *The exception is that Ryan White HIV/AIDS Program funds may NOT be used to cover a client's Medicare Part D "true out-of-pocket (i.e., TrOOP or donut hole)" costs.*
- *Consistent with the Ryan White HW/AIDS Program, "low income" is to be defined by the EMA/TGA, State or Part C Grantee.*

Vision Care

Funds also may be used to purchase corrective prescription eye wear for conditions related to HIV infection:

To cover the co-pay for prescription eye wear for eligible clients under a Ryan White HIV/AIDS Program supported Health Insurance Premium and Cost Sharing Assistance.

- g. **Home Health Care** includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.
- h. **Home and Community-based Health Services** include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.

- i. **Hospice services** include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Hospice Services are an allowable Ryan White HIV/AIDS Program core medical service. Funds may be used to pay for hospice care by providers licensed in the State in which services are delivered. Hospice services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice care to terminal patients. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.

- j. **Mental health services** are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.
- k. **Medical nutrition therapy** is provided by a licensed registered dietitian outside of a primary care visit, and may include the provision of appropriate nutritional supplements as required by the plan developed by the dietitian. Medical nutrition therapy provided by someone other than a licensed/registered dietitian must be recorded under psychosocial support services.

Medical Nutrition Therapy Services including nutritional supplements provided by a licensed registered dietitian outside of a primary care visit is an allowable core medical service under the Ryan White HIV/AIDS Program. The provision of food may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian.

Nutritional services and nutritional supplements not provided by a licensed, registered dietitian shall be considered a support service under the Ryan White HIV/AIDS Program. Food not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian also shall be considered a support service.

- l. **Medical Case management services (including treatment adherence)** are a range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professional, including both medically credentialed and other health care staff. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the needs and personal support systems of the client and other key family members. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex

HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan, at least every six months, as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face meetings, phone contact, and any other forms of communication. Medical case management may also include nursing services if those are the only services provided to a client during the course of a single day. In addition, Bridge Counseling may be included as Medical Case Management, as well as assistance in completing ADAP and PAP applications (if these activities occur outside of a regular Medical case Management visit).

Benefits and Entitlement Counseling

Funds awarded under the Ryan White HIV/AIDS Program may be used to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other State or local health care and supportive services.

- m. Substance abuse services - outpatient** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Substance Abuse Treatment Services-Outpatient is an allowable core medical service. Funds used for outpatient drug or alcohol substance abuse treatment, including expanded HIV-specific capacity of programs if timely access to treatment and counseling is not available, must be rendered by a physician or provided under the supervision of a physician or other qualified/licensed personnel. Such services should be limited to the following:

- *Pre-treatment/recovery readiness programs*
- *Harm reduction*
- *Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse*
- *Outpatient drug-free treatment and counseling*
- *Opiate Assisted Therapy*
- *Neuro-psychiatric pharmaceuticals; and*
- *Relapse prevention.*

Acupuncture Therapy

Funds awarded under the Ryan White HIV/AIDS Program may only be used to support limited acupuncture services for HIV-positive clients as part of Ryan White HIV/AIDS Program funded Substance Abuse Treatment Services (outpatient or residential), provided the client has received a written referral from his/her primary health care provider. All acupuncture therapy must be provided by certified or

licensed practitioners and/or programs, wherever State certification or licensure exists.

SUPPORT SERVICES

- n. **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. Assisting clients to complete ADAP and PAP applications may be counted if the client is a case management client and this is the only service provided during that visit (such assistance may be provided under Treatment Adherence Counseling if the client is not a case management client).

Benefits and Entitlement Counseling

Funds awarded under the Ryan White HIV/AIDS Program may be used to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other State or local health care and supportive services.

- o. **Child care services** are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training.

Child Care Services are an allowable Ryan White HIV/AIDS Program support service for the children of HIV-positive clients, while the clients attend medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups or training. More specifically, funds may be used to provide Child Care Services in these instances:

- a. *To support a licensed or registered child care provider to deliver intermittent care that will enable an HIV-positive adult or child to secure needed medical or support services, or to participate in Ryan White HIV/AIDS Program-related activities described above;*
- b. *To support informal child care provided by a neighbor, family member, or other person (with the understanding that existing Federal restrictions prohibit giving cash to individuals to pay for these services).*

In those cases where funds are allocated for Child Care Services, as described under (b) above, such allocations should be limited and carefully monitored to assure compliance with the prohibition on direct payments to eligible individuals. Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision-making process.

NOTE: This does not include child care while a client is at work.

Recreational and Social Activities

*Funds awarded under the Ryan White HIV/AIDS Program may be used for recreational and social activities as part of a Child Care or Respite Care support service provided in a licensed or certified provider setting, including drop-in centers in primary care or satellite facilities. **Funds should NOT be***

used for off-premise social/recreational activities or to pay for a client's gym membership.

- p. Pediatric developmental assessment and early intervention services** - not allowable under the Ryan White Part B program.
- q. Emergency financial assistance** is the provision of short-term payments to agencies or establishment of voucher programs when other resources are not available to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

Ryan White HIV/AIDS Program funds may be used to provide Emergency Financial Assistance (EFA) as an allowable support service.

- The decision-makers deliberately and clearly must set priorities and delineate and monitor what part of the overall allocation for emergency assistance is obligated for transportation, food, essential utilities, and/or prescription assistance. Careful monitoring of expenditures within a category of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to indicate when reallocations may be necessary.*
- In addition, Grantees and planning councils/consortia must develop standard limitations on the provision of Ryan White HIV/AIDS Program funded emergency assistance to eligible individuals/households and mandate their consistent application by all contractors. It is expected that all other sources of funding in the community for emergency assistance will be effectively utilized and that any allocation of Ryan White HIV/AIDS Program funds to these purposes will be the payer-of-last-resort, and for limited amounts, limited use and limited periods of time.*

Vision Care

Funds also may be used to purchase corrective prescription eye wear for conditions related to HIV infection:

To pay the cost of corrective prescription eye wear for eligible clients through a Ryan White HIV/AIDS Program supported Emergency Financial Assistance Program.

- r. Food bank/home-delivered meals** include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

Purchase of Non-Food Products

Funds awarded under the Ryan White HIV/AIDS Program may be used to purchase essential non-food household products as part of a Ryan White HIV/AIDS Program funded Food Bank support service. These include essential items such as:

- Personal hygiene products,*
- Household cleaning supplies, and/or*

- *Water filtration/ purification devices (either portable filter/pitcher combinations or filters attached to a single water tap) in communities/areas where recurrent problems with water purity exist. Such devices (including their replacement filter cartridges) purchased with Ryan White HIV/AIDS Program funds must meet National Sanitation Foundation standards for absolute cyst removal of particles less than one micron. This policy does not permit installation of permanent systems for filtration of all water entering a private residence.*

Funds may NOT be used for household appliances, pet foods or other non-essential products.

- s. **Health education/risk reduction** is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients with HIV improve their health status.
- t. **Housing services** are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.
- u. **Legal services** are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Legal Services are an allowable support service under the Ryan White HIV/AIDS Program. Funds awarded under the Ryan White HIV/AIDS Program may NOT be used for any criminal defense, or for class-action suits unrelated to access to services eligible for funding under the Ryan White HIV/AIDS Program. Funds may be used for legal services directly necessitated by an individual's HIV/AIDS serostatus.

These services include but are not limited to:

- a. *Preparation of Powers of Attorney, Living Wills*
- b. *Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program, and*
- c. *Permanency planning for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS; includes the provision of social service counseling or legal counsel regarding (1) the drafting of wills or delegating powers of*

attorney, and (2) preparation for custody options for legal dependents including standby guardianship, joint custody or adoption.

v. Linguistics services include the provision of interpretation and translation services.

w. Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care and other Ryan White-allowable support services.

Medical Transportation is an allowable support service under the Ryan White HIV/AIDS Program. Funds may be used to provide transportation services for an eligible individual to access HIV-related health services, including services needed to maintain the client in HIV/AIDS medical care.

Transportation should be provided through:

- a. A contract(s) with a provider(s) of such services;*
- b. Voucher or token systems;*
- c. Mileage reimbursement that enables individuals to travel to needed medical or other support services may be supported with Ryan White HIV/AIDS Program funds, but should not in any case exceed the established rates for Federal Programs. Federal Joint Travel Regulations provide further guidance on this subject. **[Per RW regulations, clients may not receive cash reimbursement for mileage costs; instead, other methods (such as vouchers or gas card) can be used to ensure that the support is used for the intended purpose.]***
- d. Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed); or*
- e. Purchase or lease of organizational vehicles for client transportation programs. **Note: Grantees must receive prior approval for the purchase of a vehicle.***

x. Outreach services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

y. Permanency planning - not allowable under the Ryan White Part B program.

z. Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling

provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Funds awarded under the Ryan White HIV/AIDS Program may be used to provide "Psychosocial Support Services" that include pastoral care/counseling services, provided that the pastoral counseling is provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, or as a component of services provided by a licensed provider, such as a home care or hospice provider). Programs are to be licensed or accredited wherever such licensure or accreditation is either required or available. In addition, Ryan White HIV/AIDS Program funded pastoral counseling MUST be available to all individuals eligible to receive Ryan White HIV/AIDS Program services, regardless of their religious or denominational affiliation.

- aa. Referral for health care/supportive services** is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

Benefits and Entitlement Counseling

Funds awarded under the Ryan White HIV/AIDS Program may be used to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g. Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other State or local health care and supportive services.

- ab. Rehabilitation services** are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Funds also may be used for Rehabilitation Services that include low-vision training by licensed provided or authorized professionals.

- ac. Respite care** is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

Respite Care is an allowable support service under the Ryan White HIV/AIDS Program. Funds may be used for periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV infected client in order to relieve the primary caregiver who is responsible for the day-to-day care of an adult or minor living with HIV/AIDS.

In those cases where funds are allocated for home-based respite care, such allocations should be carefully monitored to assure compliance with the prohibition on direct payments to eligible individuals. Such arrangements may

also raise liability issues for the funding source which should be carefully weighed in the decision-making process.

Funds awarded under the Ryan White HIV/AIDS Program may be used for recreational and social activities as part of a Child Care or Respite Care support service provided in a licensed or certified provider setting, including drop-in centers in primary care or satellite facilities. **Funds should NOT be used for off-premise social/recreational activities or to pay for a client's gym membership.**

- ad. Substance abuse services—residential** is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Substance Abuse Treatment Services-Residential is an allowable support service under the Ryan White HIV/AIDS Program. The following limitations apply to use of Ryan White HIV/AIDS Program funds for residential services:

- *Because of the Ryan White HIV/AIDS Program limitations on inpatient hospital care (see sections 2604(c)(3)(L) and 2612(b)(3)(L) of the Public Health Service Act), Ryan White HIV/AIDS Program funds may not be used for inpatient detoxification in a hospital setting.*
- *However, if detoxification is offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of a hospital), Ryan White HIV/AIDS Program funds may be used for this activity.*
- *If the residential treatment service is in a facility that primarily provides inpatient medical or psychiatric care, the component providing the drug and/or alcohol treatment must be separately licensed for that purpose.*

Funds awarded under the Ryan White HIV/AIDS Program may only be used to support limited acupuncture services for HIV-positive clients as part of Ryan White HIV/AIDS Program funded Substance Abuse Treatment Services (outpatient or residential), provided the client has received a written referral from his/her primary health care provider. All acupuncture therapy must be provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists.

- ae. Treatment adherence counseling** is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting. Assisting clients to complete ADAP and PAP applications may be counted as TAC if the service is not provided under any other allowable services (medical case management and non-medical case management).

Services specifically excluded under the Ryan White Part B Program

Clothing Ryan White HIV/AIDS Program funds may NOT be used to purchase clothing.

Employment and Employment-Readiness Services

Ryan White HIV/AIDS Program funds may NOT be used to support employment, vocational, or employment-readiness services. However, funds may be used to pay for occupational therapy as a component of allowable Rehabilitation Services.

Developmental Services for HIV + Children

Ryan White HIV/AIDS Program funds may not be used under Part B to provide clinician prescribed developmental support services for HIV-positive infants/children, even when such services are not otherwise covered by specific State and Federal legislation that mandates health care coverage for all children with developmental disabilities. (This service is only available to Part D-funded projects).

Funeral and Burial Expenses

Ryan White HIV/AIDS Program funds may NOT be used for funeral, burial, cremation, or related expenses.

Maintenance of Privately Owned Vehicles

Funds awarded under the Ryan White HIV/AIDS Program may NOT be used for direct maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees. This restriction does not apply to vehicles operated by organizations for program purposes.

Property Taxes

Funds awarded under the Ryan White HIV/AIDS Program may NOT be used to pay local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).

Appendix 21: HOPWA Service Definitions

Tenant based rental assistance (TBRA), including assistance for shared housing arrangements, is an ongoing monthly rental subsidy that pays the difference between Fair Market Rent and the amount a tenant contributes towards rent. Tenant-based rental assistance is tied to the tenant and may be used with private landlords, housing authorities or other rental units. While this program has less stringent guidelines than the Section 8 program, Housing Quality Standards still apply and the rent amount is based on the client's income. Clients with or without income are eligible to participate in the program.

Tenant based rental assistance (TBRA) Program Cost includes staff time spent on activities directly related to rental assistance such as time spent with the client household on the income determination process and follow up with employers and others to obtain required verification, annual recertification, research and documentation to establish rent reasonableness, inspection of the unit to be leased, completion of the environmental review and other required documentation.

Short-term rent, mortgage, and utility (STRMU) payments are used to prevent a tenant from becoming homeless. The amount of assistance may vary depending on funds available, tenant needs, and program guidelines. A funding cap per client may be established by the network and is usually equivalent to two monthly rent payments. STRMU cannot be used to pay first month rent or security deposits and assistance is limited to 21 weeks in a 52 week period. Assistance must be paid to a third party such as a mortgage company, landlord or a utility company.

Short-term rent, mortgage, and utility (STRMU) Program Cost are cost related to direct program expenses (e.g. costs to operate). Expenses may include the following: completion and tracking of emergency assistance requests for STRMU, eligibility determination, intake/assessment of client needs, documentation of housing needs in the individual service plan (care plan) contacting other resources (HOPWA is payer of last resort), communicating with landlords, utility companies, processing/issuing checks to landlords, utility companies, and staff costs in the form of time.

Supportive Services are services that help clients maintain stable housing. These services include mental health and substance use treatment, case management, food assistance and transportation.

Permanent Housing Placement (PHP) is a HOPWA supportive service activity that assists individuals and their families with establishing permanent residence with the goal of continued occupancy. The PHP eligible activities are, Housing referrals (e.g., sending and/or connecting individuals and their families to available housing resources and providers in order to secure stable housing living arrangements), Tenant counseling (e.g., understanding a residential lease and its obligations and mediation disputes), Costs associated with placement in housing

(e.g., application fees, credit check expenses, first month's rent, and security deposit, utility connection fees/processing costs) and Representative payee services for persons who use such services to better manage their own finances. Permanent Housing Placement cannot be used for moving expenses/costs, standard furnishing, housekeeping and household supplies. In addition, Permanent Housing Placement assistance cannot exceed two month's rent of the assisted unit.

Resource Identification funds are used to help an agency establish, coordinate, and develop housing assistance resources for eligible persons. This task might involve conducting preliminary research to determine the feasibility of specific housing-related initiatives. This work will also require that relationships are maintained with landlords and the local housing community with the goal of placing clients into units.

Housing Information services include but are not limited to developing directories of affordable housing units in a region and providing referral services to assist an eligible person to locate, acquire, finance, and maintain housing. This may also include fair housing counseling for eligible persons who may encounter discrimination on the basis of race, color, religion, sex, age, national origin, familial status, or handicap.

Operating Costs are funds used to support licensed facility-based housing such as family care homes or group homes. These funds can be used to cover the following costs: facility maintenance, insurance, upgrading appliances, utilities, rent, supplies and incidental expenses such as repairs.

Appendix 22: Ryan White and HOPWA Services List

RYAN WHITE CORE MEDICAL SERVICES Required:
* Outpatient/Ambulatory Health Services (including Treatment Adherence)
* Oral Health Care
* Health Insurance Premium and Cost-Sharing Assistance
* Mental Health Services
* Medical Case Management (including Treatment Adherence)
* Substance Abuse Services-outpatient
RYAN WHITE CORE MEDICAL SERVICES Optional:
Home and Community-based Health Services
Home Health Care
Hospice Care
Medical Nutrition Therapy
RYAN WHITE SUPPORT SERVICES Required:
* Case Management (non-Medical)
* Medical Transportation Services
RYAN WHITE SUPPORT SERVICES Optional:
Child Care Services
Emergency Financial Assistance
Food Bank/Home-delivered Meals
Health Education/Risk Reduction
Housing Services
Legal Services
Linguistic Services
Outreach Services
Psychosocial Support Services
Referral for Health Care/Supportive Services
Rehabilitation Services
Respite Care
Substance Abuse Services-residential
HOPWA SERVICES Required:
* Short-Term Rent, Mortgage, Utilities
* Tenant-Based Rental Assistance
HOPWA SERVICES Optional:
Housing Information
Operating Costs (for dedicated housing facility)
Permanent Housing Placement
Resource Identification
Supportive Services

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Appendix 23: Sample Matrix of Services Table

**SAMPLE SIMPLIFIED MATRIX OF SERVICES
(NOT ALL INCLUSIVE)**

Mountain Region Network								
Provider:	John Doe Community- Based Organization	Jane Smith AIDS Service Organization	County A Local Health Department	B-C-D District Health Department	Three-City Area Mental Health Center	Paul Smith Memorial Hospital	Sweetwater Rural Health Center	Nice County Housing Authority
<u>Ryan White Core Medical Services:</u>								
Outpatient/Ambulatory Health Services				X		X	X	
Oral Health Care							X	
Mental Health Services	X				X	X	X	
Medical Nutrition Therapy			X	X			X	
Medical Case Management	X		X	X			X	
Substance Abuse Services-outpatient		X			X			
<u>Ryan White Support Services:</u>								
Medical Transportation Services	X	X						
Treatment Adherence Counseling	X							
Health Education-Risk Reduction	X	X						
<u>HOPWA Services:</u>								
Tenant-Based Rental Assistance	X	X						X
Short-Term Rent, Mortgage, Utilities	X							

Create a spreadsheet like this sample listing each required Ryan White and HOPWA service from the table in Appendix 22 and then any additional optional services from the table in Appendix 22 that will be provided. Beside each service list the provider(s) of that service by agency name and the payor source for that service, i.e Part B, Part C, Part D, HOPWA, etc.

Appendix 24: Organizational Charts

Instructions for Creating an Organizational Chart Using Microsoft Word

Please provide an Organizational Chart detailing the hierarchy at your agency. A sample Organizational Chart has been provided along with a template for your convenience. Instructions are provided below for those who wish to develop their own Organizational Chart as opposed to using the template provided.

Step 1:

Launch Microsoft Word. To add an organizational chart to an existing document, open the file and scroll to the place for the chart. Press “Ctrl+Enter” to add a new page. Otherwise, Word starts a new blank document upon opening.

Step 2:

Click the “Insert” tab. Click the “SmartArt” button on the ribbon, which opens the “Choose a SmartArt graphic” pop-up window.

Step 3:

Click the “Hierarchy” link in the left side column. Review the different organizational chart options. These are just the Word defaults – you will be able to change the colors and add rows and boxes in later steps. Double-click a chart, such as “Organization Chart,” that best suits your agency. The chart is added to the Word document and a new purple “SmartArt Tools” tab and ribbon open at the top of the work area.

Step 4:

Click into the first/top box on the chart, which may show “[Text]” as the default. Type the name and, if desired, title of the highest-ranking person in your organization, such as the *CEO, Health Director, or Executive Director*.

Step 5:

Move to the next box, which branches below the first. Type the name of the next-highest person. Most Word templates have three boxes on this branch. If you only have one or two people on this branch, click the box and press the “Delete” key. If you have more than three, click any box on the row, then click the “Add Shape” menu on the ribbon. Click “Add Shape After” to add another box on the same branch. Continue until all persons or job titles on this level of your organization are represented.

Step 6:

Click a box on the second row. Click the “Add Shape” menu and choose “Add Shape Below.” This creates the next, lower level in the organizational hierarchy. Add boxes, names and titles for each person on this level of your company. Continue to add boxes and rows. Note that as you add boxes, Word will automatically shrink the chart to fit on the page.

Step 7:

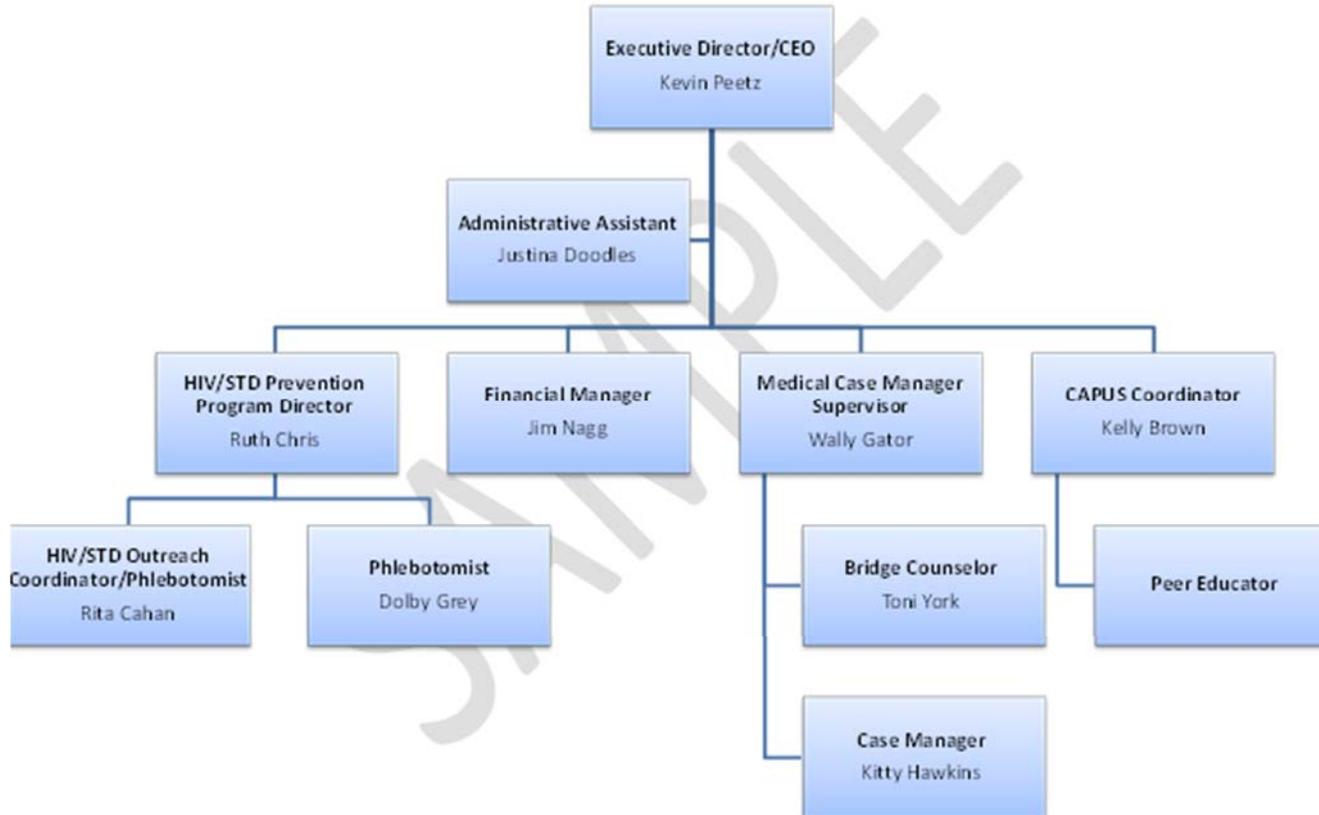
Assign administrative positions to the persons for whom they work by clicking a box, then clicking the “Add Shape” menu. Click “Add Assistant” and a link is created from the executive to the assistant.

Step 8:

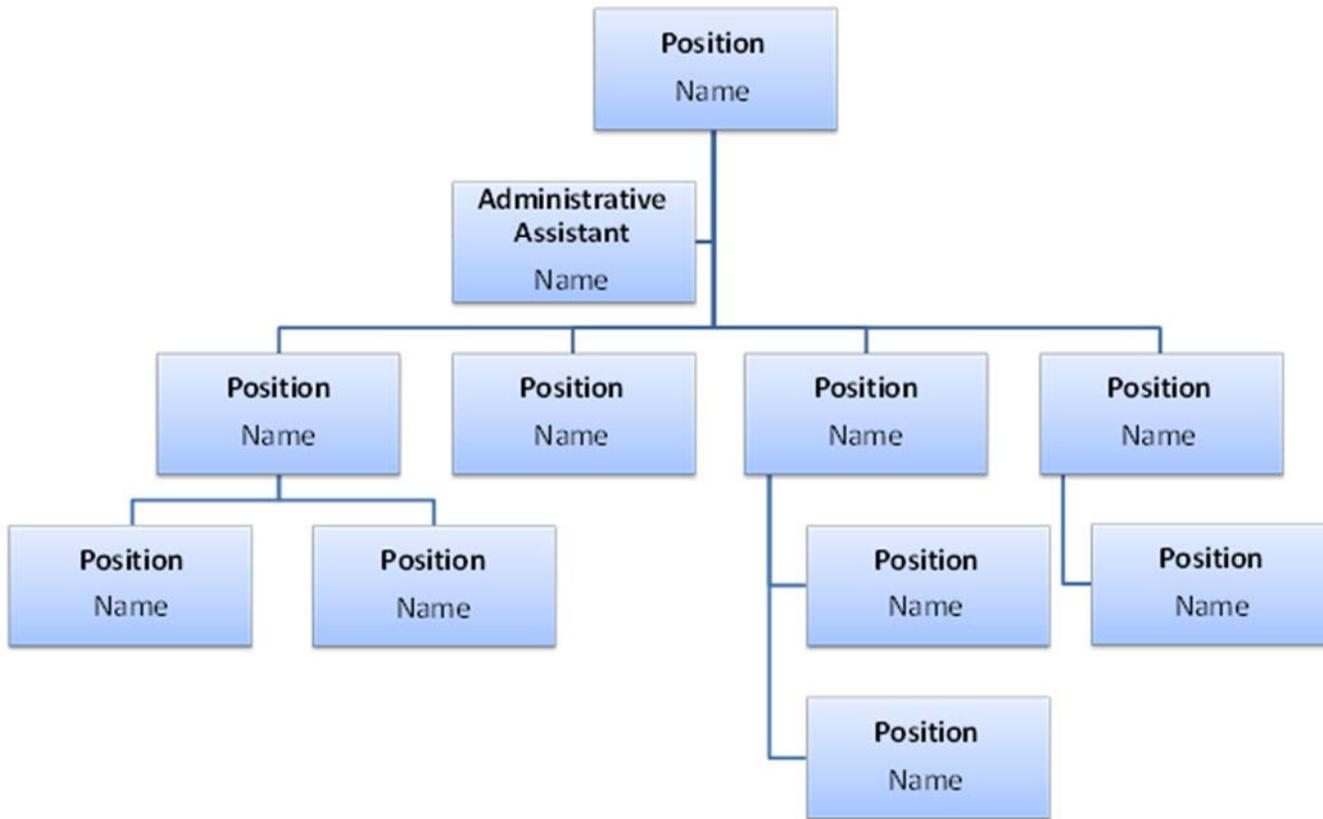
Click the “Change Colors” button on the ribbon. Choose a different set of hues from the default Word blue. You can also change individual colors in the chart. Click a box or click multiple boxes by holding down the “Ctrl” key and then clicking each box to change. Right-click any of the selected boxes and choose “Format Shape.” In the “Fill” window, choose a new color.

Step 9:

Click the “File” tab and select “Save As.” Type a name for the organizational chart and select where to save the file. Click the “Save” button.



Agency Name



Appendix 25: Projection Report

**Agency Name
Annual Projection for Testing at Funded Agencies**

Agency	Agency Staff	Testing Site or Site for Health Education Activities	County	Days/Hours	Persons Tested Quarterly	Persons Tested Annually	Persons Reached Annually through Educational Activities (outside of testing) if applicable
Example	Mary K. Sole	Teeple's House	Cumberland	Every Monday 1-3pm	36 HIV Conventional 5 HIV Rapid 36 Syphilis 20 Chlamydia 20 Gonorrhea	108 HIV 108 Syphilis	100 persons-Presentations
1.							
2.							
3.							
4.							
5.							
6.							

Appendix 26: Certification of Eligibility

CERTIFICATION OF ELIGIBILITY Under the Iran Divestment Act

Pursuant to G.S. 143C-6A-6, any person identified as engaging in investment activities in Iran, determined by appearing on the Final Divestment List created by the State Treasurer pursuant to G.S. 143C-6A-4, is ineligible to contract with the State of North Carolina or any political subdivision of the State. The Iran Divestment Act of 2015, G.S. 143C-6A-1 *et seq.* requires that each vendor, prior to contracting with the State certify, and the undersigned on behalf of the Vendor does hereby certify, to the following:

1. that the vendor is not identified on the Final Divestment List of entities that the State Treasurer has determined engages in investment activities in Iran;
2. that the vendor shall not utilize on any contract with the State agency any subcontractor that is identified on the Final Divestment List; and
3. that the undersigned is authorized by the Vendor to make this Certification.

Vendor: _____

By: _____
Signature Date

Printed Name Title

The State Treasurer's Final Divestment List can be found on the State Treasurer's website at the address www.nctreasurer.com/Iran and will be updated every 180 days. For questions about the Department of State Treasurer's Iran Divestment Policy, please contact Meryl Murtagh at Meryl.Murtagh@nctreasurer.com or (919) 814-3852.

Appendix 27: Frequently Utilized Acronyms

AA – Agreement Addendum
ACA – Affordable Care Act
ACS – AIDS Care Services
ADAP – AIDS Drug Assistance Program
AED – Academy for Educational Development
AETC – AIDS Education and Training Center(s)
AHEC – Area Health Education Center
AIDS - Acquired Immune Deficiency Syndrome
AMI – Area Median Income
APA – AIDS Pharmaceutical Assistance
APP – ADAP Pharmacy Program (part of ADAP)
ART – Anti-retroviral Therapy
ARV – Anti-retroviral medications
ASO – AIDS Service Organization
ASO - AIDS Service Organization– Budget Estimate
Branch - HIV/STD Prevention and Care Branch
BRAT - Behavioral Risk Assessment Tool
CADR – CARE Act Data Report
CAF – Contract Approval Form
CAPER – Consolidated Annual Performance and Evaluation Report (for HOPWA)
CAPUS – Care and Prevention in the United States
CARE Act - Ryan White Treatment Modernization Act of 2009
CBA - Capacity Building Assistance
CBO – Community Based Organization
CCME – Carolinas Center for Medical Excellence
CDC – Centers for Disease Control and Prevention (occasionally, CDCP)
CEO – Chief Elected Official
CEO - Chief Executive Officer
CER – Contract Expenditure Report
CFO – Chief Financial Officer
CFR – Code of Federal Regulations
CGI – Continuous Quality Improvement
CHIP – Children’s Health Insurance Program
CIF - Common Intake Form
CLI - Community Level Intervention
CM – Case Management (Non-medical)
CMS – Centers for Medicare and Medicaid Services (formerly HCFA)
CMV – Cytomegalovirus
COBRA – Consolidated Omnibus Budget Reconciliation Act
COE – Centers of Excellence
CPG – Community Planning Group
CSW - Commercial Sex Worker
CTR - Counseling, Testing and Referral

CTRPN – Counseling, Testing, Referral & Partner Notification
CTS - Counseling and Testing Sites
CY – Calendar Year
DEBI - Diffusion of Evidence-Based Interventions
DIS – Disease Intervention Service
DMA – N.C. Division of Medical Assistance
DOC – N.C. Department of Corrections
DPH –Division of Public Health
DPI - Department of Public Instruction
DSS – Division of Service Systems (within HRSA)
DSS - Division of Social Services
EBIS - Evidence-Based Intervention Services
EC – Emerging Community
ED – Executive Director
EDSS – Electronic Disease Surveillance System
EFA – Emergency Financial Assistance
eHARS – Electronic HIV/AIDS Reporting System
EIIHA – Early Identification of Individuals with HIV/AIDS
EIN – Employer Identification Number
EIS – Early Intervention Services
EMA – Eligible Metropolitan Area
EMSA – Eligible Metropolitan Statistical Area
EPI - Epidemiological Profile
FAW – Federal Award Worksheet
FDA – Food and Drug Administration
FPL – Federal Poverty Level
FSR - Financial Status Report - Form 269
FY – Fiscal Year
GAO – Government Accounting Office
HAART – Highly Active Antiretroviral Therapy
HAB – HIV/AIDS Bureau
HCBC – Home and Community Based Care
HCFA – Health Care Financing Administration (now CMS)
Hep A – Hepatitis Virus A
Hep B – Hepatitis Virus B
Hep C – Hepatitis Virus C
HIHP - High-Impact HIV Prevention
HIPAA – Health Insurance Portability and Accountability Act
HIPCSA – Health Insurance Premium and Cost-Sharing Assistance
HIV – Human Immunodeficiency Virus
HMA - High Morbidity Area
HMO – Health Maintenance Organization
HOPWA – Housing Opportunities for People with AIDS
HPCAC – HIV/AIDS Prevention and Care Advisory Committee
HRSA – Health Resources and Services Administration

HSC- Heterosexual Contact
HUD – Housing and Urban Development
ICAP – Insurance Copayment Assistance Program (part of ADAP)
IDU – Injection Drug User
ITTS - Integrated HIV/STD Targeted Testing Sites
KS – Kaposi’s sarcoma
LER – Local Expense Report
LGBTQ – Lesbian, Gay, Bisexual, Transgender, and Questioning
LHD – Local Health Department
MAI – Minority AIDS Initiative
MCM – Medical Case Management
MER – Monthly Expenditure Report
MFR - Monthly Financial Report
MMWR – Morbidity and Mortality Weekly Report
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MSM – Men who have Sex with Men
NA – Needs Assessment
NAESM National AIDS Education Services for Minorities
NAPWA – National Association of People With AIDS
NASTAD – National Alliance of State and Territorial AIDS Directors
NC DHHS - North Carolina Department of Health and Human Services
NC -North Carolina
NCAAC
NCAS – North Carolina Accounting System
NGA – Notice of Grant Award
NGO – Non-governmental Organization
NHAS - National HIV/AIDS Strategy
NMAC – National Minority AIDS Council
NNRTI – Non-Nucleoside Reverse Transcriptase Inhibitor
NRTI – Nucleoside Analog Reverse Transcriptase Inhibitor
OA – Outpatient/Ambulatory
OI – Opportunistic Infection
OMB – Office of Management and Budget
OW – Open Window
PCIP – Pre-existing Conditions Insurance Program
PCP – Pneumocystis Pneumonia
PCRS - Partner Counseling and Referral Services
PEP – Post-exposure Prophylaxis
PfP – Prevention For Positives (now Prevention With Positives)
PHS – U.S. Public Health Service
PI – Protease Inhibitor
PIRR - Parity, Inclusion, Representation and Retention
PLWH – People Living with HIV Disease
PLWHA – People Living with HIV/AIDS

PMDC – Primary Medical and Dental Care
PN - Partner Notification
POMCS – Purchase of Medical Care Services
PPO – Preferred Provider Organization
PrEP – Pre-Exposure Prophylaxis
PSA - Public Service Announcement
PWID – People Who Inject Drugs
PwP – Prevention With Positives (was Prevention for Positives)
QA – Quality Assurance
QATD - Quality Assurance and Training Development
QI – Quality Improvement
REM - Racial and Ethnic Minorities
RFA – Request for Application
RFP – Request for Proposal
RSR – Ryan White Program Services Report (replaced RDR)
Ryan White CARE Act – CARE = Comprehensive AIDS Resources Emergency Act
SAMHSA – Substance Abuse and Mental Health Services Administration
SAS – Substance Abuse Services
S-CHIP – State Children’s Health Insurance Program
SCPG - Statewide Community Planning Group
SCSN – Statewide Coordinated Statement of Need
SES - Socioeconomic status
SHIIP – Seniors’ Health Information Insurance Program
SMART - Specific, Measurable, Appropriate, Realistic and Time phased
SOW – Scope of Work
SPAP – State Pharmaceutical Assistance Program (part of ADAP)
SPNS – Special Projects of National Significance
SSDI – Social Security Disability Insurance
SSI – Supplemental Security Income (from Social Security)
STD – Sexually transmitted infections
STI - Sexually Transmitted Infection
STRMU – Short Term Rent, Mortgage, and Utility (assistance)
TA – Technical Assistance
TAC – Treatment Adherence Counseling
TB - Tuberculosis
TBRA – Tenant Based Rental Assistance
TGA – Transitional Grant Area
TrOOP – True Out Of Pocket (Expenditures)
WIRM – Web Identity Role Management

Appendix 28: Glossary of Terms

Acquired Immune Deficiency Syndrome (AIDS): a medical condition where the immune system cannot function properly and protect the body from disease. As a result, the body cannot defend itself against infections (like pneumonia). AIDS is caused by the Human Immunodeficiency Virus (HIV). This virus is spread through direct contact with the blood and body fluids of an infected individual. High risk activities include unprotected sexual intercourse and intravenous drug use (sharing needles). There is no cure for AIDS; however, research efforts are on-going to develop a vaccine.

AIDS Drug Assistance Program (ADAP): ADAP was created as part of the Ryan White CARE Act and is administered under Title II. ADAP provides medications to low income people living with HIV/AIDS that are uninsured or under-insured and lack coverage for medications.

AIDS Education and Training Center (AETC): AETC was created as part of the Ryan White CARE Act and is administered under Part F. The AETC program is a network of regional centers that conduct targeted, multi-disciplinary education and training programs for health care providers.

AIDS Service Organization (ASO): ASO is an organization which provides a variety of services to the community, for example health and prevention services, housing and advocacy.

Allocations: refers to the distribution of dollar amounts or percentages of funding to established priorities – service categories, geographic areas, populations, or subpopulations.

Antibody: a protein found in the blood that is produced in response to foreign substances (e.g. bacteria or viruses) invading the body. Antibodies protect the body from disease by binding to these organisms and destroying them.

Barrier: a factor or circumstance that prohibits or inhibits access and/or use of services.

Baseline: measures of the dependent variable taken prior to the introduction of the treatment in a time-series experimental design and used as the standard of comparison.

Behavioral Intervention: programs that aim to change individual behaviors only, without explicit or direct attempts to change the norms (social or peer) of the community, e.g., geographically defined area, or the target population, e.g., drug users or men having sex with men. Typical examples of these interventions include health education, risk reduction counseling, and other individual-level interventions.

Behavioral Science: an area of social sciences research that examines individuals' behaviors in depth; it explores what people do and why they do it.

Bylaws: standing rules written by a group to govern business processes.

Capacity Building: one or more activities that contribute to an increase in the quality, quantity, and efficiency of program services and the infrastructure and organizational systems that support these program services. In the case of HIV prevention capacity building, the activities are associated with the core competencies of an organization that contribute to its ability to develop and implement an effective HIV prevention intervention and to sustain the infrastructure and resource base necessary to support and maintain the intervention.

Case Management: a system for assuring effective delivery of services and maintaining access to resources for individuals with multiple, changing service needs.

Centers for Disease Control and Prevention (CDC): the lead federal agency for protecting the health and safety of people, providing credible information to enhance health decisions, and promoting health through strong partnerships. Based in Atlanta, Georgia., this agency of

the U.S. Department of Health and Human Services serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

Client Level Data: data that is derived from individual clients.

Close-ended Questions: questions in an interview or survey format that provide a limited set of predefined alternative responses; for example, a survey might ask respondents if they are receiving case management services, and if they say yes, ask “About how often have you been in contact with your case manager for services during the past six months, either in person or by telephone?” and provide the following response options: Once a week or more, two to three times a month, approximately once a month, three to five times, one to two times, not at all.

Collaboration: working with another person, organization, or group for mutual benefit by exchanging information, sharing resources, or enhancing the other’s capacity, often to achieve a common goal or purpose.

Community-based Organization (CBO): a structured group offering services to a specific group of people in a defined area. These groups may include minority groups, housing for the homeless, and AIDS service organizations.

Community Forum (or Public Meeting): a small-group method of collecting information from community members in which a community meeting is used to provide a directed and highly interactive discussion.

Community-Level Interventions (CLI): an intervention that seeks to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening only with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

Community Mobilization: the process by which community citizens take an active role in defining, prioritizing, and addressing issues in their community. This process focuses on identifying and activating the skills and resources of residents and organizations while developing linkages and relationships within and beyond the community for the purpose of expanding the current scope and effectiveness of HIV/STD prevention.

Community Planning: a term used to describe a community-based planning process, whereby a plan is developed based on data of a defined community (geographic or population specific). **Community Planning Co-Chairs:** persons assigned by the grantee and elected from community members to particular community planning areas. They are responsible for organizing, covering, and leading the HIV Prevention Groups.

Community Planning Groups (CPGs): the official HIV prevention planning body that follows the HIV Prevention Community Planning Guidance to develop a comprehensive HIV prevention plan for a project area. CPGs are composed of community representatives and other technical experts, and staff of non-governmental organizations; also departments of health, education, and substance abuse prevention.

Community Planning Leadership Orientation & Training (CPLLOT): a national program sponsored by the National Minority AIDS Council (NMAC) that provides training in community planning processes for HIV prevention.

Comparison Group: individuals whose characteristics (such as race/ethnicity, gender, and age) are similar to those of the program participants. These individuals may not receive any services, or they may receive a different set of services, activities, or products. As part of the evaluation process, the experimental (or treatment) group and the comparison group are assessed to determine which type of services, activities, or products provided by the program produced the expected changes.

Comprehensive HIV prevention plan: a plan that identifies prioritized target populations and describes what interventions will best meet the needs of each prioritized target population. The primary task of the community planning process is developing a comprehensive HIV prevention plan through a participatory, science-based planning process. The contents of the plan are described in the HIV Prevention Community Planning Guidance, and key information necessary to develop the comprehensive HIV prevention plan is found in the epidemiologic profile and the community services assessment.

Comprehensive Planning: refers to the consideration and inclusion of *all* priority needs in HIV prevention and services in a written plan, although some of the needs may not be funded.

Comprehensive Risk Counseling and Services (CRCS, formerly PCM): CRCS is an intensive, individualized client-centered counseling for adopting and maintaining HIV risk-reduction behaviors. CRCS is designed for HIV-positive and HIV-negative individuals who are at high risk for acquiring or transmitting HIV and STDs and struggle with issues such as substance use and abuse, physical and mental health, and social and cultural factors that affect HIV risk.

Confidentiality: pertains to the disclosure of personal information in a relationship of trust and with the expectation that it will not be divulged to others in ways that are inconsistent with the original disclosure. Indirect must be maintained for persons who are recommended and/or who receive HIV counseling, testing, and referral (CTR) services.

Conflict of Interest: conflict between the private interests and public obligations of a person in an official position.

Consensus: an agreement or decision that all parties can support.

Contemplation: one of the stages of the *Stages of Change* behavioral theory; person is aware that a problem exists, is seriously thinking about overcoming it, but has not yet made a commitment to take action.

Continuum of Care: a set of services and linkages that responds to an individual or a family's changing needs for HIV prevention and care. A continuum of care is the complete system of providers and available resources for people at risk for, or living with HIV, and their families within a particular geographic service area.

Core Group: subgroups within a larger planning area. For prevention planning, the prioritizing of subpopulations and the selection of interventions occurs at the core group level.

Correlation: a statistical measure of the degree of relationship/association between variables.

Cost Effectiveness Analysis: a type of analysis that involves comparing the relative costs of operating a program with the extent to which the program met its goals and objectives; for example a program to reduce HIV transmission would estimate the dollars that had to be expended for prevention efforts compared to dollars expended for HIV related treatment and services.

Counseling and Testing: the voluntary process of client-centered, interactive information sharing in which an individual is made aware of the basic information about HIV/AIDS, testing

procedures, how to prevent the transmission and acquisition of HIV infection, and given tailored support on how to adapt this information to their life.

Counseling, Testing, Referral, and Partner Notification: CTRPN refers to voluntary HIV/AIDS counseling and testing, referral to appropriate medical and social services, and anonymous or confidential partner notification of sex or needle-sharing partners by health department staff when accompanied by testing; includes pre-test counseling, for example, when it is clear that testing is being offered as an option for the individual to consider.

Cultural Competence: capacity and skill to function effectively in culturally diverse environments that are composed of distinct elements and qualities.

Culture: the learned patterns of behavior with traits characteristic of large, autonomous or semi-autonomous, human social groups. These patterns prescribe the acceptable values, norms, attitudes, social roles and statuses, etiquette, interpersonal and familial relationships, and personal conduct of the members of the culture. They also define the behavior expected of other people. Culture is expressed and reinforced through shared language, group identity, religion/belief system, folklore, social and legal institutions, traditions, customs, history, and arts.

Data: specific information or facts that are collected. A data element is usually a discrete or single measure. Examples of client-level data elements are sex, race/ethnicity, age, and neighborhood.

Data Analysis: the process of systematically applying statistical and logical techniques to describe, summarize, and compare data collected.

Data System: a systematic structure that contains and tracks data.

Database: an accumulation of information that has been systematically organized for easy access and analysis. Databases are typically computerized.

Demographics: the statistical characteristics of human populations such as age, race, ethnicity, and sex that can provide insight into the development, culture, and sex specific issues that the intervention will need to account for.

Determinants of Behavior: the external and internal factors that determine or influence individuals' actions.

Drop-off Site: locations that volunteer to distribute HIV prevention materials. Typically outreach workers keep these sites supplied.

Eligible Metropolitan Area (EMA): a designation used by the Ryan White CARE Act to identify an area eligible for funds under Title I.

Epidemic: a disease that spreads rapidly through a demographic segment of the human population, such as everyone in a given geographic area; a military base, or similar population unit; or everyone of a certain age or sex, such as the children or women of a region. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

Epidemiologic Profile: a description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.

Epidemiology: the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.

Evaluation: a process for determining how well health systems, either public or private, deliver or improve services and for demonstrating the results of resource investments.

Evidence-based: based on evidence that is collected from scientific data. Some examples of evidence-based decisions in HIV/STD prevention planning are the prioritization of subpopulations based on epidemiological and needs assessments data, and the selection of interventions that have been demonstrated to be effective in research studies.

Evidence-Based Intervention Services (EBIS), formerly Health Education and Risk Reduction Interventions (HE/RR): organized efforts to reach persons at increased risk of becoming HIV-infected or, if already infected, of transmitting the virus to others, with the goal of reducing the risk of these events occurring; activities range from individual case management to broad community-based interventions.

Factors Influencing Behaviors (FIB) or Influencing Factors: the underlying reasons that individuals exhibit certain behaviors. FIBs are an important consideration in selecting appropriate HIV/STD interventions as part of the prevention planning process.

Fidelity, also accuracy: the exact adherence to established protocols, procedures, and content in implementation or replication of a program.

Fixed-site Outreach: activities conducted at a specific place, e.g., setting up a table at a corner or working out of a mobile van or store front.

Focus Group: a method of information collection involving a facilitated discussion among a small group and led by a trained moderator.

Formative Evaluation: a systematic determination of a subject's merit, worth and significance, using criteria governed by a set of standards, undertaken during the design and pretesting of programs to guide the design process. Emphasizes questions related to how the program is operating. Used to assist planners, managers and staff to develop a new program or improve an on-going program.

Generalizability: the extent to which findings or conclusions from a sample can be assumed to be true for the entire population from which the sample was drawn; findings can be generalized only when the sampling procedure and the data meet certain methodological standards.

Group-Level Interventions (GLI): health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying sizes. Group-level interventions use peer and non-peer models involving a range of skills, information, education, and support.

Goals: broad aims/statements that describe what the proposed project hopes to accomplish.

Health Resources and Services Administration (HRSA): HRSA directs national health programs that improve the Nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA is the Federal agency responsible for administering the Ryan White CARE Act.

HIV Prevention Community Planning: the cyclical, evidence-based planning process in which authority for identifying priorities for funding HIV prevention programs is vested in one or more planning groups in a state or local health department that receives HIV prevention funds from CDC.

Hepatitis B: a liver disease caused by the Hepatitis B virus (HBV). HBV is found in the blood of infected persons and is most commonly transmitted through unprotected sex.

Hepatitis C: a liver disease caused by the Hepatitis C virus (HCV), which is found in the blood of persons who have the disease. HCV is spread by contact with the blood of an infected person, most commonly through injection drug use.

High-Impact HIV Prevention: CDC initiative that seeks to use a combination of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas; this approach promises to increase the impact of HIV prevention efforts – an essential step in achieving the goals of NHAS.

High Morbidity Analysis Zone (HMAZ): a term used in the TDH 2000 Area Epidemic Profiles to denote clusters of counties that show higher numbers of reported cases of HIV/AIDS and/or STDs.

HIV (Human Immunodeficiency Virus): the virus that causes AIDS. Several types of HIV exist, with HIV-1 being the most common in the United States.

HIV Services Delivery Area, also known as Health Service Delivery Area: a designation used by the Ryan White CARE Act to identify an area eligible for funds under Title II (formula funding to States and territories).

HIV Test: more correctly referred to as an HIV antibody test, the HIV test is a laboratory procedure that detects antibodies to HIV, rather than the virus itself.

Housing Opportunities for People with AIDS (HOPWA): is a Federal program of the Department of Housing and Urban Development that provides housing assistance and supportive services for low-income people with HIV/AIDS and their families.

Human Immunodeficiency Virus (HIV): see HIV.

Inclusion: the assurance that the views, perspectives, and needs of all affected communities are included and involved in a meaningful manner in the community planning process.

Injection Drug User (IDU): people who are at risk for HIV infection through the use of equipment used to inject drugs, e.g., syringes, needles, cookers, spoons, etc.

Implementation: to put into effect according to or by means of a definite plan or procedure, e.g., collecting information about the interventions identified in the HIV prevention comprehensive plan.

Incidence: the number of new cases in a defined population within a certain time period, often a year that can be used to measure disease frequency. It is important to understand the difference between HIV incidence, which refers to new cases, and new HIV diagnosis, which does not reflect when a person was infected.

Information: in the context of HIV counseling, information encompasses the topics HIV transmission and prevention and the meaning of HIV test results.

Informed Consent: permission granted by a participant in a research study after he/she has received comprehensive information about the study. This is a statement of trust between the institution performing the research procedure and the person on whom the research procedures are to be performed.

Intervention: a specific activity (or set of related activities) intended to bring about HIV risk reduction in a particular target population using a common strategy of delivering the prevention message. An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation.

Intervention Plan: a type of plan for setting forth the goals, expectations, and implementation procedures for an intervention. It should describe the evidence or theory basis for the

intervention, justification for application to the target population and setting, and the service delivery plan.

Justification: a judgment about whether the intervention plan does or does not explain how the intervention will lead to the specified outcomes.

Linkage: the connection between the comprehensive HIV prevention plan and resource allocation in order to determine if the resources allocated in the previous year (meaning the year that has just ended) corresponded with recommendations in the plan from the previous year.

Men who have Sex with Men (MSM): men who report sexual contact with other men, e.g., homosexual contact, or men who report sexual contact with both men and women, e.g., bisexual contact.

MSM/IDU: men who report both sexual contact with other men and injection drug use.

Mass Media: the use of print, radio, and television, to communicate with specific populations. It includes public service announcements, news broadcasts, infomercials, magazines, newspapers, billboards, etc., which reach a large-scale audience in a short period of time.

Methodology: a plan that defines outcome measures, the choice of a research design, sampling, sample size, and choice of data systems.

Monitoring: routine documentation of characteristics of the people served, the services that were provided, and the resources used to provide those services.

National Association of State and Territorial AIDS Directors (NASTAD): the national association that supports health department AIDS directors and coordinates peer technical assistance for prevention planning processes.

NHAS (National HIV/AIDS Strategy): created by the White House; a more coordinated national response to the HIV epidemic that seeks to accomplish three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. This Strategy is intended to be a concise plan that will identify a set of priorities and strategic action steps tied to measurable outcomes.

National Minority AIDS Council (NMAC): a national agency that focuses on the provision of technical assistance to prevention planning groups.

Needs Assessment: the process of obtaining and analyzing information from a variety of sources in order to determine the needs of a particular client, population, or community.

Non-occupational HIV Exposure: a reported sexual, injection-drug--use, or other non-occupational HIV exposure that might put a patient at high risk for acquiring HIV infection.

Objectives: specific statements which describe what is intended to be done with the proposed program within a given period.

Open-ended Questions: an interview or survey format that allow those responding to answer as they choose, rather than having to select one of a limited set of predefined alternative responses.

Opt-Out HIV Counseling and Testing: at the time pre-test counseling is provided, and, after informed consent is obtained, the counselor shall test the client for HIV infection, unless the client refuses the HIV test.

Outcome Evaluation: the application of rigorous methods to assess whether the prevention program has an effect on the predetermined set of goals; the use of rigorous methods allows one to rule out factors that might otherwise appear responsible for the changes seen; for

example outcome evaluation determines whether a particular intervention had a desired effect on the targeted population's behavior; whether the intervention provided made a difference in knowledge, skills, attitudes, beliefs, behaviors, or health outcomes.

Outcome Monitoring: the procedures for assessing whether providers are meeting the outcome objectives that they set for themselves and efforts to track the programs of clients in a program based upon outcome measures set forth in program goals. In many cases - especially for individual and group level counseling interventions - this may simply require administering a brief questionnaire before the intervention begins and then again after it's finished.

Outcome Objectives: the overall intended effects of the intervention, specifying its purpose and mission. These might include increasing knowledge about HIV, changing risk-related behaviors, promoting community norms for safer sex, or reducing HIV transmission.

Outreach: HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials.

Parity: a situation in which all members of the planning group are provided opportunities for orientation and skills building to participate in the planning process and to have an equal voice in voting and other decision-making activities.

Parity, Inclusion and Representation (PIR): a principle applied to CPG membership to assure that planning for HIV prevention needs is done by the individuals most affected or by those who can represent the viewpoints of those most affected.

Partner Services: a public health strategy to identify, contact, and provide HIV prevention services to the sex and needle sharing partners of Persons Living with HIV, formerly referred to as Partner Counseling and Referral Services.

Pilot Test: a trial run with a few subjects to assess the appropriateness and practicality of the procedures and data collecting instruments.

Planning Council: volunteer planning groups composed of community members who prioritize services and allocate funds under Title I of the Ryan White CARE Act.

PLWH/A: people (or person) living with HIV/AIDS. PLWH and PLWA also are used.

Policy Intervention: an aim to change/influence policies that serve as barriers to behavior change. These interventions include, for example, decisions such as those that permit advertising and social marketing of condoms, allow for pharmacy sales of needles, and decriminalize prostitution.

Population: a population is any entire collection of people, animals, plants or things from which data may be collected.

Positive Test: for HIV, a specimen sample that is reactive on an initial ELISA test, repeatedly reactive on a second ELISA run on the same specimen, and confirmed positive on Western blot or other supplemental test indicates that the client is infected.

Pretest: test of planned public information strategies, messages, materials or measurement tools before completion or release to allow for feedback and revision to help assure effectiveness.

Prevalence: the total number of persons living with a specific disease or condition during a given time period.

Prevention Case Management (PCM): See CRCS

Prevention Counseling and Partner Elicitation (PCPE): a set of program activities widely used to counsel and test persons and their sex and/or needle -sharing partners who are at risk for acquiring or transmitting HIV infection.

Prevention Programs: interventions, strategies, programs, and structures designed to reduce risk behaviors that may lead to HIV infection or other disease. Successful HIV prevention programs include outreach to the populations at highest risk and the subsequent referral into prevention counseling, testing, and other targeted, intensive interventions.

Primary Prevention: intervention and education activities that are intended to help people reduce risk behaviors that may lead to infection with HIV. Examples of primary prevention include skills building for condom use, counseling that focuses on the reduction of the number of sex partners and HIV and STD testing.

Priority population: a population identified through the epidemiologic profile and community services assessment that requires prevention efforts due to high rates of HIV infection and the presence of risky behavior.

Priority Setting: a system used to determine numerical priorities of categories, such as subpopulations for prevention planning or service categories for services planning.

Process Evaluation: a descriptive assessment of the implementation of program activities; what was done, to whom, and how, when, and where, e.g., assessing such things as an intervention's conformity to program design, how it was implemented, and the extent to which it reaches the intended audience.

Process Monitoring: the collection of data to describe and assess intervention implementation; for example routine documentation of characteristics describing the target population served, the services that were provided, and the resources used to deliver those services.

Process Objectives: the specific intervention activities, the projected level of effort needed to carry them out, the people responsible for carrying them out, and when they will be completed.

Program: a program is an organized effort to attain a set of predetermined goals; a program is a distinction often used by an agency to describe a related set of interventions serving a particular population.

Program Evaluation: the systematic assessment of the means and ends of some or all of the action program stages, including program planning, implementation, and outcomes, in order to determine the value of and to improve the program.

Public Health Surveillance: an ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases, in order to monitor these health problems, such as the Centers for Disease Control and Prevention's (CDC) surveillance system for AIDS.

Qualitative Data: data presented in narrative form that generally are not expressed numerically, such as the information collected from focus groups or key informant interviews.

Quality Assurance: an ongoing process for ensuring that the CTR program effectively delivers a consistently high level of service to the clients.

Quantitative Data: data presented in numerical terms, such as survey data and data from epidemiologic reports.

Rapid HIV Test: a test to detect antibodies to HIV that can be collected and processed within a short interval of time (e.g., approximately 10--60 minutes).

Referral: a process by which an individual or client who has a need is connected with a provider who can serve that need (usually in a different agency); for example individuals with high risk behaviors and those infected with HIV are guided towards prevention, psychosocial, and medical resources needed to meet their primary and secondary HIV prevention needs.

Relevance: the extent to which an intervention plan addresses the needs of affected populations in the jurisdiction and of other community stakeholders. As described in the CDC Guidance, relevance is the extent to which the population targeted in the intervention plan is consistent with the target population in the comprehensive HIV prevention plan.

Reliability: the consistency of a measure or question, in obtaining very similar or identical results when used repeatedly; for example, if a test was done on the same blood sample several times, it would be reliable if it generated the same results each time.

Representation: the assurance that the persons representing a specific community truly reflect that community's values, norms, and behaviors.

Representative: the term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to draw conclusions about that population.

Request for Proposals (RFP): public announcements regarding the availability of grant funding.

Risk Behavior: behavior or other factor that increases the chance that a person may acquire disease. For HIV/AIDS, includes such factors as sharing of injection drug use equipment, unprotected male-to-male sexual contact, and commercial sex work without the use of condoms.

Ryan White CARE Act: on August 18, 1990, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Reauthorized in 1996 and 2000, the CARE Act is designed to improve the quality and availability of care for individuals and families affected by HIV/AIDS. The CARE Act includes the following major programs: Title II, Title III, Title IV, Part F, and I. The CARE Act is now the largest sole source of HIV funding in the nation.

Sample: a group of subjects selected from a total population or universe with the expectation that studying the group will provide important information about the total population.

Sampling Frame: the list from which the sample population is drawn, i.e., the telephone directory is often used for general population surveys.

Sample Size: the number of people from whom data are collected.

Scientific Soundness: the application of behavioral and social science theories developed or adapted by the provider agency or agreement of principles of a program with accepted scientific findings or theories.

Screening Test: an initial test, usually designed to be sensitive, to identify all persons with a given condition or infection (e.g., enzyme immunoassay [EIA] or enzyme-linked immunosorbent assay [ELISA]).

Secondary Prevention: prevention programs that serve the needs of people infected with HIV, the goals of which are to prevent further transmission and to link the infected person to early intervention services in order to minimize the disease progression.

Secondary Source Data: existing information that was collected by someone else, but which can be analyzed or re-analyzed to use. Such data may be in "raw" (unanalyzed) or analyzed form.

Self-efficacy: belief in one's ability to perform the desired behavior.

Semi-structured Questionnaires: referring to questionnaires that combine structured questions with open-ended questions.

Seroprevalence: HIV seroprevalence refers to the number of persons in a population who test HIV+ based on serology (blood serum) specimens; often presented as a percent of the total specimens tested or as a ratio per 1,000 persons tested.

Seroprevalence Reports: reports which provide information about the percent or rate of people in specific testing groups and populations who have tested positive for HIV.

Sexually transmitted infections (STD) or Sexually Transmitted Infection (STI): an infection that is spread through intimate sexual contact. HIV, herpes, syphilis, and gonorrhea are commonly known STDs.

Stakeholders (federal, state and local community): those who have an interest in and can affect implementation of an intervention or program; key players; influentials.

Statewide Coordinated Statement of Need (SCSN): the Ryan White CARE Act requires all CARE Act grantees to participate in this representative process. The purposes of the SCSN are to provide a mechanism to collaborate in identifying and addressing significant HIV care issues related to the needs of people and families living with HIV and to maximize coordination, integration, and effective linkages across the CARE Act Titles.

Street Outreach: HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients' typically congregate. Usually includes distribution of condoms, bleach, safer sex kits and educational materials.

Structural Intervention: interventions designed to remove barriers and incorporate facilitators of an individual's HIV prevention behaviors. These barriers or facilitators include physical, social, cultural, organizational, community, economic, legal, or policy circumstances or actions that directly or indirectly affect an individual's ability to avoid exposure to HIV.

Structured Survey/Questionnaire: questionnaires or surveys that are pre-determined and standardized that include close-ended responses that are easily quantifiable and typically pre-coded to facilitate the transfer of data to the computer.

Summative Evaluation: evaluation designed to present conclusions about the merit or worth of an intervention and recommendations about whether it should be retained, altered, or eliminated.

Sufficiency of the Service Plan: in reference to the CDC's evaluation guidance, the SSP provides details about whether the resources and operational plan for the intervention will allow it to be executed given its current context within the jurisdiction.

Surveillance: the ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition. As part of a surveillance system to monitor the HIV epidemic in the United States, the Centers for Disease Control and Prevention (CDC), in collaboration with state and local health departments, other federal agencies, blood collection agencies, and medical research institutions, conducts standardized HIV seroprevalence surveys in designated subgroups of the U.S. population. Collecting blood samples for the purpose of surveillance is called serosurveillance.

Surveillance Data: statistics representing people with HIV or AIDS in a particular area. Statistics are reported to the Centers for Disease Control and Prevention from the public health officials who collect them from testing sites, treatment facilities, and other groups, and analyze them to produce a full picture of trends in the epidemic.

Surveillance Report: reports providing information on the number of reported AIDS and HIV cases nationally and for specific locations and subpopulations; the Centers for Disease Control and Prevention (CDC) issues such a report twice a year, providing both cumulative cases and new cases reported during specific time periods.

Target Populations: determined groups of people to be reached through some action or intervention. In HIV prevention community planning, refers to populations that are the focus of HIV prevention efforts due to high rates of HIV infection, usually defined based on a review of the HIV epidemiologic profile, and high levels of risky behavior. Groups often defined based on a combination of characteristics such as race or ethnicity, age, gender, risk factor/behavior, and geographic location.

Technical Assistance: the delivery of expert programmatic, scientific and technical support to organizations and communities in the design, implementation and evaluation of HIV prevention interventions and programs.

Title I: under the Ryan White CARE Act, funding is given to eligible metropolitan areas hardest hit by the HIV epidemic.

Title II: under the Ryan White CARE Act, assists states and territories in improving the quality, availability, and organization of health care and support services for individuals and families with HIV disease and provides access to needed pharmaceuticals through the AIDS Drug Assistance Program (ADAP).

Title III: under the Ryan White CARE Act, provides support for early intervention and primary care services for people with HIV/AIDS.

Title IV: under the Ryan White CARE Act, provides coordinated HIV services and access to research for women, infants, children, youth, and families with, or at risk for, HIV/AIDS, focusing on the development and operation of family-centered systems of primary health care and social services that benefit these population groups.

Transmission Categories: in describing HIV/AIDS cases, same as exposure categories; how an individual may have been exposed to HIV, such as injecting drug use, Men who have Sex with Men, and heterosexual contact.

Universe: the total population from which a sample is drawn.

Validity: the extent to which a survey question or other measurement instrument actually measures what it is supposed to measure; for example, a question that asks young adults how often they use a condom is valid if it accurately measures their actual level of condom use.

Variable: a characteristic of finding that can change or vary among different people or in the same person over time; for example, race or ethnicity varies among individuals, and income varies for the same individual over time.

Voluntary HIV testing: HIV testing that is offered free of coercion. With voluntary HIV testing, participants have the opportunity to accept or refuse HIV testing.