Request for Applications

RFA # *A-379*

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 HIV Care Programs

ISSUE DATE: May 3, 2021

DEADLINE DATE: July 9, 2021

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 **May 27, 2021**

Applications will be received until 5:00 pm on July 9, 2021.
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.

Mailing Address:
HIV/STD Prevention and HIV Care Programs
North Carolina Communicable Disease Branch
1933 Mail Service Center
Raleigh, North Carolina 27699-1900

Street/Hand Delivery Address:
1200 Front Street, Suite 104
Raleigh, North Carolina 27609

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, Communicable Disease Branch is inviting submission of applications to fund and support HIV Care, HOPWA, and Prevention services within 10 geographically defined Regional Networks of Care and Prevention. Funding also supports Prevention services within the Charlotte Transitional Grant Area (*see **Appendix 1**: Map of Regional Care and Prevention Networks and **Appendix 2**: List of Network Region and Transitional Grant Area counties)*.

Historically the Branch awarded funding for HIV Care, HOPWA and Prevention services separately. In order to ensure greater collaboration and integration in the provision of these services, in 2016 the Branch combined separate funding announcements into one. This integration allows jurisdictions to better align prevention, care, 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. Also, 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: https://www.hiv.gov/federal-response/policies-issues/hiv-aids-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: https://epi.dph.ncdhhs.gov/cd/stds/figures/factsheet_HIV_care_outcomes_2018.pdf.

The overriding goal for funding HIV Care, HOPWA, and Prevention services is to end the HIV epidemic in North Carolina as explained in the CDB's Ending the Epidemic in North Carolina Plan which is currently under development. Several broad objectives which are aligned with our priorities for ending the epidemic in North Carolina have been identified as being crucial to achieving these goals and include:

1. Implementing PrEP services across the state to reduce new HIV infections;
2. Identifying undiagnosed people living with HIV earlier through increased testing for HIV and STDs among populations at greatest risk across the state;
3. Linking newly diagnosed individuals into care within one week of diagnosis to improve health outcomes;
4. Providing Rapid ARV medication to positive individuals at time of diagnosis;
5. Re-engaging out-of-care individuals into care through bridge counseling and peer support services to improve health outcomes;
6. Maintaining individuals in care to increase and ensure ongoing viral suppression in order to eliminate new infections and reduce transmission of HIV and other STDs;
7. Ensuring access to permanent housing to improve healthcare outcomes; and
8. Eliminating HIV-related disparities, health inequities, and stigma to increase access to medical care and improve health care outcomes.

Activities that facilitate the accomplishment of these objectives include:

1. Partnering with organizations who serve youth to conduct comprehensive sex education across the state;
2. Creating and providing social media/social marketing and health literacy campaigns that promote testing and treatment;
3. Establishing PrEP services in all regional Networks to reduce the risk of new HIV infections;

4. Providing HIV/STD counseling and testing, referral and active linkage to care services for young African American MSM;
5. Identifying all syringe 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;
6. Testing and linking persons identified as HIV+ to HIV Infectious Disease medical care within one week of diagnosis;
7. Establishing patient navigation and/or peer support networks to link clients to care and retain clients in care;
8. Ensuring rural communities have access to transportation services for increased access to care and support services;
9. Providing rapid ART medication to newly diagnosed individuals at the time of diagnosis;
10. Providing necessary core medical and support services to keep clients in medical care;
11. Identifying and locating clients who have dropped out of care and linking them back into care. This includes collecting, reporting and tracking Viral Load tests to monitor client health outcomes and assuring Viral Load suppression; and
12. Providing necessary HOPWA housing services to ensure clients are stably housed.

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

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)
e. For-Profit entities may apply for funding but must explain in their application why not-for-profit organizations in the Network region are unavailable to do the work they propose to perform.

Many cultural, socioeconomic, and environmental factors have an impact on health equity 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. All funded agencies and funded positions will be required to attend Cultural Competency/Cultural Literacy training developed by the North Carolina HIV Prevention and Care Unit. Attendance in this training is a continued condition of award.

FUNDING

Funding will be available for the following three (3) program areas (*Contractors will be funded for one or more of the following program areas*):

1. Prevention (Integrated Targeted Testing Services (ITTS))
2. HIV Care (Ryan White Part B)
3. Housing Opportunities for Persons with AIDS (HOPWA)

Award funding will span a period of three years: 2022-2023, 2023-2024, and 2024-2025. Funds will be allocated for one year initially, (2022-2023). Funding for 2nd and 3rd year periods will depend on

both performance of the funded agencies and availability of funds. Regional funding allocations may be reduced depending on the state's need for increased Disease Intervention Specialist and linkage/re-engagement activities. The next joint Care and Prevention RFA is planned for release in 2024 for funding in 2025- 2026, 2026-2027 and 2027-2028.

Program Area	1st Year Funding Cycles
HIV Care (Ryan White Part B)	April 1, 2022 – March 31, 2023
HOPWA	January 1, 2022 – December 31,2022
Prevention (ITTS)	June 1, 2022 – May 31, 2023

Ryan White Part B funding available per region:
Ryan White Part B funds allocated per region reflect 2021-2022 Ryan White Part B funding. **If the 2022-2023 Ryan White Part B allocation is lower, the Branch will adjust these allocations accordingly.** Similarly, if the base allocation is higher, the Branch will review these allocations based on current needs and resources. This will include a review of previous network expenditure rates and prior performance in service delivery, as applicable.

The table below represents the Ryan White Part B allocations per region for April 1, 2022 – March 31, 2023. Please note that there is an overall funding reduction from prior years due to a reduction in funding from the Ryan White Part B program through HRSA. The amounts per region listed below include base funding and quality improvement funding.

Region*	Ryan White Part B Base Funding	Quality Improvement Funding	Total
1	$711,688	$35,584	$747,272
2	$354,821	$17,741	$372,562
3	$1,088,390	$54,420	$1,142,810
4	$912,299	$45,615	$957,914
5	$882,536	$44,127	$926,663
6	$2,156,903	$107,845	$2,264,748
7	$656,369	$32,818	$689,187
8	$395,245	$19,762	$415,007
9	$313,792	$15,690	$329,482
10	$513,085	$25,654	$538,739
TOTAL	$7,985,128	$399,256	$8,384,384

**** See Appendix 2** for a list of counties included in each Network Region.*

HOPWA funding available per region:
HOPWA Network Region and one-time funding allocations are based on NCDHHS receiving the full projected allocation from HUD that is anticipated for the 2022 HOPWA program year and the availability of prior years' funding that may still be expended. **If the 2022 HOPWA allocation or available prior years' funding is lower, the Branch will adjust these allocations accordingly.** Similarly, if the base allocation or available prior years' funding is higher, the Branch will review these allocations based on current needs and resources. This will include a review of previous network

expenditure rates, as applicable. **Please note that one-time funding is open to any agency meeting the applicant eligibility requirements listed on page 5 of the RFA.**

The table below represents the HOPWA allocations per region and available for one-time funding for January 1, 2022 – December 31, 2022

Region*	HOPWA Funding
1	$726,638
2	$109,498
3	$588,048
4	$47,001
5	$575,625
6	$123,341
7	$245,155
8	$246,762
9	$112,580
10	$317,120
Total Network Funding	$3,091,768
Available One-Time Funding	$3,850,725
Total HOPWA Funding	**$6,942,493**

*See **Appendix 2** for a list of counties included in each Network Region. Please note:

Region 2 – Lincoln County is not funded with HOPWA.

Region 3 – Davidson, Davie, Forsyth, Iredell, Rowan, Stokes, Surry and Yadkin counties are currently funded with state HOPWA dollars. At some point in 2022 the City of Winston-Salem HOPWA Metropolitan Statistical Area (MSA) will assume funding responsibility for Davidson, Davie, Forsyth, Iredell, Rowan, Stokes and Yadkin counties. At that time, any state HOPWA contracts that were awarded through this RFA will be amended to reduce funding to an amount sufficient to ensure HOPWA service provision in Surry County which will then be the only county in Region 3 funded with state HOPWA dollars.

Region 4 – Guilford, Randolph and Rockingham counties are not funded with HOPWA.

Region 5 – Includes Anson County for HOPWA funding.

Region 6 – Wake, Johnston, Franklin, Durham, Orange and Chatham counties are not funded with HOPWA.

Region 9 – Currituck County is not funded with HOPWA.

Prevention funding available per region:
Approximately $3,638,914 in State and Federal CDC funds is available to support Prevention (ITTS) services. These initial funds will support the first 12-month contract cycle. Funding for subsequent years will depend on performance and review of expenditures of funded applicants, as well availability of funds. The Branch also reserves the right to amend funding allocations based on current needs and resources.

Region**	Average Prevention Funding Allocation**
1	$200,044
2	$123,758
3	$302,791
4	$407,440
5	$422,718
6	$733,398
7	$233,294
8	$250,850
9	$96,193
10	$233,875
TGA	$634,553
TOTAL	$3,638,914

*****See **Appendix 2** for a list of counties included in each Network Region.

**Prevention Agencies may receive 20% above or below the average funding identified in the table above based on regional needs, regional resources and quality of application.

Target Populations

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

- Men who have Sex with Men (MSM) of all races and ethnicities (with a focus on African American/Black gay and bisexual men)
- African American and Latino men and women
- Minority Youth ages 13 to 24 years
- Persons Who Inject Drugs (PWID)
- Transgender persons (with a focus on African American/Black transgender women)

Excluded Services

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.

Number of potential contracts awarded per region

The Branch will award contracts to an unlimited number of Prevention providers, a maximum of two Care providers and an unlimited number of HOPWA providers per region. In addition, the Branch will consider HOPWA funding requests form the Charlotte Transitional Grant Area (TGA) and HOPWA MSAs. (See chart below). The Branch will primarily fund providers (agencies) that have historically provided Prevention, HIV 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. Each Network should convene planning meetings of all funded and non-funded entities interested in providing HIV Care, HOPWA and Prevention services to discuss and decide the services that will be provided in the Network and identify the agencies that will provide each service. There is no limit to the number of subcontractors a provider can have. Branch funded providers are responsible for sub-recipient monitoring of their sub-contractors in accordance with the Branch sub-recipient monitoring processes.

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

II. BACKGROUND

HIV/AIDS and sexually transmitted infections (STI) acquisition, transmission and their complications, burdens and costs continue to be a significant public health problem. In 2018 in North Carolina alone:

- There were an estimated 35,457 persons living with HIV disease (including an estimated 4,900 individuals who may have been unaware of their infection).
- Every county in our State is impacted by HIV disease.
- 27% of persons living with HIV disease were estimated to have an unmet need for HIV care (no evidence of being in care in the past 12 months).
- NC surveillance data suggests that nearly 38% of people were not receiving the full benefit of treatment (they were not virally suppressed).
- The rate of new diagnoses for adult/adolescent Black/African American men was 68.7 per 100,000, which was 8 times higher than that of White/Caucasian men (8.1 per 100,000).
- The rate of new HIV diagnoses for Hispanic adult/adolescent men was 30.0 per 100,000, which was 3 times greater than the rate among White/Caucasian (non-Hispanic/Latino) men.
- The rate of new diagnoses for adult/adolescent Black/African American women was 15.9 per 100,000, which was nearly 8 times higher than that of White/Caucasian women (1.9 per 100,000).
- The rate of new HIV diagnoses for Hispanic adult/adolescent women was 4.1 per 100,000, which was nearly 2 times greater than the rate among white non-Hispanic/Latina women.
- 26% of all newly diagnosed HIV disease cases were among adolescent males 13-24 years old.
- 65% of people newly diagnosed with HIV were men who reported sex with men.
- 17% 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 was 1,914, with a rate of 18.4 per 100,000 populations. This number is an increase from 2013, when 688 early syphilis cases were diagnosed (7.0 per 100,000 populations).
- 41% 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 was 22,736 at a rate of 227.2 per 100,000 populations, compared to 14,114 cases (rate of 143.3 per 100,000 populations) in 2013.
- The number of chlamydia cases diagnosed in 2014 was 66,763 at a rate of 643.0 per 100,000 populations, compared to 49,220 cases (rate of 499.9 per 100,000 populations) in 2013.
- Data suggests that between 7-13% of HIV infected persons are coinfected with HCV.

The U.S. Department of Health and Human Services (US HHS) has launched *Ending the HIV Epidemic: A Plan for America (EHE).* The goal of this initiative is to reduce new HIV infections by 90% by 2030, and proposes four pillars (Diagnose, Treat, Prevent, Respond) to reach this goal.

The CDB is developing a *Ending the HIV Epidemic in North Carolina (NC ETE) Plan* and has identified NC priorities in this effort. The NC ETE Plan includes three pillars (Engage and Embrace, Test and Treat, Policy and Promotion) focused on reducing new HIV infections, increasing the number of people with HIV who are virally suppressed, improving HIV healthcare outcomes and ending the epidemic in North Carolina. The Branch understands that HIV is an issue that affects us all – but not equally; we will not shy away from these inequities or associated stigma but name them and address them head on. Both EHE and ETE are the basis for our HIV Care and Prevention efforts and for this RFA. The priorities below reflect both the *US HHS EHE* and the *NC ETE Plan*:

The Branch will focus on the following priorities for increasing the impact of HIV prevention efforts in reducing new infections:

- Expanding and increasing testing and linkage to care for HIV/STD/Viral Hepatitis in traditional and nontraditional settings including syringe services programs (SSPs)
- Normalizing assessments and offering PrEP in all health settings
- Addressing stigma and health care disparities as major drivers of HIV acquisition
- Ensuring HIV/STI education for providers including anti-stigma education

See the US HHS EHE*: A Plan for America* at**:**
https://www.cdc.gov/endhiv/index.html and
https://www.cdc.gov/endhiv/docs/ending-HIV-epidemic-overview-508.pdf

Regional Networks of Care and Prevention (RNCP)
North Carolina is divided into 10 Networks of Care and Prevention that provide HIV Care (Ryan White Part B Core Medical and Support), HOPWA, and Prevention (Integrated Targeted Testing Services (ITTS)) services. In addition to the ten Branch funded Networks, North Carolina has one Ryan White Part A TGA located in Charlotte that is severely affected by the HIV/AIDS epidemic.

Networks are expected to provide HIV Care and HOPWA services for clients in every county of their 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 each region, focusing on those counties and communities most in need of prevention services. However, it is not required that every county receives prevention services. Each network will be required to collaborate to determine prevention needs, how those needs will be met, which agencies will get letters of support from the Network and must describe this plan in their application. Available resources as well as unmet needs in each county should be taken into consideration when developing plans for funding HIV prevention activities. Each Network will convene planning meetings of all funded and non-funded entities interested in providing HIV Care, HOPWA, and Prevention services to discuss and decide the services that will be provided in the Network and identify the agencies that will provide each service. HOPWA MSAs provide HOPWA services in some counties of the Networks and if planning to apply for funding are expected to participate in Network planning meetings to discuss the HOPWA services to be provided to ensure coordinate service delivery.

RNCP Services
HIV Care (Ryan White Part B)
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, which 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. In North Carolina, ADAP funding which is known as the HIV Medication Assistance Program (HMAP), covers all 100 North Carolina counties. The Branch receives funding from Ryan White Part B (direct assistance to States and Territories) from HRSA.

The Branch also collaborates with other Ryan White Parts across the State including the Part A TGA in Charlotte based at the Mecklenburg County Health Department, which is direct assistance to an Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA) serving Anson, Cabarrus, Gaston, Mecklenburg and Union counties in North Carolina and York County in South Carolina; Part C, Early

Intervention Services including HIV Counseling and Testing; and Part D, which provides services for women, infants, children and youth.

HOPWA
The HOPWA program addresses specific housing needs of persons living with HIV/AIDS and their families. The NC HOPWA Program supports tenant-based rental assistance; short-term rent, mortgage and utilities payments; short-term hotel/motel assistance; 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. The Branch receives HOPWA funds from HUD. NC HOPWA funds are currently used to provide housing related services in 82 of the 100 North Carolina Counties. Counties *not* covered by under the NC 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.

Prevention (Integrated Targeted Testing Services – (ITTS))
The CDB has designated funding from the CDC and the State to support High Impact Prevention activities in North Carolina. Emphasis will be given to programs that conduct targeted HIV/STD 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 individuals at risk for HCV. 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 syringe exchange programs in NC, agencies funded for HIV/STD prevention should identify all syringe 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 all syringe exchange programs that they work with outlining the services that the HIV/STD prevention agency will provide.

III. SCOPE OF SERVICES

The Regional Network of Care and Prevention is a group of collaborative counseling, testing and referral, core medical, support, housing/social service, PrEP, and syringe service providers in a geographic region that work together to create a community of services to address the goals, objectives and activities of the Network and assist in meeting the Branch goal of ending the epidemic in North Carolina.

The Network may include as many providers as necessary to plan and carry out the goals, objectives, and activities of the Network. The Network can and should include all providers for which the network will be requesting HIV Care/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 work in partnership with the Network to carry out the goals, objectives and activities of the Network.

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.

Prevention/ITTS 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.

The Branch views peer navigation activities as very high priority activities of the Networks that are necessary and required to engage and maintain persons living with HIV (PLWH) in core medical and support services which will result in improved viral suppression rates, decreased viral transmission rates and an end to the epidemic in North Carolina. As a result, each Network is encouraged to ensure that at least one peer staff member is available to assist PLWH with engagement and retention in care to ensure that individuals are engaged with medical treatment, adherent to medications and reducing risk behaviors that could lead to transmission of the disease.

Any agency that applies for funding within a regional Network of Care and Prevention must agree to actively engage and collaborate in network activities including the creation and maintenance of deliverables and participation in network meetings. HIV Care/Ryan White Part B and HOPWA service providers must participate in the creation and maintenance of the following Network deliverables: Evaluation Plan, Client Grievance Policy, and Client Satisfaction Assessment. HOPWA service providers must participate in the annual Housing Needs Assessment. Network Meetings must occur quarterly, at a minimum, and are a mandatory requirement of each Prevention, HIV Care and HOPWA contract. During each Network meeting, the progress made in meeting the objectives of the RFA and ending the epidemic in North Carolina must be discussed by HIV Care, Prevention and HOPWA providers; barriers and progress made in meeting the objectives and ending the epidemic in North Carolina must be identified; and any changes to be implemented to improve successful completion of the RFA objectives must be documented and submitted to the NC HIV Care Program with the submission of each Network quarterly report for review by HIV Prevention and Care Unit staff. Each Network must have at least one representative from each funded Prevention, HIV Care, and HOPWA provider present at each HIV Prevention and Care Unit sponsored Provider Meeting 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. See **Appendix 3**: North Carolina Branch Regional Offices.

Program Descriptions, Application and Performance Requirements

PROGRAM AREA ONE

Prevention (Integrated Targeted Testing Services (ITTS))
The NC Communicable Disease Branch intends to fund local health departments, community-based organizations, and other entities across the state to conduct HIV/STD and HCV counseling, testing, and linkage to care activities. HIV testing is a gateway to HIV diagnosis, treatment, prevention, and response. Great strides have been made in HIV prevention, but approximately 1 in 7 (14%) of the estimated more than 1 million people with HIV in America still do not know they have HIV. 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 ensures people living with HIV receive lifesaving medical care services and helps reduce their risk of transmitting HIV. STDs and HCV play a major role in increasing an individual's risk of acquiring and transmitting HIV or developing complications of HIV.

The epidemic in the US is concentrated in certain key populations and geographic areas. Therefore, testing should follow the epidemiological data of each region and the state and should include cost-effective, scalable interventions that are prioritized in the communities where HIV is most concentrated. The following **key priority groups** should be the primary focus areas of all ITTS activities as they share the greatest burden of HIV/STDs:

- Men who have Sex with Men (MSM) of all races and ethnicities (with a focus on African American/Black gay and bisexual men)
- African American and Latino men and women
- Minority Youth ages 13 to 24 years
- People Who Inject Drugs (PWID)
- Transgender persons (with a focus on HIV among African American/Black transgender women)

ITTS projects strive to identify persons who are unaware of their HIV status and actively facilitate getting them into treatment/care if needed or prevention services to include PrEP (if appropriate). They conduct HIV, STD and HCV counseling and testing in areas frequented by persons at high risk of contracting these infections and during times that these persons can be engaged. These projects ensure that clients testing positive are successfully linked to medical care and other services. ITTS projects are required to offer HIV and syphilis testing but preference is given to projects that also test for HCV, gonorrhea, and chlamydia.

ITTS projects work with their Regional Networks of Care and Prevention to ensure integrated care and prevention services. All agencies funded for ITTS are required to attend quarterly RNCP meetings and participate in the RNCP decision making process. Agencies applying for ITTS funding are strongly encouraged to submit a Letter of Support from their RNCP.

ITTS projects work to reach people in the key priority groups listed above wherever they can be found. Testing may be offered in public parks, street corners, and at other community settings or at fixed testing sites including homeless shelters, jails, syringe exchange sites, drug treatment centers, migrant health centers, mental health facilities, nightclubs and colleges. Testing is offered at locations and during hours that are accessible to persons at highest risk for HIV. Agencies applying for ITTS funding are strongly encouraged to use blood draws as their primary method of testing.

ITTS projects implement strategies and/or interventions to reduce barriers to testing and address health inequities among key groups disproportionately affected by the HIV epidemic. These strategies focus on how to reach the MSM community as well as other priority groups with consideration given to potential testing venues/locations frequented by these groups.

ITTS projects implement strategies to provide counseling and testing in Syringe Services Programs (SSPs) which can provide an entry point for a range of services to help stop drug use, overdose deaths, and infectious diseases. Research shows that new users of SSPs are five times more likely to enter drug treatment, and about three times more likely to stop using drugs than people who do not use the programs.

ITTS projects implement strategies to increase access to PrEP using North Carolina's criteria for who is appropriate for PrEP. ITTS projects educate all clients and actively refer to PrEP those clients that meet the state criteria. This includes utilizing Prevention funds for linkage to PrEP and utilizing Early Intervention Services (EIS) under Ryan White Part B for targeted HIV testing and referral to HIV care and treatment services if the individual is found to be living with HIV.

ITTS projects integrate social media strategies into testing and PrEP activities to help spread key messages and increase awareness and access to 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.

Applicants of <u>Program Area ONE</u> must adhere to the following requirements:

1. Agency must include HIV and syphilis counseling, testing, referral, and active linkage to care activities at hours and locations that are accessible to persons at highest risk in the key priority groups. Agency must offer hepatitis C testing to people who inject drugs or have a history of injecting drugs, and test for gonorrhea and chlamydia, when appropriate. Note: If agency predominantly uses rapid testing, you must have the capability to draw blood for confirmatory testing, as needed.
2. Agency must include the following services:
    a) Collaborate with youth organizations, school health educators and universities to better address sexual health education for young people to include community outreach testing and educational workshops in settings that this group frequents. Note: 20% of total tests should be done among non-MSM youth.
    b) Identify needle or syringe exchange programs in the service area and work with these programs to ensure that HIV/STD/HCV counseling, testing, referral and linkage to care and treatment occur.
    c) Provide counseling and testing, referral, and active linkage to care services for young African American MSM. Note: 25% of total tests must be among young African American MSM.

3. Agency must implement a Condom Distribution Program to increase the availability and accessibility of condoms among populations at risk for HIV/STD/HCV. Guidance can be found at https://www.cdc.gov/hiv/effective-interventions/prevent/condom-distribution-programs/index.html
4. Agency must follow the current CDC HIV testing guidelines and guidance on implementing HIV testing in non-clinical settings found at https://www.cdc.gov/hiv and follow the State's Communicable Disease Branch guidance as follows:
    a) Program testing staff must attend the Communicable Disease Branch's (CDB) sponsored HIV CTR Training.
    b) HIV counseling and testing must be offered on a voluntary basis that includes informed consent, per the Communicable Disease Branch guidance. 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.
    c) Physician and managerial oversight must ensure counseling, testing and referral activities, and medical/patient records, laboratory forms and risk assessments must be completed accurately and in compliance with agency procedures.
    d) Mechanism must be in place to collect, track and report required HIV/STD/HCV testing data in EvaluationWeb in accordance with the guidelines established by the state and CDC data requirements.
    e) Confirmed positive laboratory results for HIV/STD/HCV must be reported to the local health department, DIS and/or the medical provider for partner notification, and linkage to care and treatment.
    f) Post-test counseling must be provided for clients testing positive for HIV. 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 be given N.C. Communicable Disease Control Measures. A physician can delegate the post-test counseling responsibility to agency staff that have attended the CD Branch sponsored HIV CTR training.
    g) Referral and linkage activities must be collected, documented, and tracked to include the number of HIV-positive clients "actively" linked and the number of clients that complete an initial visit with a HIV care provider. Agencies should work with State Bridge Counselors or DIS in facilitating these linkages, if appropriate.
5. Agency must make PrEP referrals for HIV negative clients that meet N.C. PrEP criteria. (See **Appendix 4**)
6. Agency must implement social marketing activities 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 (ages 13-24).
7. Agency 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. Agency must utilize appropriate assessment tools to address site productivity, client satisfaction surveys, staff development and training needs, record review, referral tracking and data collection process, and a description of how observations and feedback will be documented and provided to the staff.
8. Agency must obtain Letters of Support from each local health department where services will be offered and obtain a Memorandum of Agreement (MOA) from each established site where agency intends to conduct testing, condom distribution and referral/linkage activities. Each MOA must describe the specific collaborative activities and commitment of the agency/ies. (See **Appendix 5.**)

9. Agency must work with the Regional Networks of Care and Prevention to ensure integrated care and prevention services. All agencies funded for ITTS must attend quarterly RNCP meetings and participate in the RNCP decision making process.
10. Agency must create a current resource list that includes information about available services in the community.
11. Agency must maintain resumes or curriculum vitae on all project staff. Project staff must have a minimum of one-year experience related to community organizing in community settings and in computer skills for using web-based testing data system. Agency's Financial Officer must have a minimum of one year in accounting experience. Agency must be able to provide backup documentation of agency's financial stability.
12. Agency 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. Agencies must enter all testing data into EvaluationWeb. **(**See **Appendix 6.)**
14. Agency must maintain a policy and procedure manual in place by the end of the first quarter of the funding cycle to address the areas listed in **Appendix 7.**

PROGRAM AREA TWO

HIV Care (Ryan White Part B)
Currently the Ryan White HIV/AIDS Program (RW) provides services to an estimated 550,000 people in the United States each year. The grant awards made under the Ryan White Program legislation are the "payor 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 payor.

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 focuses on 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 ending 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 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 suppression. Once this is accomplished those living with HIV are less likely to transmit the virus. Services that are administered with RW Part B funds are necessary to those who are HIV positive and assist them in obtaining HIV viral 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 (Please note that Oral health services have been identified as a high priority service need across the State as a result of feedback received from Ending the Epidemic community planning meetings. The application should include an explanation detailing how the provision of oral health services will be prioritized in the Network).
- Mental Health Services
- Medical Case Management (including Treatment Adherence)
- Substance Abuse Services-outpatient
- Health Insurance Premium and Cost-Sharing Assistance

- Early Intervention Services (Please note that this is the first time Early Intervention Services (EIS) have been required. Early Intervention Services include targeted HIV testing and referral to HIV care and treatment services. As a result, the Network may be able include some testing services under EIS which could be used to supplement testing services provided through Prevention. However, HIV testing services paid for by EIS cannot supplant testing efforts paid for by other sources.

Support Services:

- Medical Transportation Services

The above-listed HIV Care/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, each of the services listed above must be available to clients in each county of the Network.

In addition to the required core medical and support services listed above, each Network is encouraged to provide peer navigation services to assist PLWH with engagement and retention in care.

Networks can also provide any of the optional Ryan White Part B services listed in **Appendix 8** based on the needs of clients and available resources in the geographic area covered by the network.

Definitions of Ryan White Part B Services can be found in the HIV/AIDS Bureau, Division of State HIV/AIDS Programs Policy Clarification Notice 16-02 located at:
https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
and in the National Monitoring Standards for Ryan White Part B Grantees which can be found at:
https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
Applicants should be prepared to comply with any subsequent revisions of these documents released by HRSA/HAB.

Applicants of Program Area TWO must adhere to the following requirements:

1. Ensure that Core Medical, Support and MAI/HMAP services are 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: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf;
    c) The North Carolina Ryan White Part B Patient Management Model Performance Requirements/Standards; and
    d) Policy Clarification Notices (PCNs), including PCN 16-02 (updated 10/22/18) which details Ryan White Program Service Definitions, posted at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

2. 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. 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.

3. Understand that Ryan White Part B services shall not be reimbursed unless the client is authorized for the service at the time of delivery. Accordingly, the Contractor shall assure that each client's eligibility is assessed when the client initially requests a service for the first time and then is reassessed during each reassessment period to determine continued eligibility for Ryan White Part B HIV Care Program services. Documentation of income for the client and countable family members utilizing a Modified Adjusted Gross Income (MAGI) – based methodology, proof of North Carolina Residency and proof of Insurance or Medicaid/Medicare, shall be collected during initial authorization, during reauthorization as needed and maintained in each client record. Reauthorization shall be completed as follows:

    a) Complete reauthorization for clients receiving HMAP services every six months according to the HMAP schedule: January – March (Winter) or July – September (Summer). Documentation of income, proof of NC residency, and proof of Insurance or Medicaid/Medicare is always required during the Summer reauthorization period. If there has been a change in income, NC residency, Insurance or Medicaid/Medicare, then documentation is required during the Winter reauthorization period.

    b) Complete reauthorization for clients receiving only non-HMAP RW Part B services every six months. Documentation of income, proof of NC Residency, proof of Insurance or any other third-party payor such as Medicaid or Medicare is required.

    c) Complete reauthorization every six months for those clients with an FPL between 301% and 500% who were 'grandfathered' into RW Part B services (and are not HMAP clients) in order to maintain their eligibility for RW Part B services. If these clients fail to reauthorize every six months, they will have fallen out of the program and if their income is above the eligibility limit of 300% FPL, they will no longer be eligible for the program, until such time as their FPL falls back to 300% FPL or less.

       As part of each reassessment, the Ryan White Part B HIV Care Program/HMAP Eligibility Checklist shall be completed with all supporting documentation attached and shall be maintained in the contractor's file. Ryan White Part B services cannot be

provided under presumptive eligibility, except in the case of newly diagnosed clients. Eligibility must be confirmed prior to initial enrollment and at each subsequent reauthorization.

4. Assure that policies and procedures shall be established and maintained detailing the Contractor's premium tax credit reconciliation process when Ryan White Part B funds are used to pay a client's premium tax credit:

    a) The Contractor and subcontractors must vigorously pursue any Internal Revenue Service (IRS) funds that a client receives as a result of premium tax credit reconciliation if a client was underpaid in advance premium tax credits. The Contractor and subcontractors shall document the steps that were taken to pursue these funds from clients. Recovered tax credit refunds must be used in the Health Insurance Premium and Cost-sharing Assistance service category in the contract year when the refund is received by the Contractor. Recovered excess premium tax credits shall not be considered program income.

    b) Ryan White Part B funds may be used to assist a client's payment to the IRS as a result of premium tax credit reconciliation. The Contractor and subcontractor are responsible for coordinating payments to the IRS. Direct payments to clients are prohibited. Payments to the IRS must be made from funds available in the year when the tax liability is due, even if premiums that generated the tax liability were incurred in a previous contract year. The Contractor and subcontractor may only pay the amount directly attributed to the reconciliation of the premium tax credits. Ryan White Part B funds cannot be used to pay the fee/penalty for a client's failure to enroll in minimum essential coverage.

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 people who inject drugs and their partners, homeless people, women, children, youth, and men who have sex with men (MSM).

6. Include participation by individuals and families with HIV, as well as agencies and community-based organizations that are representative of populations and subgroups reflecting the local incidence of HIV, during the ongoing needs assessment, planning and implementation of services. This shall include organizations that represent key points of access to the HIV care system, including other funded Ryan White Projects.

7. Establish and maintain relationships with entities in the Network region that constitute key points of access to the health care system for individuals with HIV (including emergency rooms, substance abuse treatment programs, detoxification centers, syringe exchange sites, 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, PrEP Clinics/access points, Ryan White Part A, C, D and F grantees, for the purpose of facilitating early intervention for individuals newly diagnosed with HIV and individuals knowledgeable of their HIV status but not in care.

8. Consult with Ryan White Part C and D projects or, if none are operating in the area, representatives of organizations with a history of serving children, youth, women, and families with HIV. The Contractor shall demonstrate that adequate needs assessment and

planning has occurred to meet the special needs of families with HIV disease, including family centered and youth centered care. In addition, the plan for services shall be in accordance with the Prevention and Care Statewide Coordinated Statement of Need/Needs Assessment/ Integrated Plan, and any local and/or regional needs assessment(s).

9. Assure 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 is 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 4/1/17 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.

10. Accept all referrals from Disease Intervention Specialists (DIS)/Bridge Counselors, strive to get the referred individuals into care as quickly as possible, and maintain data in CAREWare for clients entering care. Make every effort to get clients referred from other sources and self-referred clients into care as quickly as possible and assure these clients remain in care.

11. Refer HIV negative individuals to appropriate supportive services that will contribute to keeping them HIV negative, including PrEP access points.

12. Establish and submit to the HCP signed electronic or printed copy Memorandums of Agreement or Understanding (MOAs or MOUs) and subcontracts (for all service providers identified as a subcontractor) within 30 days of signature:

    a. Documenting direct medical care provider oversight for all Medical Case Management providers serving Network clients; and

    b. Documenting the services to be provided by each Network provider regardless of funding source.

    All Network MOAs/MOUs/subcontracts shall include specific agreements for sharing client data among all Network providers for coordination of care, tracking, monitoring health outcomes, quality improvement, and reporting purposes. The Contractor shall ensure that all Network MOAs/MOUs and subcontracts detail specific requirements concerning data sharing among all Network providers.

All Network MOAs/MOUs/subcontracts shall also include specific agreements for obtaining documentation from Network providers to ensure that all HRSA Ryan White Part B Monitoring Standards are met.

13. Adhere to the requirement that at least 75% of all client services funds, network wide, shall be for Core Medical Services. No more than 25% of client services funds, network wide, can be used for Support Services.

14. Spend no more than 5% of the contractor's total Ryan White Part B HIV Care Program expenditures (Part B only, not inclusive of any MAI dollars) on Quality Improvement activities. While other regional quality improvement initiatives are allowable, at minimum, the contactor must participate in quarterly meetings of the HIV Care Program Regional Quality Council (RQC).

15. Spend no more than 5% of the total current budget period expenditures for direct and indirect costs associated with planning and evaluation activities or no more than 10% of the total current budget period expenditures for direct and/or indirect costs associated with administering the Ryan White Part B HIV Care Program award. The aggregate total of sub-recipient administrative expenditures, including all indirect costs, cannot exceed 10% of the aggregate total of funds expended by the sub-recipient. The aggregate total of the subrecipient's administrative costs may not exceed the 10% limit.

16. Submit expenditure reports within 10 days after the month of service in order for the Ryan White Part B Program to be adequately monitored and funds efficiently utilized. Reports to be submitted monthly include the following: a detailed monthly expenditure report and the Contract Expenditure Report (CER) for the relevant month of service documenting Ryan White Part B expenditures. The Contractor shall assure each month that the total Ryan White Part B federal expenditure on the monthly CER matches the total on the Contractor's detailed expenditure report. Contractors may only submit reimbursement requests for funds they have already disbursed.

17. Review budget expenditures quarterly by line item and request approval for line-item revisions as necessary to assure accurate and efficient reporting and expenditure of Ryan White Part B funds. No expenditures will be approved for payment prior to budget realignment approval.

18. Submit quarterly program reports to the HCP and all Care and Prevention provider agencies within the Network detailing Contract Ryan White Part B activities according to the following schedule:

Service Quarter	Report Submission Deadline
April – June 2022	July 29, 2022
July – September 2022	October 31, 2022
October – December 2022	January 31, 2023
January – March 2023	April 28, 2023

19. Attend all scheduled mandatory meetings sponsored by the HCP, including HCP Provider Meetings, webinars, trainings, and conference calls.

20. Participate in HRSA's Client Level Data (CLD) initiative including electronic submission by February 22, 2022 of the Ryan White Services Report (RSR) listing core medical and support services provided for calendar year 2021.

21. Provide all medical and/or dental care services in accordance with applicable Federal guidelines found at: http://aidsinfo.nih.gov/guidelines.

22. Monitor all sub-recipients through two site visits during the contract period to assure that their operations are compliant with all state and federal policies and procedures. Each review should include a review of expenditure source documentation for two months as well as a review of agency and client records. Expenditure source documentation, agency records and client records should be reviewed during each sub-recipient monitoring site visit to ensure compliance with the most current release of the HIV/AIDS Bureau National Monitoring Standards: Universal, Program and Fiscal. The total number of client records to be reviewed during the Agreement Period for each individual sub-recipient should be based on the total number of unduplicated clients served by the sub-recipient during the prior contract period and the record review sample size chart below:

    - </= 49 clients – review 75% of records (minimum of 10 records and maximum of 37)
    - 50 to 99 clients – review 40% of records (20 to 36 records)
    - 100 to 500 clients – review 10% of records (10 to 50 records)
    - 501 – 999 clients – review 5% of records (25 to 50 records)
    - >/= 1,000 clients – review 3% of records (minimum of 30 records)

23. Understand that effective December 26, 2014, all references to OMB Circulars for the administrative and audit requirements and the cost principles that govern Federal monies associated with this award are superseded by the Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75.

24. Obtain prior approval from the HRSA Division of Grants Management Operations (DGMO) through the HIV Care Program (HCP) in order to use Ryan White Part B funds for the purchase of vehicles of any value or equipment whose value is in excess of $25,000.

25. Understand that recipients and sub-recipients of Federal funds are subject to the strictures of the Medicare and Medicaid anti-kickback statute (42 U.S.C.1320a - 7b(b) and should be cognizant of the risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. 1320 7b(b) Illegal remunerations which states, in part, that whoever knowingly and willfully: (A) Solicits or receives (or offers or pays) any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring (or to induce such person to refer) an individual to a person for the furnishing or arranging for the furnishing of any item or service, OR; (B) In return for purchasing, leasing, ordering, or recommending purchasing, leasing, or ordering, or to purchase, lease, or order, any goods, facility, services, or item for which payment may be made in whole or in part under subchapter XIII of this chapter or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

26. Understand that recipients and sub-recipients of Federal funds are subject to the requirements of 48 CFR section 3.908 found at http://www.ecfr.gov entitled "Pilot Program for Enhancement of Contractor Employee Whistleblower Protections". Recipients and sub-recipients should be cognizant of the statute, specifically under 41 U.S.C. 4712 stating "an

employee of a contractor, subcontractor, or grantee may not be discharged, demoted, or otherwise discriminated against as a reprisal for disclosing to a person or body described in paragraph (2) information that the employee reasonably believes is evidence of gross mismanagement of a Federal contract or grant, a gross waste of Federal funds, an abuse of authority relating to a Federal contract or grant, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation related to a Federal contract (including the competition for or negotiation of a contract) or grant". Recipients and sub-recipients are required to inform their employees in writing of employee whistleblower rights and protections under 41 U.S.C. 4712 in the predominant language of the workforce.

27. Understand that recipients and sub-recipients of Federal funds are subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104) found at https://www.state.gov/j/tip/laws/61124.htm and at https://www.hrsa.gov/sites/default/files/hrsa/grants/manage/trafficking-in-persons.pdfRecipients and sub-recipients may not "engage in severe forms of trafficking in persons during the period of time that the award is in effect; procure a commercial sex act during the period of time that the award is in effect; or use forced labor in the performance of the award or sub awards under the award". Recipients and sub-recipients should be cognizant of the risk of criminal and administrative liability under this statute.

28. Take steps to ensure that people with limited English proficiency can meaningfully access health and social services. A program of language assistance should provide for effective communication between the service provider and the person with limited English proficiency to facilitate participation in, and meaningful access to, services. The obligations of recipients are explained on the Office of Civil Rights OCR website at: http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/ and on the US Department of Health and Human Services website at: http://www.hhs.gov/civil-rights/for-individuals/section-1557.

29. Not use Ryan White Part B funds to pay the salary of an individual in excess of $197,300. This amount reflects the individual's base salary exclusive of fringe benefits. An individual's institutional base salary is the annual compensation that the recipient organization pays an individual and excludes any income that an individual may be permitted to earn outside the applicant organization duties. HRSA funds may not be used to pay a salary in excess of this rate. This salary limitation also applies to sub-recipients under a HRSA grant or cooperative agreement.

30. Ensure that Ryan White Part B HIV Care Program funds will not be used for any of the following unallowable costs:

    a) Purchase or construction of real property
    b) Cash payments to recipients of services. This includes cash incentives and cash intended as payment for Ryan White services
    c) Fund programs or develop materials designed to directly promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual
    d) Purchase sterile needles or syringes for the purposes of hypodermic injection of any illegal drug
    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-premises 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) International travel
u) Purchase of gift cards that can be exchanged for cash or used for anything other than allowable goods or services. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as VISA, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are also unallowable.

31. Assure 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.

32. Adhere to the requirement that the following acknowledgement and disclaimer, modified to include the correct grant information as provided by the HIV Care Program, is used when issuing statements, press releases, requests for proposals, bid solicitations, websites, and other HRSA supported publications and forums describing projects or programs funded in whole or in part with HRSA funding.

"This [project/publication/program/website, etc.] [is/was] supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $XX with XX percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official

views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov."

33. Submit to the HCP a written certification statement of time and effort worked of each person paid from this contract according to the following schedule:

Service Period	Certification Statement Submission Deadline
April – September 2022	October 31, 2022
October 2022 – March 2023	April 28, 2023

34. Understand that any program income received within the contractor's Ryan White Part B Care Program during this Contract's payment period must be spent within its Ryan White Part B HIV Care Program before utilizing funds awarded through this contract. HRSA defines "program income" as gross income earned by the non-Federal entity that is directly generated by a supported activity or earned as a result of the federal award during the period of performance except as provided on 45 CFR §75.307 (f). See HRSA's Policy Clarification Notice 15-03 posted at: http://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters for additional information.

35. Understand that recipients and sub-recipients of Ryan White Part B funds shall not discriminate based on age, disability, sex, race, color, national origin, or religion. Recipients and sub-recipients shall also be cognizant of Title VI of the Civil Rights Act of 1964. The obligations of recipients are explained on the US Department of Health and Human Services website at: http://www.hhs.gov/civil-rights/for-individuals/section-1557.

36. Understand that recipients and sub-recipients of any grant-related activity in which family, marital, or household considerations are, by statute or regulation, relevant for purposes of determining beneficiary eligibility or participation, grantees must treat same-sex spouses, marriages, and households on the same terms as opposite-sex spouses, marriages, and households, respectively. By "same-sex spouses" Health and Human Services (HHS) means individuals of the same sex who have entered into marriages that are valid in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "marriage," HHS does not mean registered domestic partnerships, civil unions, or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than marriage.

37. Provide to the HCP any additional assurances, data and/or information needed to meet the Ryan White Part B requirements or to implement the North Carolina HIV Program. The HCP reserves the right to amend any of the above pursuant to changes in State or Federal legislation or regulation, with appropriate notification to contractor. Such changes will not be retroactive to the beginning of the contract, unless required by State or Federal legislation or regulation.

38. Attend and participate in all trainings designated as mandatory by the HCP.

39. Establish and maintain relationships with entities in the Network region that offer syringe exchange services. While no Ryan White Part B funding may be utilized to fund syringe exchange services, such entities shall be included as a non-funded regional partner, included in regional planning activities, and attending Quarterly Network Meetings.

40. Understand when pursuing rapid eligibility for a newly diagnosed client the contractor must agree to provide the necessary services to get the client into care as swiftly as possible. The contractor understands that this service has to be provided simultaneously with the Ryan White Part B/HMAP certification. If it is later deemed that the client is ineligible for Ryan White Part B or HMAP services, then the contractor must reimburse the grant for any services provided to the client. The same rule applies to newly diagnosed clients that are later deemed eligible for other 3rd party payor sources (e.g., Medicaid, Medicare, ACA, private insurance, etc.).

41. Cooperate with any federal and/or state investigations regarding the Part B program when necessary.

42. Coordinate the HIV Care Network itself, including convening and facilitating quarterly Network meetings. Meeting minutes shall be submitted to the HCP Program Consultant via email or USPS no more than 14 calendar days after the meeting date.

43. Coordinate HIV Care Network services throughout the region.

44. Participate in any required annual updates to the Statewide Coordinated Statement of Need (SCSN) and Needs Assessment process that may be required by the Centers for Disease Control and Prevention (CDC) and HRSA. Possible participation may include attendance at meetings, town hall meetings, focus groups, and surveys.

45. Develop and implement an Evaluation Plan for the HIV Care Network and submit to the HCP Program Consultant via email or printed copy no later than August 31, 2022. Evaluation results shall be submitted to the HCP Program Consultant via email or USPS no later than February 28, 2023.

46. Develop an HIV Care Network client grievance policy and procedures and assure all HIV Care Network clients are aware of the grievance policy/procedures and provided a copy. A copy of the grievance policy shall be submitted to the HCP Program Consultant via email or USPS no later than July 29, 2022.

47. Conduct an assessment of client satisfaction with HIV Care Network services and provide an analysis of the results to the HCP Program Consultant via email or USPS no later than January 31, 2023.

48. Implement all HRSA/HAB Quality Improvement Performance measures required by the State Ryan White Part B Program and RQC.

49. Use performance measures data in the development and implementation of Network-wide quality improvement projects.

50. Attend and participate in at least 4 North Carolina RQC meetings and conduct agreed-upon quality improvement projects within the HIV Care Network.

51. Utilize health outcome data to facilitate improved health outcomes of clients served by the Network.

52. Provide updates of HIV Care Network Quality Improvement activities in quarterly reports and any other reports to the HCP. Each quarterly report is due no later than 30 days after the end of the quarter and shall be submitted to the HCP Program Consultant via email or USPS.

53. Provide all medical and/or dental care services in accordance with applicable Federal guidelines found at: http://aidsinfo.nih.gov/guidelines.

54. Utilize the CAREWare application to record all client demographic, service, and encounters data on the State CAREWare server within 30 days of the service provided. The CAREWare dataset is the property of the State. The HIV Care Program (HCP) and the Epidemiology Section (IT Staff) shall work with the Contractor to ensure maximum access to and control of this dataset to include control and delineation of permission rights and use of the State CAREWare server. Should issues arise regarding access to the State CAREWare server, the Contractor is required to notify the CAREWare Program Coordinators promptly by either phone or e-mail. In addition, the Contractor shall be responsible for developing, in conjunction with the HCP, a regional CAREWare system to ensure that all active Network partners have access to client information necessary to provide high quality client care.

PROGRAM AREA THREE

Housing Opportunities for Persons with AIDS (HOPWA)
The primary goal of the HOPWA Program is to increase access to and ensure the provision of safe, decent and affordable housing and housing-related services to persons living with HIV infection and their families in North Carolina and to ensure that all HOPWA recipients living with HIV infection are receiving medical care.

HOPWA is designed to promote client housing stability and to bridge participants to long-term assistance programs, such as Section 8, the Targeting Program, 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 a client needs-based program and is not an entitlement program. Participation in HOPWA is optional 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. Completion and submission of an application does not guarantee funding, nor does a previous allocated HOPWA award.

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

- Tenant-Based Rental Assistance (TBRA)
- Short-Term Rent, Mortgage, and Utility Assistance (STRMU)
- Permanent Housing Placement (PHP)
- Resource Identification (RI)

In addition to Tenant-Based Rental Assistance, Short-Term Rent, Mortgage, and Utility Assistance, Permanent Housing Placement, and Resource Identification, HOPWA Project Sponsors may also

provide the following optional NC HOPWA Eligible Activities based upon regional need and resources:

- Hotel/Motel (H/M) Assistance: The H/M component of HOPWA funds are designed to provide motel and hotel vouchers for up to 60 days if no appropriate shelter beds are available and subsequent rental housing has been identified but is not immediately available for move-in by the program participants.
- Housing Information (HI): The HI component of HOPWA provides counseling, information, and referral services to assist in locating, acquiring, financing and maintaining housing.
- Transitional Housing (TH): The TH component of HOPWA supports facility-based housing (operating or leasing) providing up to 24 months of housing as individuals and families move to permanent housing.
- Supportive Services (SS): The SS component of HOPWA supplements housing with services that help clients manage their HIV/AIDS condition.
- Emergency/minor repair costs for HOPWA facilities or units.

HOPWA's approach to Fair Housing Laws, Affirmatively Furthering Fair Housing, and Gender Identity Final Rule

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.

On September 21, 2016, HUD published a final rule in the Federal Register entitled "Equal Access in Accordance with an Individual's Gender Identity in Community Planning and Development Programs." Through this final rule, HUD ensures equal access to individuals in accordance with their gender identity in programs and shelter funded under programs administered by HUD's Office of Community Planning and Development (CPD). This rule builds upon HUD's February 2012 final

rule entitled "Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity" (2012 Equal Access Rule), which aimed to ensure that HUD's housing programs would be open to all eligible individuals and families regardless of sexual orientation, gender identity, or marital status. The final rule requires that recipients and subrecipients of CPD funding, as well as owners, operators, and managers of shelters, and other buildings and facilities and providers of services funded in whole or in part by any CPD program to grant equal access to such facilities, and other buildings and facilities, benefits, accommodations and services to individuals in accordance with the individual's gender identity, and in a manner that affords equal access to the individual's family.

Applicants of <u>Program Area THREE</u> must adhere to the following requirements:

1. Ensure that HOPWA services are 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; and
    b) State rules, regulations and guidance for the HOPWA program.

2. Understand that HOPWA services shall not be reimbursed unless the client is authorized for the service at the time of delivery. Accordingly, the Contractor shall assure that each client's eligibility is assessed when the client initially requests a service for the first time and then is reassessed annually during each reassessment period to determine continued eligibility for HOPWA services. Documentation of income for the client and countable family members, proof of North Carolina Residency and proof of HIV status, shall be collected during initial authorization, during reauthorization as needed and maintained in each client record.

3. Ensure that HOPWA funds are used to leverage other housing related programs including, but not limited to, Emergency Solutions Grant, Community Development Block Grants, 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.

4. Ensure that under totally favorable conditions, housing is made available within two weeks of eligibility determination to all eligible clients seeking stable housing. If housing cannot be made available within two weeks, clients shall be placed on a waiting list and shall receive help identifying other potential housing resources.

5. Adhere to the North Carolina HOPWA Program Waiting List Guidance ensuring waiting lists are managed in a manner that eliminates unfair selection processes and preferential treatment:
    a) Ensure written procedures are in place describing the waiting list, how names are placed on the list, who shall be responsible for maintaining the list, and how rental assistance slots shall be filled from the list; and
    b) Update the waiting list at least quarterly through actively following up with clients on the list.

6. Ensure that all eligible clients receiving HOPWA services have access to a case manager.

7. Ensure that all eligible clients receiving TBRA, STRMU, and Supportive Services have a housing care plan documenting goals and activities to maintain stable housing.

8. Ensure that all clients receiving HOPWA services are also receiving HIV Infectious Disease Care. HIV Infectious Disease Care shall be in accordance with the standards adopted by the Health Resources and Services Administration (HRSA).

9. Spend no more than 7% of the current budget period funds for direct and/or indirect costs associated with administering the HOPWA program award. The aggregate total of sub-recipient administrative expenditures, including all indirect costs, cannot exceed 7% of the aggregate total of funds expended by the sub-recipient. The aggregate total of the subrecipient's administrative costs may not exceed the 7% limit.

10. Ensure delineation of Program Costs for all HOPWA eligible activities. Program Costs shall be reflected as staff time spent delivering the service.

11. Submit expenditure reports within 10 days after the month of service to the HCP program consultant for the HOPWA Program to be adequately monitored and funds efficiently utilized. Reports to be submitted monthly include the following: a detailed monthly expenditure report and the Contract Expenditure Report (CER) for the relevant month of service documenting HOPWA expenditures. The Contractor shall assure each month that the total HOPWA federal expenditure on the monthly CER matches the total on the Contractor's detailed expenditure report. Contractors may only submit reimbursement requests for funds they have already disbursed.

12. Review budget expenditures monthly by line item to ensure that expenditures are appropriate based on the approved budget and request approval for line-item revisions no more than quarterly to assure accurate and efficient reporting and expenditure of HOPWA funds. No expenditures will be approved for payment prior to budget realignment approval.

13. Submit a quarterly program report to the HCP program consultant detailing HOPWA activities according to the following schedule:

Service Quarter	Report Submission Deadline
January – March 2022	April 29, 2022
April – June 2022	July 29, 2022
July – September 2022	October 30, 2022
October – December 2022	January 31, 2023

14. Attend all scheduled mandatory meetings sponsored by the HCP, including HCP Provider Meetings, webinars, and conference calls.

15. Participate in quarterly Network meetings to ensure that providers are aware of housing needs and available housing services within the Network.

16. Establish and submit to the HCP program consultant signed electronic or printed copy Memorandums of Agreement or Understanding (MOAs or MOUs) and subcontracts for all service providers identified as a subcontractor within 30 days of signature documenting the services to be provided by each HOPWA provider regardless of funding source.

17. Monitor all sub-recipients through two site visits during the contract period to assure that their operations follow all state and federal policies and procedures. Each review should include a review of expenditure source documentation for two months as well as a review of agency and client records. Expenditure source documentation, agency records and client records

shall be reviewed during each sub-recipient monitoring site visit to ensure compliance with the U.S. Department of Housing and Urban Development (HUD) HOPWA program requirements.

18. Ensure that all Contractor personnel who regularly perform HOPWA fiscal duties including creation of budgets, budget realignments, monthly expenditure reports, and contract expenditure reports complete *HOPWA Financial Management Training* which is a HUD requirement and a condition of award. Training should be completed during the contract period and then every three years. Certificates of Completion for each training module shall be maintained for each staff person.

19. Ensure that all Contractor personnel working directly with HOPWA clients complete the *Getting to Work Training* curriculum which is a HUD requirement and a condition of award. Training should be completed during the contract period and then every three years. Certificates of Completion for each training module shall be maintained for each staff person.

20. Ensure that all Contractor personnel who are directly involved with the management/oversight of the HOPWA program complete the *HOPWA Oversight Training* curriculum which is a HUD requirement and condition of award. Training must be completed during the contract period and then every three years. Certificates of Completion for each training module shall be maintained for each staff person.

21. Ensure that all Contractor personnel responsible for the inspection of HOPWA client housing units complete *Housing Quality Standards (HQS)* training offered through the HIV Care Program which is a HUD requirement and condition of award. Training must be completed during the contract period and Certificates of Completion for each training module shall be maintained for each staff person.

22. Attend and participate in any additional trainings designated as mandatory by the HIV Care Program (HCP).

23. Submit a Consolidated Annual Performance and Evaluation Report (CAPER) by January 16, 2023, detailing HOPWA activities for calendar year 2022. This report must be submitted to the HOPWA Program Administrator via email for submission to HUD as part of the State's HOPWA Integrated Disbursement Information System (IDIS) reporting requirements.

24. Utilize the CAREWare application to record all client demographic, service, and encounters data on the State CAREWare server within 30 days of the service provided. The CAREWare dataset is the property of the State. The HIV Care Program (HCP) and the Epidemiology Section (IT Staff) shall work with the Contractor to ensure maximum access to and control of this dataset to include control and delineation of permission rights and use of the State CAREWare server. Should issues arise regarding access to the State CAREWare server, the Contractor is required to notify the CAREWare Program Coordinators promptly by either phone or e-mail. In addition, the Contractor shall be responsible for developing, in conjunction with the HCP, a regional CAREWare system to ensure that all active Network partners have access to client information necessary to provide high quality client care.

25. Understand and ensure compliance with the requirements of the 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 the parents or legal custodians, pregnant women, and people securing custody of children under the age of 18), and disability.

26. Understand and ensure compliance with "The Duty to Affirmatively Further Fair Housing (AFFH) Rules" that are designed to increase fair housing choice or decrease disparities. These rules include:

    a. Americans with Disabilities Act of 1990 - Federal law that prohibits discrimination by local governments (Title II) and in all buildings open to the public (Title III);

    b. Title IV of the Civil Rights Act of 1964 – Federal law that prohibits all recipients of federal financial assistance from discriminating based on race, color or national origin;

    c. The Housing and Community Development Act of 1974 – Federal law that prohibits recipients of federal funding from discriminating on the basis of sex or gender (42 USC 5309);

    d. Executive Order 13166: Limited English Proficiency – Federal mandate that requires recipients of federal financial assistance to provide "meaningful access" to applicants and beneficiaries of their programs who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English;

    e. Section 504 of the Rehabilitation Act of 1973 – Federal law that prohibits discrimination against persons with disabilities in any program or service receiving federal financial assistance. In addition, this law requires providers to take additional steps to accommodate people with disabilities, such as paying for certain structural changes to increase the accessibility of housing and common areas; and

    f. U.S. Department of Housing and Urban Development (HUD)-CPD-15-02, Issued: February 20, 2015, Cross References: 24 CFR 5.105(a)(2); 24 CFR Parts 574 and 576; 77 FR 5662-Subject: Appropriate Placement for Transgender Persons in Single-sex Emergency Shelters and Other Facilities - HUD's housing programs be made available to individuals and families without regard to actual or perceived sexual orientation, gender identity, or marital status. The rule defines "gender identity" to mean "actual or perceived gender-related characteristics." 24 CFR 5.100; 77 FR at 5665. The final rule also prohibits owners and administrators of HUD-assisted or HUD-insured housing, approved lenders in an FHA mortgage insurance program, and any other recipients or subrecipients of HUD funds from inquiring about sexual orientation or gender identity to determine eligibility for HUD-assisted or HUD-insured housing. The rule does not, however, prohibit voluntary self-identification of sexual orientation or gender identity, and it provides a limited exception for inquiries about the sex of an individual to determine eligibility for temporary, emergency shelters with shared sleeping areas or bathrooms, or to determine the number of bedrooms to which a household may be entitled. 24 32 CFR 5.105(a)(2).

27. Collaborate on an on-going basis, but at least annually with community-based organizations, AIDS service organizations, and other community agencies to establish and maintain a referral Network.

28. Conduct an assessment annually (at a minimum) of the housing assistance and supportive services required by participants as identified in individual housing care plans.

29. Conduct an assessment annually of the participant's housing situation, a reevaluation of the appropriateness of rental subsidies or other support.

30. Ensure that all required HOPWA services are available to all counties in the Network.

31. Participate in the development of the Network Client Grievance Policy and Procedures to ensure that the policy includes the process to be followed in addressing HOPWA service grievances. Ensure that each HOPWA client is aware of the grievance policy/procedures and receives a copy of the policy/procedures. A copy of the Grievance Policy shall be submitted to the HCP Program consultant via email or USPS no later than July 29, 2022.

32. Develop an Equal Access to Housing policy that is in accordance with HUD's Equal Access rules entitled "Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity" and "Equal Access in Accordance with an Individual's Gender Identity in Community Planning and Development Programs". These rules can be found at: https://files.hudexchange.info/resources/documents/Equal-Access-Final-Rule-2016.pdf. A copy of the Equal Access Policy shall be submitted to the HCP program consultant via email or USPS no later than April 1, 2022.

33. Develop a Limited English Proficiency/Language Access Plan to ensure that HOPWA clients who do not speak English as their primary language and who have limited ability to read, write, speak or understand English have access to HOPWA services. A copy of the Limited English Proficiency/Language Access Plan shall be submitted to the HCP program consultant via email or USPS no later than April 1, 2022.

34. Develop a Fair Housing and Affirmatively Furthering Fair Housing Policy that is in accordance with HUD's Affirmatively Furthering Fair Housing (AFFH) requirements to overcome historic patterns of segregation in housing, promote fair housing choice, and foster inclusive communities that are free from discrimination. The policy should include a process for outlining program violations and consequences of violations of AFFH rules. A copy of the Fair Housing and Affirmatively Furthering Fair Housing Policy shall be submitted to the HCP program consultant via email or USPS no later than April 1, 2022.

35. Assess client satisfaction with HOPWA services, using a client satisfaction survey, at each client's annual redetermination of eligibility and provide an analysis of the results to the HCP program consultant via email or USPS according to the following schedule:

Assessment Completion Period	Analysis Submission Deadline
January 2022 – June 2022	July 29, 2022
July 2022 – December 2022	January 31, 2023

36. Develop a Code of Conduct Policy for staff and clients and ensure that clients receive a copy of the policy at the time of application for housing services. A copy of the Code of Conduct Policy shall be submitted to the HCP program consultant via email or USPS no later than April 1, 2022.

37. Develop a Confidentiality Policy to ensure the protection of client data and information. A copy of the Confidentiality Policy shall be submitted to the HCP program consultant via email or USPS no later than April 1, 2022.

38. Develop a Conflict of Interest Policy that specifies agency staff and Board of Directors cannot directly benefit from HOPWA project services. A copy of the Conflict of Interest Policy shall be submitted to the HCP program consultant via email or USPS no later than April 1, 2022.

39. Develop a Termination Policy that explains under what circumstances a client can be terminated from the HOPWA program, how the client can appeal the termination, and under what circumstances a terminated client may be re-enrolled in the HOPWA program. A copy of the Termination Policy shall be submitted to the HCP program consultant via email or USPS no later than April 1, 2022.

40. Develop HOPWA Program Policy and Procedures that define the process to be followed in administering all HOPWA services for which the Contractor is funded. A copy of the HOPWA Program Policy shall be submitted to the HCP program consultant via email or USPS no later than April 1, 2022.

41. Conduct a Housing Needs Assessment to identify existing housing resources and needed housing resources within the Network. Results of the Needs Assessment and plans to address the identified housing needs shall be submitted to the HCP program consultant via email or USPS no later than August 1, 2022.

42. Implement HOPWA Quality Improvement Performance measures required by the state HOPWA Program to ensure that clients have access to decent, safe and affordable housing.

43. Use performance measures data in the development and implementation of HOPWA Network-wide quality improvement projects.

44. Provide updates of HOPWA Network Quality Improvement activities in quarterly reports and any other reports to the HCP. Each quarterly report is due no later than 30 days after the end of the quarter and shall be submitted to the HCP program consultant via email or USPS.

45. Utilize HOPWA service outcome data to facilitate improved housing outcomes of clients served by the Network.

46. Provide to the HCP program consultant any additional assurances, data and/or information needed to meet the HOPWA reporting requirements.

IV. GENERAL INFORMATION ON SUBMITTING APPLICATIONS

1. **Award or Rejection**
   All qualified applications will be evaluated, and awards 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. The funding agency reserves the unqualified right to reject any or all offers if determined to be in its best interest. Successful applicants will be notified by 08/17/2021.

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/organization to removal from consideration of future RFAs. Email Decline is acceptable.

3. **Cost of Application Preparation**
   Any cost incurred by the agency or organization in preparing or submitting an application is the agency/organization's sole responsibility; the funding agency/organization will not reimburse any agency/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**
   The funding agency/organization 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/organization'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/organization may be grounds for rejection of that agency's/organization's application. Funded agencies/organizations specifically agree to the conditions set forth in the Performance Agreement (contract).

10. **Advertising**
    In submitting its application, agencies and organizations agree not to use the results therefrom or as part of any news release or commercial advertising without prior written approval of the funding agency/organization.

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/organization will become the property of the funding agency/organization 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. **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/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.

    Agencies/Organizations shall also ensure that subcontractors are not on the state's Suspension of Funding List available at: https://www.osbm.nc.gov/stewardship-services/grants/suspension-funding-memos.

15. **Proprietary Information**
Trade secrets or similar proprietary data which the agency/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/organization 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 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 May 3, 2021: http://epi.publichealth.nc.gov/cd/stds/program.html.

2. **Bidder's Conference / Teleconference / Question & Answer Period**
   All prospective applicants are encouraged to participate in a virtual Bidder's Conference on **Monday, May 24, 2021** from 9:30 p.m. – 1:30 p.m. through Microsoft Teams meeting. The purpose of the conference is to provide an overview of the RFA. Participation in the RFA Bidders' Conference is not required but is highly encouraged.

   Requests to participate in the conference should be faxed to 919-733-2054 or e-mailed to Prevention.Care.RFA@dhhs.nc.gov by **May 20, 2021.** Please limit participation to two (2) representatives per program area. Microsoft Teams meeting invitations will be sent to all interested participants and acceptance of the invitation serves as confirmation for participation in the conference.

   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 **May 27, 2021**. Answers will be posted on the Branch websites at: http://epi.publichealth.nc.gov/cd/stds/program.html on **June 7, 2021**. 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 This 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 July 9, 2021 at 5:00 p.m. 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. On the front of each application envelope or package submitted, please include the agency/organization name, RFA number and RFA deadline date.

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 HIV Care Programs by the date and time on the cover sheet of this RFA by **5:00 pm on July 9, 2021**. 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 enough time for delivery to the Branch **by 5:00 pm on July 9, 2021**.

7. **Receipt of Applications**
   Applications from each responding agency or 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 August 17, 2021.**

   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 for 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, organizations 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 organization.

10. **Audit**
    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.

    G.S. 143C-6-23 requires every nongovernmental entity that receives State or Federal pass-through grant funds directly from a State agency to file annual reports on how those grant funds were used.

    There are 3 reporting levels which are determined by the total direct grant receipts from all State agencies in the entity's fiscal year:

    Level 1: Less than $25,000
    Level 2: At least $25,000 but less than $500,000
    Level 3: $500,000 or more

Level 3 grantees are required to submit a "Yellow Book" Audit done by a CPA. Only Level 3 grantees may include audit expenses in the budget. Audit expenses should be prorated based on the ratio of the grant to the total pass-through funds received by the entity.

If an organization receives equal to or more than $750,000 in Federal financial assistance, then the organization is required by Uniform Guidance 2 CFR § 200 to provide a (federal-defined) single audit (or an audit prepared in accordance with 2 CFR § 200 to the funding agency. If an organization receives equal to or more than $500,000 in State (including Federal pass-through) financial assistance, then the organization is required to by 09 NCAC 03M to provide an audit prepared in accordance with GAGAS (Yellow Book).

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 to Include 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 organization's 501(c) (3) tax-exempt status. (This letter normally includes the organization'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 page verifying existence of the organization's 501(c) (3) status. (See **Appendix 9.**)

13. Federal Certifications

Agencies or organizations 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 (see **Appendix 10**). 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, agencies will be contacted about providing the following documentation:

a. A completed and signed letter from the agency's/organization's Board President/Chairperson identifying individuals as authorized to sign contracts. (A reference version appears in **Appendix 11**.)

b. A completed and signed letter from the agency's/organization's Board President/Chairperson identifying individuals as authorized to sign expenditure reports. (A reference version appears in **Appendix 12**.)

c. Documentation of the organization'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 organization's legal name, address, and DUNS number. In lieu of a document from D&B, a copy of the organization's SAM record is acceptable.

If your agency/organization 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 and signed statement which includes the organization's Conflict of Interest Policy. (A reference version appears in **Appendix 13**.)

b. A completed, signed, and notarized page certifying that the organization has no overdue tax debts. (A reference version appears in **Appendix 14**.)

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 15**). Contractor Certifications should NOT be signed or returned with application.

Note: Towards the end of each calendar year, all agencies/organizations with current DPH contracts are required to update their contract documentation. Agencies/organizations will be contacted a few weeks prior to the due date and will be provided the necessary forms and instructions.

15. Registration with 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. (For more information, refer to: https://www.sosnc.gov/divisions/business_registration)

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

Agencies or organizations must 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 16**.

17. System for Award Management Database (SAM)

All grantees receiving federal funds must be actively registered in the federal government's System for Award Management (SAM) database or be willing to complete the registration process in conjunction with the award (see www.sam.gov). To maintain an active SAM record, the record must be updated no less than annually.

18. Boycott Israel Divestment Policy

As provided in Session Law 2017-193, any company that boycotts Israel, determined by appearing on the Final Divestment List created by the State Treasurer pursuant to Session Law 2017-193 is ineligible to contract with the State of North Carolina or any political subdivision of the State.

19. Application Process Summary Dates

05/03/2021: Request for Applications released to eligible applicants.
05/20/2021: Bidder's Conference / Request to Participate Deadline

05/24/2021: Bidder's Conference
05/27/2021: Written inquiries due to Branch staff (via email)
06/07/2021: Answers to Questions released to all applicants
07/09/2021: Applications due to HIV/STD Prevention an HIV Care Programs **by 5:00 p.m**.
08/17/2021: Awards announced

01/01/2022: Proposed contracts/Agreement Addenda begin – HOPWA
04/01/2022: Proposed contracts/Agreement Addenda begin – HIV Care (RW Part B)
06/01/2022: Proposed contracts/Agreement Addenda begin – Prevention (ITTS)

VI. APPLICATION EVALUATION CRITERIA

Applications which meet 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 Appendices 5 and 18 for sample Memoranda of Agreement.**

1. Application Scoring

Applications can receive a maximum score of 12 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 three (3) Program Areas will be provided in the Network region.

Note: Requirements for what must be included in the description of the Regional Network of Care and Prevention and the three (3) Program Areas can be found in Section III.

The description of the Regional Network of Care and Prevention and each of the three (3) 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 three (3) Program Areas were addressed with minimal response).

2 = Descriptions were addressed (each element of the Network description and three (3) Program Areas were addressed with minimal response).

3 = Descriptions were addressed (each element of the Network description and three (3) Program Areas were addressed with detailed response).

In order to receive a maximum score of 12 the reviewer must be able to clearly find all requirements within the application response without posing any additional questions to the applicant.

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

2. Preliminary Screening

Applications will be screened for completeness and compliance with the requirements specified in the RFA Application Checklists on pages 45-47. Applications that do not adhere to instructions for completion or do not 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.

3. Review and Selection Process

The HIV/STD Prevention and Care Unit 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.

4. Second Tier Screening and Selection/ Pre-Decisional Site Visits

With the recommendations from the independent review panel, the Branch will conduct pre-decisional site visits with selected Prevention, HIV Care/Ryan White, and HOPWA applicants. Pre-decisional site visits will generally be limited to applicants that do not have an existing funding relationship with the Branch. The purpose of pre-decisional site visits is to ensure that applicants have accurately characterized their administrative and technical ability to perform the proposed activities. Pre-decisional site visits will only impact those applicants that scored high enough to be considered for funding. Areas will be evaluated during this process include:

- 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.

5. Post Applicant Selection

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

VII. APPLICATION

1. Application Checklist for PROGRAM AREA ONE (Prevention / ITTS)

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 F**: Project Objectives

___**Attachment G**: Projection Report

___**Attachment H**: Physician's Standing Orders

___**Attachment I**: Memoranda 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.)

___**Attachment J**: Project Organizational Chart

___**Attachment K**: Staff Plans/Job Descriptions for Key Personnel

___**Attachment L**: Project 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. Reference each program area for contract year.)

___**Attachment M:** 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)
and

Verification of 501(c)(3) Status Form (private non-profits))

___**Attachment N**: Confidentiality Policy

___**Attachment O**: Indirect Cost Rate Approval Letter (if applicable) (See Appendix 26)

2. **Application Checklist for PROGRAM AREA TWO & THREE (HIV Care/RW Part B & HOPWA)**
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 P:** Memorandum of Agreement (MOA): 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.

___**Attachment Q:** Letters of Support

___**Attachment R**: Organizational Chart

___**Attachment S**: 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. Reference each program area for contract year.)

___**Attachment T**: Indirect Cost Rate Approval Letter (if applicable) (See Appendix 26)

___ **Attachment U**: 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)

and

Verification of 501(c)(3) Status Form (private non-profits)

___**Attachment V**: Confidentiality Policy

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

3. Application Face Sheet

This form provides basic information about the applicant and the proposed project with DPH, Regional Networks of Care and Prevention, 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-379** 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: ▪ Name: ▪ Title:	▪ Telephone Number: ▪ Fax Number: ▪ E-mail Address
7. Agency Status (check all that apply): ☐ Public ☐ Private Non-Profit ☐ 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 ☐ No ☐	
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

4. Applicant's Response

Each Network should convene planning meetings of all funded and non-funded entities interested in providing Prevention/ITTS, HIV Care/Ryan White Part B core medical and support services, and HOPWA services to discuss and decide the services that will be provided in the Network and identify the agencies that will provide each service.

Each Network must submit at least one application for each of the three Program Areas as follows:

Program Area One (Prevention/ITTS): An unlimited number of applications may be submitted.
Program Area Two (HIV Care): A maximum of two applications may be submitted per Network.
Program Area Three (HOPWA): An unlimited number of applications may be submitted.

Each application submitted for Program Area One: ITTS is encouraged, but not required, to have a Letter of Support from the Network. Interested applicants who were not selected through the Network planning process to be a Network service provider may still submit an application and these applications will be evaluated to determine if they should be funded. This will provide agencies not previously funded by the Network an opportunity to be considered for funding.

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 all agencies, organizations, stakeholders in the region, the services they provide, and explain how their feedback was included in the development of the application. Identify all agencies that will be directly funded and subcontracted by the HIV/STD Prevention and HIV 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 Network region. Prevention services do not have to be provided in all counties of a Network region but must be provided in every Network 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 the providers included in the response to the RFA application are coordinated and not duplicated. Provide an explanation on why the excluded providers were not included in the application process and the criteria utilized for exclusion.

d. Include a diagram of the Network model as **Attachment A.**

e. 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. Include as **Attachment B** 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.

f. Explain how the Network will participate in existing housing task forces or planning bodies within the region to identify all existing housing resources within the region, identify needed housing services and ensure housing services are coordinated throughout the region. If housing task forces or planning bodies do not exist within the Network, explain how the Network will establish a housing planning body of housing service providers for conducting the activities above.

g. Describe who will develop, implement/update and oversee the overall quality improvement program. Describe the quality improvement plan that will be utilized by the Network.

h. Include as **Attachment C** a list of all Ryan White Part B, C, and D, HOPWA, MAI and Prevention services to be provided by the Network. Identify by name the agency(ies) that will be responsible for providing each service and the source of funding for each service to be provided.

i. 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.

j. Describe how the Network will ensure that all funds are leveraged with other federal, state, county, local and other funding resources to utilize these limited funds most efficiently. 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.

k. 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.

l. Explain how the Network will ensure client confidentiality.

m. Describe how the Network will provide culturally and linguistically appropriate services.

n. Explain how PLWHA will be involved in guiding the development, implementation and evaluation of the network operations and services.

o. 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 as **Attachment D** a copy of the client grievance policy that will be used by the network. 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.

p. Each Network will be expected to assess client satisfaction with Network Prevention, Care and HOPWA services at minimum annually. Explain how client satisfaction will be assessed. Submit as **Attachment E** a copy of all client satisfaction survey tools that will be used by the Network. 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.

q. Describe how clients will access the Network and identify the agencies, positions, staff persons that will serve as access points for clients.

r. Explain how providers of counseling and testing services in the region will relate to the Network. Identify the providers and the specific linkages.

s. Explain how the Network will ensure the availability and provision of PrEP services across the region.

t. Explain how the Network will collaborate with syringe service programs across the region.

u. Explain how the Network will participate in existing task forces or planning bodies within the region that are focused on sexual disease education for youth to identify all existing youth focused education resources within the region, identify needed educational services and ensure educational services are coordinated throughout the region. If these task forces or planning bodies do not exist within the Network, explain how the Network will establish a youth focused sexual disease education planning body of service providers for conducting the activities above.

v. If the applicant is a for-profit entity, the entity must explain why not-for-profit organizations in the Network region are unavailable to do the work they propose to perform.

A. Program Area One
Prevention (Integrated Targeted Testing Services (ITTS))

Applicants **must** submit one application for Program Area One: Integrated Targeted Testing Services. This application may include subcontracted agencies.

Applications should not exceed 50 pages (not including attachments) 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.

Applicant must adhere to the program requirements listed above under Program Area One: ITTS.

Project Narrative

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

1. Summarize the need for Integrated Targeted Testing Services and identify how your agency collaborates with other agencies within the Regional Network for Care and Prevention. Address how your agency uses local, regional, State and Federal data, and other sources to address the health inequities and the burden of the epidemic in your region. Highlight disparities in testing to determine the anticipated benefit these activities will fulfill and how they will meet an unmet need in your region. Sources may include NC's Ending the Epidemic Plan, CDC's Ending the HIV Epidemic: A Plan

for America, Community Health Assessments, NC Epidemiologic Profile, CDC HIV/STD Surveillance Reports.

2. Address how your agency will recruit key priority groups (men who have sex with men of all races and ethnicities with an emphasis on African American MSM, African American women, minority youth aged 13 to 24 years, people who inject drugs, commercial sex workers and transgender persons) for testing services. Services may include testing through street and community outreach and/or at fixed testing sites including homeless shelters, jails, syringe exchange sites, drug treatment centers, migrant health centers, mental health facilities, nightclubs, colleges and universities. Address how your agency will reach youth serving organizations, school health educators, and universities to better address sexual health education for young people, and how your agency will work with needle exchange programs to provide testing.

3. Address how your agency will provide post-test counseling and linkage to care for clients testing positive for HIV, syphilis, hepatitis C, gonorrhea and/or chlamydia.

4. Address how your agency will provide PrEP activities using the State Pre-Exposure Prophylaxis guidance on referral, linkage and data collection/ submission process of HIV negative clients. **(See Appendix 4).**

5. Address how your agency will implement condom distribution activities into the testing program.

6. Address how your agency will implement social media activities to enhance testing services and increase awareness.

7. Address how your agency will implement a quality assurance/improvement plan to maintain the integrity of your HIV/STD prevention program.

Project Attachments

Applicants should provide the following items in the order specified below to complete the application. Attachments do not count toward the application page limit. **You must clearly label each attachment. The attachments are included in the Application Checklist on pages 45-47.**

Attachment F: Project Objectives (See Appendix 19)

Objectives should include activities detailed in the Program Narrative above.

a. How many HIV, syphilis, hepatitis C, gonorrhea and chlamydia tests will be provided to key priority groups?
   - 25% of testing should be conducted during outreach outside of fixed sites
   - 20% of testing should be among non-MSM youth, ages 13 - 24 years old
b. How many clients will be referred to PrEP?
c. How many condom distribution sites will be utilized and how many condoms will be distributed to at-risk clients?
d. How many and which social media platforms will be established, maintained and evaluated?

Attachment G: Projection Reports (See Appendix 20)
Projection report should include outreach and fixed testing sites.

Attachment H: Physician's Standing Orders (only for CBOs) or Testing Protocols (only for LHDs) (See Appendix 21)
Standing Orders are required for community-based organizations and should include who will oversee agency's community testing program in proposed counties. Testing protocols are required for local health departments and should be approved by the Medical Director of the Laboratory for specimen collection by non-clinical staff in settings outside of the local health department.

Attachment I: Memoranda of Agreement (MOA) and Letters of Support (See Appendix 5)
MOAs should describe working relationships between your organization and other entities and/or programs for testing, condom distribution and referral/linkage activities. Documents that confirm actual or pending agreements should describe the specific roles of the individual contractors and any deliverables or commitments from the agencies. MOAs should be signed and dated. Letters of Support should be included from each local health department where services will be offered and from the Regional Network for Care and Prevention, if possible.

Attachment J: Project Organizational Chart (See Appendix 22)
A one-page organizational structure of the project should include all program-related staff involved in implementing programmatic goals and objectives as. If you need to create an organizational chart, Microsoft Excel has a template that is relatively easy to use.

Attachment K: Staff Plans/Job Descriptions for Key Personnel
Keep each job descriptions to one page. Include the role, responsibilities and qualifications of proposed project staff. Project staff must have a minimum of one-year experience related to community organizing in community settings and in computer skills for using web-based testing data system. Financial Officer must have a minimum of one-year experience in accounting.

Attachment L: Itemized Budget (See Appendix 23)
Include an itemized program budget with a budget justification for each line item. The first-year budget should run from June 1, 2022 – May 31, 2023 and should include the following:

- Proposed positions by name (if known), 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)".
- Costs for prevention supplies, travel, condoms, printing, office supplies, test kits, etc.
- 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.

Attachment M: 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) and Verification of 501(c)(3) Status Form (private non-profits))

Attachment N: Confidentiality Policy

Attachment O: Indirect Cost Rate Approval Letter (if applicable)

B. Program Area Two
HIV Care/Ryan White Part B

Applicants **must** submit one application for Program Area Two: Ryan White Part B Services. This application may include subcontracted agencies.

Applications should not exceed 50 pages (not including attachments) 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.

Applicant must adhere to the program requirements listed above under Program Area Two: Ryan White Part B.

1. Identify and describe the most pressing needs of PLWH in the region and explain how the Network will address those needs.

2. Explain how PLWH are involved in the Network and helping to identify services to be provided by the Network

3. Describe how the Network will "bridge" newly diagnosed and/or newly referred or self-referred individuals into the network. This description should explain the following:
    - Agency, position, identified staff who will be responsible for identifying newly diagnosed PLWHA and working with them to get them engaged in care.
    - Agency, position, identified staff who will be responsible for locating clients who have dropped out of care and "bridging" them back into care.
    - The process that will be followed to re-engage out-of-care clients including the timeline for accessing their first appointment to care.
    - How the Network will coordinate regional bridge counseling services with State Bridge Counselors, Patient Navigators, and Peer Navigators using the State Bridge Counselor map in **Appendix 3.**

    Note: The Branch views bridge counseling and peer navigation 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 are Psychosocial Support, Early Intervention Services and Medical Case Management.

4. Explain how peer navigation services, if being provided, will be established and provided in the Network to ensure that clients are engaged with medical treatment, adherent to medications and reducing risk behaviors that could lead to transmission of the disease.

5. 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.

6. Explain how the Network will assure that persons identified as HIV positive are provided medical care within one week of diagnosis.

7. Identify the number of RW Part B clients the Network proposes to serve.

8. Explain how the Network plans to assure clients are “navigated” into the Affordable Care Act Insurance Marketplace.

9. Explain who (agency, position, identified staff) will monitor 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.

10. 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), Substance Abuse Services-outpatient and Early Intervention Services*. This explanation should describe how Oral health services have been prioritized in the Network. If HIV testing will be provided under Early Intervention Services, the explanation should describe how testing services will be provided without supplanting existing testing services paid for through other funding streams.

11. Explain how the following required Ryan White Support Service will be provided in the Network and identify the agency/agencies that will be responsible for providing the service: Medical Transportation Services.

12. Explain which optional Ryan White services will be provided in the Network and identify which agency/agencies will provide each service. **See Appendix 8 for a list of optional Ryan White services.**

13. 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

14. 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
- 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 for all Network services provided, compiling those results and developing/implementing a plan to improve service delivery when needed

15. Explain who (agency, position, identified staff) in the Network will be responsible for the following required Quality Improvement activities:

    - Conducting Quality Improvement activities and collecting/reporting Quality Improvement performance indicators
    - Participating in Regional Quality Council and statewide Quality Improvement meetings/initiatives

16. Explain who (agency, position, identified staff) will assist clients with HMAP enrollment and reauthorization processes and help them with any questions they have about the HMAP Program.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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 strength

Project Attachments
Applicants should provide the following items in the order specified below to complete the application. Attachments do not count toward the application page limit. **You must clearly label each attachment. The attachments are included in the Application Checklist on pages 45-47.**

Attachment P: Memorandum of Agreement (MOA)
Each MOA should clearly describe the specific activities to be completed by each agency agreeing to participate in the MOA**. Refer to sample MOA in Appendix 18**. (MOAs do not count toward the page limit.)

Attachment Q: Letters of Support
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).

Attachment R: Agency Organizational Charts
Provide an organizational chart of all program-related staff at each agency including volunteers involved in implementing programmatic goals and objectives. **A sample organizational chart is provided in Appendix 22.** *(If you need to create an organizational chart, Microsoft Excel has a template that is relatively easy to use).*

Attachment S: Itemized Budget Narrative and Spreadsheet
Include an itemized program budget with a budget justification for each line item. **See Appendix 24.** The first-year budget should run from April 1, 2022 – March 31, 2023 and should include the following:

- Proposed positions by name (if known), 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)"
- Costs for supplies, travel, printing, office supplies, etc.
- 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.

Attachment T: Indirect Cost Rate Approval Letter (if applicable)
Include the indirect cost rate approval letter for each agency that will be claiming indirect costs

Attachment U: 501 (c)(3) Status Form or IRS Letter
Submit the IRS letter documenting each organization's tax identification number (public agencies) or IRS determination letter regarding the agency's 501 (c)(3) tax exempt status (private non-profit agencies), or verification of 501 (c)(3) status form (private non-profits).

Attachment V: Confidentiality Policy
Submit the Confidentiality Policy for each agency to be funded.

Attachment W: Staff Job Description and Resumes
Submit a job description for each position to be funded with HOPWA funds and the resume for each staff person currently in each position. For vacant positions, please list TBD.

C. Program Area Three
HOPWA

Applicants **must** submit one application for Program Area Three: Housing Opportunities for Persons with AIDS (HOPWA). This application may include subcontracted agencies.

Applications should not exceed 50 pages (not including attachments) 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.

Applicant must adhere to the program requirements listed above under Program Area Three: HOPWA.

1. Explain who (agency, position, identified staff) will provide the following required HOPWA services in the Network: Tenant-based Rental Assistance, Short-Term Rent, Mortgage and Utilities, Permanent Housing Placement and Resource Identification.

2. Explain which optional HOPWA services will be provided by the Network and identify which agency/agencies will provide each service. **(See Appendix 8 for a list of optional HOPWA services)**

3. If applying for available one-time funding, please explain the funding plan for ongoing service delivery after the one-time funding ends on December 31, 2022. The ongoing funding plan is especially critical when utilizing one-time funding for TBRA services because there must be a clear plan in place to ensure that clients housed under one-time funding will remain housed after the one-time funding ends on December 31, 2022.

4. Describe how HOPWA funds will be leveraged with other housing programs such as Section 811, Community Development Block Grant programs, Emergency Solutions Grant program, Targeting program, HOME Investment FUNDS, and other housing resources, Ryan White and all other types of public and private assistance.

5. Describe the anticipated timeline for securing housing for an individual once eligibility for assistance has been determined.

6. Explain your wait list policy for clients.

7. Explain how clients will access case management services.

8. Describe how all HOPWA services provided will comply with Fair Housing Laws, Fair Housing Counseling requirements and HOPWA provider training requirements.

9. Describe specific meaningful actions that will be completed (e.g., outreach activities, fair housing counseling and fair housing training) to Affirmatively Further Fair Housing.

10. 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 strength.

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Attachment R: Agency Organizational Charts
Provide an organizational chart of all program-related staff at each agency including volunteers involved in implementing programmatic goals and objectives. **A sample organizational chart is provided in Appendix 22.** *(If you need to create an organizational chart, Microsoft Excel has a template that is relatively easy to use*).

Attachment S: Itemized Budget Narrative and Spreadsheet
Include an itemized program budget with a budget justification for each line item. **See Appendix 25.** The first-year budget should run from January 1, 2022 – December 31, 2022.

- 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.

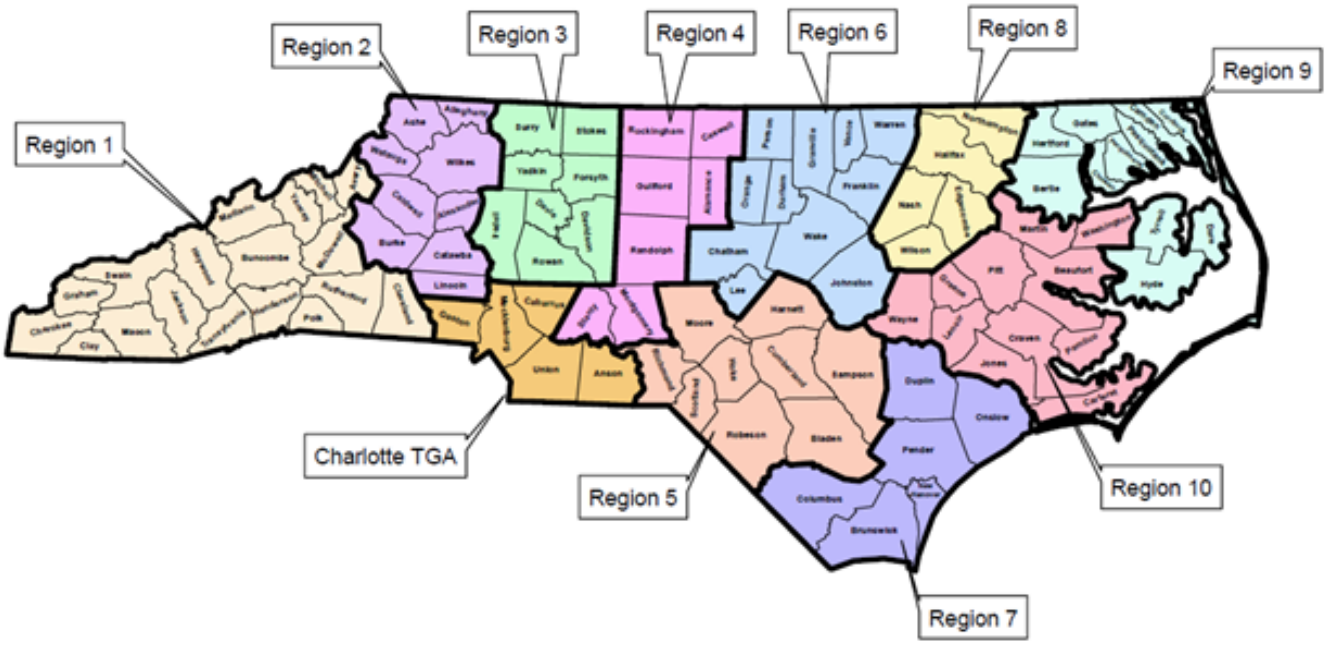
Attachment T: Indirect Cost Rate Approval Letter (if applicable)
Include the indirect cost rate approval letter for each agency that will be claiming indirect costs.

Attachment U: 501 (c)(3) Status Form of IRS Letter
Submit the IRS letter documenting each organization's tax identification number (public agencies) or IRS determination letter regarding the agency's 501 (c)(3) tax exempt status (private non-profit agencies), or verification of 501 (c)(3) status form (private non-profits).

Attachment V: Confidentiality Policy
Submit the Confidentiality Policy for each agency to be funded.

Attachment W: Staff Job Description and Resumes
Submit a job description for each position to be funded with HOPWA funds and the resume for each staff person currently in each position. For vacant positions, please list TBD.

Appendix 1: North Carolina Regional Networks of Care and Prevention (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

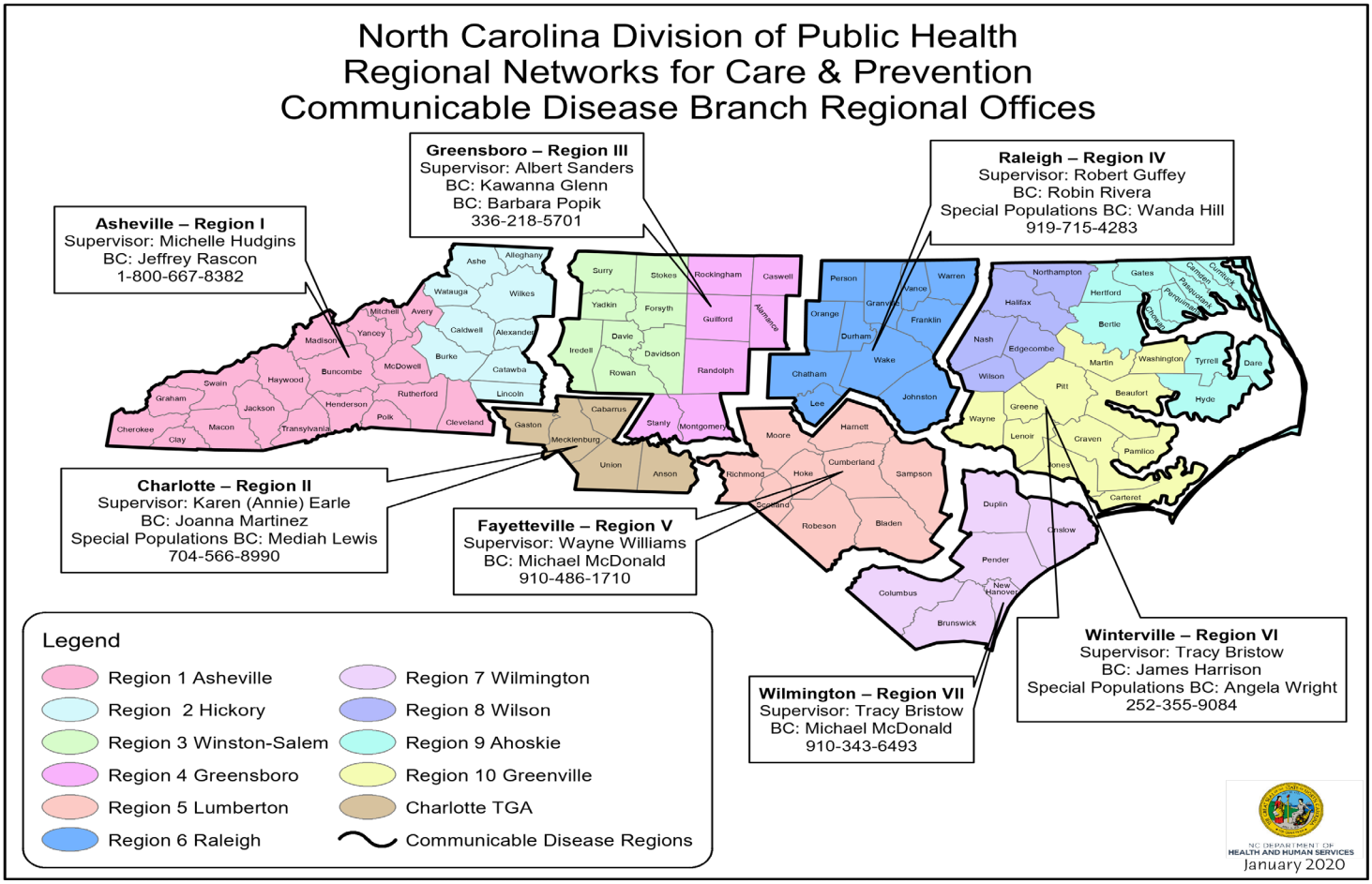
Region 9: Bertie, Camden, Chowan, Currituck, Dare, Gates, Hertford, Hyde, Pasquotank, Perquimans, Tyrrell

Region 10: Beaufort, Carteret, Craven, Greene, Jones, Lenoir, Martin, Pamlico, Pitt, Washington, Wayne

Charlotte Transitional Grant Area (TGA) Counties

Anson, Cabarrus, Gaston, Mecklenburg, Union and York County, South Carolina

Appendix 3: North Carolina Branch Regional Offices



Appendix 4: North Carolina PrEP Criteria

Please use these guidelines when determining eligibility for PrEP. If a client is eligible based on these criteria, please complete a PrEP Referral and Linkage Form and send to your PrEP Coordinator.

PrEP may benefit you if you are HIV-negative and ANY of the following apply to you:

You are a gay/bisexual man or a Transgender person and have at least one of the following

- have an HIV-positive partner.
- have multiple partners, a partner with multiple partners, or a partner whose HIV status is unknown–and you also
    - have anal sex without a condom, or
    - recently had a sexually transmitted disease (STD).

You are a heterosexual man or woman and have at least one of the following

- have an HIV-positive partner.
- have multiple partners, a partner with multiple partners, or a partner whose HIV status is unknown–and you also
    - don't always use a condom for sex with people who inject drugs, or
    - don't always use a condom for sex with bisexual men.

You inject drugs and have at least one of the following

- share needles or equipment to inject drugs.
- are at risk for getting HIV from sex.

NC PrEP Criteria Referral Exceptions:

a. Staff determines that a PrEP referral is appropriate
b. Client requests a PrEP referral
   NOTE: All PrEP protocols should be followed in these instances

Adapted from: https://www.cdc.gov/hiv/pdf/library/factsheets/prep101-consumer-info.pdf
Updated 2/20/2020

Appendix 5: Sample ITTS Memorandum of Agreement (MOA)

Awesome County Health Department and
North Carolina Ending the Epidemic HIV/STD Program

This Memorandum of Agreement is entered by and between Awesome County Health Department and North Carolina's Ending the Epidemic HIV/STD 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 Awesome County Health Department will be Thom Goodman, Health Director, 135 Outreach Street, Community, North Carolina 01235, (252) 000-0000. The Administrator for the Contractor will be Telly Tubby, Executive Director, 357 Main Street, Hometown, North Carolina 01234, (919) 000-0000.

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 Awesome County Health Department agrees to provide the following:

- Certified staff that can provide free pre-and post-test counseling, testing and referrals (trained in the State approved CTR and phlebotomy training)
- Laboratory and testing supplies, condoms and literature
- Paperwork and data entry as required by the State Prevention Program 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/PrEP treatment/care, and, any other risk reduction or psychosocial needs

The Contractor agrees to provide the following:

- A secure free testing space, which allows for privacy, does not compromise confidentiality and is near a telephone, water source and restrooms for counseling and testing services that are provided at least twice each month
- Social marketing strategies to actively market the program in an effort to raise community awareness about counseling, testing and referral activities, including the distribution of brochures and posting flyers about planned testing events and activities

This MOA shall begin on June 1, 2022 and end on May 31, 2023.

Awesome County Health Department	**North Carolina Ending the Epidemic Program**
BY: Thom Goodman	BY: Theodore Hawkins
TITLE: Health Director	TITLE: Executive Director
DATE: June 1, 2022	DATE: June 1, 2022

Appendix 6: EvaluationWeb for ITTS

Evaluation Web ® HIV Testing Data Form – NORTH CAROLINA
Data Collection / Data Entry Procedures

1. **Use Form for All HIV Testing Events as of 01/01/19**
    a. Applies to agencies and health departments funded or supported through the following:
        i. Expanded Testing (Community Health Centers, Emergency Departments, Jails)
        ii. Integrated Targeted Testing (ITTS)
        iii. Rapid Kits Only – *when the test event involves the Rapid Kit/s provided by the State Prevention Program*
        iv. Substance Abuse Centers (SAC)
    b. Does NOT apply to regular testing in health department clinics
    c. If a client declines HIV testing but is tested for other STIs, still use the form to enter the data
    d. Use this form to *collect* your data as of 1/1/2019

2. **Printing and Copying**
    a. The form can be printed locally and it is fine to photocopy it as well
    b. We suggest that you fill in a form with your Agency ID and photocopy that is 2-sided
    c. If you are doing any point of care (POC)/Rapid testing for HIV, Syphilis or HCV, you will need all 3 pages of the form because we are using Local Use Fields in Section 8 to track rapid testing
    d. If you are NOT doing any POC/Rapid tests, you can use just pages 1-2

3. **Use with Agency Intake Forms**
    a. Data should ultimately be recorded on the HIV Testing Data Form but if your agency uses a separate client or counselor 'intake' form first, that is fine
    b. If so, make sure that all of the necessary data elements are covered on your local intake form and transferred to the HIV Testing Data Form.
    c. The HIV Testing Data Form is designed to be filled out by a trained HIV test counselor
        i. Please do not give this form to the tested client for them to fill out
        ii. Any forms that are given to clients to fill out should be designed specifically for that purpose

4. **Format**
    a. The order of the data elements follows the order of data entry in Evaluation Web
        i. The order may not make the most sense for client encounters so you will need to skip around a little
        ii. Oval bubbles mean "select only one" and square boxes mean "check all that apply"
        iii. Note that Name and full Date of Birth are needed by CDB in order to look up the client in the Surveillance system in the event that the person tests positive for HIV. Evaluation Web does *not* capture name and requires only year of birth

5. **Data to Collect at Time of Testing**
    a. Name and Program information at the top
        i. Repeat Client name on page 2 and page 3
        ii. Skip Form ID – this ID number is created by Evaluation Web at the time of data entry
    b. Section 1 – Agency and Client Information
        i. Program Announcement = PS18-1802
    c. Section 2 –Testing Information
        i. HIV Test Election = Confidential
        ii. HIV Test Type
            1. For Rapid testing complete CLIA-waived point-of-care (POC)/Rapid test/s
            2. For lab testing complete Laboratory-based Test
            3. If both Rapid/POC testing and Laboratory-based testing was done
                a. Fill out both results sections
                b. Complete Local Use Field 1 on page 3 “RHIV”
    d. Section 3 – Negative Test Result
        i. Collect information for <u>all</u> tested persons
        ii. Use the Eval Web PrEP Questions Guidance to complete the screened, eligible, referral given questions
        iii. If the client is eligible for PrEP based on the NC PrEP Criteria, please complete the PrEP Referral and Linkage Form and accompanying guidance
        iv. Do Not complete the last question “Was the client provided with services to assist with linkage to a PrEP provider?” as this will be completed only by PrEP Coordinators
        v. The HIV Testing and PrEP Data Collection Guide provides an overview of PrEP and HIV Prevention testing
    e. Section 5 – Additional Tests
        i. Fill out which tests were performed and wait for results
        ii. If Syphilis Rapid Test was done, record results and complete Local Use Field 2 on page 3 “RSYPH”
        iii. If HCV Rapid Test was done, record results and complete Local Use Field 3 on page 3 “RHCV”
    f. Section 6 – PrEP Awareness & Priority Populations
    g. Section 7 – Essential Support Services
        i. Complete the last 4 rows of questions; this includes health benefits navigation and enrollment, evidence-based risk-reduction intervention, behavioral health services, and social services
    h. Section 8 – Local Use Fields. As of now, we are using fields 1, 2, 3 to indicate rapid testing for HIV, Syphilis, HCV. Local Use Field 4 is to be completed only by PrEP Coordinators. Local Use Fields 1-4 have been assigned and are not available for any other use. Please refrain from assigning or using Local use Fields 5-8.

6. **Fill Out Separate Form(s) to Order HIV and STI Testing from Laboratories**
    a. For HIV and HCV testing at the State Laboratory of Public Health (SLPH), use the current HIV testing form.
        i. You can skip Test1, Test2 and the behavioral risk factors
        ii. Send Lab form and blood sample to SLPH for testing

b. For Syphilis, Chlamydia, Gonorrhea testing, fill out form(s) for appropriate State, County, or Private Lab
    i. Send Lab form and blood sample to appropriate lab for testing

7. Agency Filing System Needed

a. Forms awaiting Laboratory Results
b. Forms with all results complete awaiting data entry
c. Forms that have been entered
d. Forms for HIV-Positives that have been copied and sent to CDB
e. All forms need to be kept in a secure, locked location
    i. Preferably a locked cabinet within a locked room

8. Record All Results on HIV Testing Data Form

a. Record POC/Rapid test results immediately
b. Record Lab test results as they come in
    i. If HIV-positive, fill out as much of Section 4 – Positive Test Result as you are able; it is fine if you don't know all of it, Communicable Disease Branch staff will check the surveillance system for some of these answers
    ii. Keep forms filed as above until all results have been recorded

c. When ALL HIV/STI test results have been recorded, file separately:
    i. HIV Negative, Invalid tests (regardless of results from other STI testing)
        1. These forms are now ready for data entry
        2. Further sort the forms by Program Funding and Region
           This will make data entry easier (see below)
    ii. HIV Positive, Preliminary Positive, Discordant, and Inconclusive HIV tests
        1. Make a photocopy and send to us in CDB
           Place forms in an inner envelope that is sealed and marked "Confidential"
           Place that envelope inside an outer envelope and send to:
           Meghan Furnari, MA
           Prevention Program
           1200 Front St, Suite 104
           Raleigh, NC 27609
        2. CDB Staff will check the HIV Case Surveillance system and will fill out the remainder of Section 4 (Positive Test Result) and Section 9 (Health Department Use Only)
        3. CDB Staff will then enter the forms in Evaluation Web

9. Entry into Evaluation Web – please use Google Chrome as your web browser, Firefox and Microsoft Edge are alternative options as well

a. Agencies will enter the data for the HIV-Negative forms
    i. Enter regularly, preferably several times per month.
    ii. Enter stacks of similar Program/Region together.
    The first data field chosen will be called "Program" which is a combination of the CDB Program/Funding and the Region. Many agencies will only have one or two choices.
    iii. Indicate that each form has been entered.
    As each form is entered, the Evaluation Web system will generate a Form ID for each form entered. Since EW does not include data on Client Name or full Date of Birth, the Form ID is the only unique identifier that will link a database record to a form. Agency staff must write the Form ID on the HIV Testing Data Form during data entry. If the client has been

referred to PrEP the Form ID must be noted on the PrEP Referral and Linkage Form as well.

iv. File entered forms. We suggest filing them by date.

1. For now, ***please keep all forms***.
   We will verify the State records retention policy and advise further.

b. CDB staff will enter the data for the HIV-Positives, Preliminary Positives, Inconclusives, and Discordant HIV results.

10. Rapid Testing Data Procedures - Recap

a. HIV POC Rapid Test(s) only - Negatives
   i. Use the POC Rapid Test Result in Section 2
b. HIV POC Rapid Test(s) only - Positives
   i. Make a copy of the form and send the copy to CDB. File your own copy. CDB will enter data.
c. HIV POC Rapid Test(s) AND Laboratory-based test – Negatives
   i. Fill out information for both types of testing.
   ii. In Evaluation Web, choose Laboratory-based testing and enter the Lab result.
   iii. Enter RHIV in Local Use Field 1 on page 3
d. HIV POC Rapid Test(s) AND Laboratory-based test – Positives
   i. Fill out information for both types of testing in Section 2.
   ii. Enter RHIV in Local Use Field 1 on page 3
   iii. Make a copy of the form and send the copy to CDB. File your own copy. CDB will enter data.
e. Syphilis POC Rapid Test
   i. Enter test result (all results)
   ii. Enter RSYPH in Local Use Field 2 on page 3
f. Hepatitis C POC Rapid Test
   i. Enter test result (all results)
   ii. Enter RHCV in Local Use Field 3 on page 3

Eval Web Data Entry Guide (the short version)

1. Your HIV testing data forms should be separated out into different batches
    - waiting on lab results; all results awaiting data entry with HIV results of Negative and Invalid, or no HIV test
    - forms that have already been entered with Form ID's written down
    - forms that need to be double enveloped and mailed to Prevention for all HIV results of Positive, Preliminary Positive, Inconclusive, and Discordant (mail as soon as forms are complete)
    - forms that have been mailed to Prevention
2. Grab the batch of forms ready for data entry (all with HIV testing results of Negative and Invalid, or no HIV test). Make sure they are separated by Program (if your agency participates in multiple programs with Prevention, like ITTS, SAC, ET) and Region (if applicable).
3. Take out your Grid card, open Chrome, and Log into SAMS (SAMS.CDC.GOV)
4. Click through several screens until you make it to the Eval Web Welcome page.
5. Click "Data" or the arrow beside it, click HIV Testing Form, and begin data entry.
6. Remember to click on every answer, as only that allows the system to populate more questions.
7. Be sure to **WRITE DOWN THE FORM ID** on HIV Testing Form's "Form Id" line.
8. If Eval Web asks you for information about HIV medical care, or if the person ever had a positive HIV test PLEASE STOP. This means you chose a Positive result as the result of the HIV. Go back and change the HIV test result to match the paper form. And if your paper form has an HIV result of Positive, Preliminary Positive, Inconclusive or Discordant please put that form to the side as it should not be entered by agency staff (these are the forms must be mailed to Prevention).
9. Please answer all the questions in Eval Web EXCEPT the Section 3 PrEP Linkage question.
10. Please use the Local Use Fields as applicable:
    - if testing event started with a Rapid HIV test followed by a Lab/Blood HIV test then please type "RHIV" into Local Use Field 1
    - if a Rapid Syphilis test was used please type "RSYPH" into Local Use Field 2
    - if a Rapid Hepatitis C test was used please type "RHCV" into Local Use Field 3
11. Before you click to save the test event DOUBLE CHECK that you entered the FORM ID on the upper right side of page 1.
12. Now click SAVE to save the test event.
13. Repeat data entry processes as needed.
14. If you encounter any issues during the data entry process please call the Luther Consulting at 866-517-6570 option 1, and email or call Meghan to fill her in on what the help desk said/did.

Once you have completed data entry for all test events in this Program and Region file these forms with the others that have already been entered.

Recommendations: *Enter HIV Neg., HIV Invalid, and test events that do not involve an HIV test into Eval Web at least weekly. Mail copies of forms for all HIV Positive, Preliminary Positive, Inconclusive and Discordant results to Prevention as soon as the forms are complete. Please do not enter these test events into Eval Web. If you did enter it, please be sure that you*

wrote down the Form ID on page one of the testing data form before you send a copy to Prevention.

Any questions, issues, comments, guidance or help needed call or email Meghan: (919) 755-3147 or Meghan.Furnari@DHHS.NC.GOV

Appendix 7: ITTS Policy and Procedures Manual Requirements

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 process and forms
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 8: Ryan White and HOPWA Service 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
*Early Intervention Services
RYAN WHITE CORE MEDICAL SERVICES Optional:
Home and Community-based Health Services
Medical Nutrition Therapy
RYAN WHITE SUPPORT SERVICES Required:
***** Medical Transportation Services
RYAN WHITE SUPPORT SERVICES Optional:
Emergency Financial Assistance
Food Bank/Home-delivered Meals
Housing Services
Linguistic Services
Psychosocial Support Services
Substance Abuse Services-residential
HOPWA SERVICES Required:
* Short-Term Rent, Mortgage, Utilities
* Tenant-Based Rental Assistance
* Permanent Housing Placement
* Resource Identification
HOPWA SERVICES Optional:
Housing Information
Supportive Services
Hotel/Motel Assistance
Transitional Housing
Emergency/minor Repair Cost for HOPWA facilities/units

HOPWA Service Definitions

Emergency Housing the Hotel/Motel (H/M) component of HOPWA funds are designed to provide short-term hotel and motel stays for eligible clients under the leasing line item in the HOPWA program; these units are preferably located within extended stay hotels/motels. Clients can remain in these units for no more than 60 days in a six-month period (90 with an approved waiver), only if no appropriate housing or shelter beds are available and if subsequent rental housing has been identified but is not immediately available for move-in by the program participants.

Housing Information include costs for housing counseling, housing advocacy, information and referral services, fair housing information, and housing search and assistance. 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 based on race, color, religion, sex, age, national origin, familial status, or handicap.

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 includes costs to develop housing assistance resources, outreach and relationship building with landlords, costs involved in creating brochures, web resources, and time to locate and identify affordable housing vacancies. funds are used to help an agency establish, coordinate, and develop housing assistance resources for eligible persons. This work will also require that relationships are maintained with landlords and the local housing community with the goal of placing clients into units.

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.

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.

Transitional housing is technically called "Short-term supportive housing" are intended to provide temporary shelter to eligible individuals to prevent homelessness and allow an opportunity to develop an individualized housing and service plan to guide the client's linkage to permanent housing. These facilities provide temporary shelter to persons living with HIV/AIDS (PLWHA) who are homeless. "A short-term supportive housing facility may not provide residence for any individual for more than 60 days in any 6-month period." 24 CFR 574.330 (a). "A short term supported facility may not provide shelter or housing at any single time for more than 50 families or individuals." "A program assisted under this section shall provide each assisted individual with an opportunity to receive case management services from the appropriate social services agencies." Placement in Permanent Housing: Each short-term facility must, to the maximum extent possible, offer individuals residing in such housing the opportunity for placement in permanent housing.

Emergency/Minor Repair funding is used for the improvement or repair of an existing structure, or an addition to an existing structure that does not increase the floor area by more than 100 percent. The HOPWA eligible activity repair includes routine maintenance, preventative measures to keep the building in working order, and periodic replacement of fixtures and appliances on an as-needed basis. HOPWA funds spent on repairs in facility-based housing units are categorized as operating funds APR or CAPER.

IRS Tax Exemption Verification Form (Annual)

I, _____, hereby state that I am _____ of
(Printed Name) (Title)
_____ ("Organization"), and by that authority duly given
(Legal Name of Organization)
and as the act and deed of the Organization, state that the Organization's status continues to be designated as 501(c)(3) pursuant to U.S. Internal Revenue Code, and the documentation on file with the North Carolina Department of Health and Human Services is current and accurate.

I understand that the penalty for perjury is a Class F Felony in North Carolina pursuant to N.C. Gen. Stat. § 14-209, and that other state laws, including N.C. Gen. Stat. § 143C-10-1, and federal laws may also apply for making perjured and/or false statements or misrepresentations.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this the _____ day of _____, 20_____.

_____
(Signature)

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.

5.

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

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
☐ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance	☐ a. Bid/offer/application ☐ b. Initial Award ☐ c. Post-Award	☐ a. initial filing ☐ b. material change **For Material Change Only:** Year_____ Quarter_____ Date of Last Report:_____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier _____, (if known) Congressional District (if known)	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District (if known)
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number (if applicable) _____
8. Federal Action Number (if known)	9. Award Amount (if known) : $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLL-A, if necessary*)	b. Individuals Performing Services (*including address if different from No. 10a.*) (*last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLL-A, if necessary*)
11. Amount of Payment (*check all that apply*): $ _____ ☐ actual ☐ planned 12. Form of Payment (*check all that apply*): ☐ a. cash ☐ b. In-kind; specify: Nature _____ Value _____	13. Type of Payment (*check all that apply*): ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other; specify: _____

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*):

15. Continuation Sheet(s) SF-LLL-A attached: ☐ Yes ☐ No

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 11: Letter to Identify Individuals to Sign Contracts

[Delete this note before printing this page on your letterhead]

Individuals Authorized to Sign Contracts

I, _____, Board President/Chairperson of

_____ [Entity's legal name]

hereby identify the following individuals who are authorized to sign **Contracts** for the entity named above:

Printed Name	Title

Signature	* Title	Date

Appendix 12: Letter to Identify Individuals to Sign Expenditure Reports

[Delete this note before printing this page on your letterhead]

Individuals Authorized to Sign Contract Expenditure Reports (CERs)

I, _____, Board President/Chairperson of

_____ [Entity's legal name]

hereby identify the following individuals who are authorized to sign **Contract Expenditure Reports** for the entity named above:

Printed Name	Title

Signature	* Title	Date

Appendix 13: Conflict of Interest Policy

Directions for *this* Conflict of Interest Policy

All organizations are to submit two items regarding the Conflict of Interest:

1. A completed ***Conflict of Interest Acknowledgement and Policy*** page (which is provided in a separate Microsoft Word file)
2. Your organization's Conflict of Interest Policy

    - **If your organization...already has its own Conflict of Interest Policy...**
      please provide a copy of it with the *Acknowledgement* form.

    - **does not have a Conflict of Interest Policy yet...**
      You must adopt a Conflict of Interest Policy before you can submit your forms. Your organization must have a Conflict of Interest Policy in place to be able to contract with DHHS.

      You may provide your own policy or use the generic policy that DHHS provides (which is included in the following pages).

        - If you are going to use this generic policy, it will need to be adopted by your Board of Directors. This adoption date is one piece of information that you will write on the *Acknowledgement* form.

        - If your Board of Directors has already adopted this generic COI Policy in the past, then your organization *does* have its own COI Policy and this generic one is it.

          Please attach your COI policy to your completed *Acknowledgement* page and include that prior date that your board adopted it on the *Acknowledgement* page.

CONFLICT OF INTEREST ACKNOWLEDGEMENT AND POLICY

State of _____

County _____

I, _____ hereby state that I am the _____ (Printed Name) (Title)

of _____ ("Organization"), and by that authority (Legal Name of Organization)
duly given and as the act and deed of the Organization, state that the following Conflict of Interest Policy was adopted by the Board of Directors/Trustees or other governing body in a meeting held on the _____ day of _____, _____. I understand that the penalty (Day of Month (Month) (Year)
for perjury is a Class F Felony in North Carolina pursuant to N.C. Gen. Stat. § 14-209, and that other state laws, including N.C. Gen. Stat. § 143C-10-1, and federal laws may also apply for making perjured and/or false statements or misrepresentations.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this the _____ day of _____ __, 20_____.
(Day of Month) (Month) (Year)

_____
(Signature)

****

Instruction for Organization:
Sign and attach the following pages after adopted by the Board of Directors/Trustees or other governing body OR replace the following with the current adopted conflict of interest policy.

_____
Name of Organization

_____
Signature of 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:

_____
Name of Organization

_____
Signature of Organization Official

_____
Date

Conflict of Interest Verification (Annual)

We, the undersigned entity, hereby testify that our Organization's Conflict of Interest Acknowledgement and Policy adopted by the Board of Directors/Trustees or other governing body, is on file with the North Carolina Department of Health and Human Services (NCDHHS). If any changes are made to the Conflict of Interest Policy, we will submit a new Conflict of Interest Acknowledgment and Policy to the Department (NCDHHS).

Name of Organization	
Signature of Organization's Authorized Agent	Date
Printed Name of Organization's Authorized Agent	Title
Signature of Witness	Date
Printed Name of Witness	Title

Appendix 14: No Overdue Tax Debts Certification

[Delete this note before printing this page on your letterhead]

State Grant Certification – No Overdue Tax Debts[1]
Date of Certification: _____

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 [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-10-1(b).

Sworn Statement:

_____ and _____ [*Names of Board Chair and Second Authorizing Official*] being duly sworn, say that we are the Board Chair and _____ [*Title of Second Authorizing Official*], respectively, of _____ [*Organization's legal name*] of _____ [*City*] in the State of _____; 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.

_____	Board Chair
Signature	Title
_____	_____
Signature	Title of Second Authorizing Official

Sworn to and subscribed before me on the day of the date of said certification.

_____
Notary Signature and Seal

Notary's commission expires _____, 20 ___

Appendix 15: Contractor Certifications

State Certifications
Contractor Certifications Required by North Carolina Law

Instructions: The person who signs this document should read the text of the statutes and Executive Order listed below and consult with counsel and other knowledgeable persons before signing. The text of each North Carolina General Statutes and of the Executive Order can be found online at:

Article 2 of Chapter 64: **http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf**
G.S. 133-32: **http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=133-32**
Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009): **http://www.ethicscommission.nc.gov/library/pdfs/Laws/EO24.pdf**
G.S. 105-164.8(b): **http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf**
G.S. 143-48.5: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-48.5.html
G.S. 143-59.1: **http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf**
G.S. 143-59.2: **http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf**
G.S. 143-133.3: **http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-133.3.html**
G.S. 143B-139.6C: **http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143B/GS_143B-139.6C.pdf**
Certifications

(1) **Pursuant to G.S. 133-32 and Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009)**, the undersigned hereby certifies that the Contractor named below is in compliance with, and has not violated, the provisions of either said statute or Executive Order.

(2) **Pursuant to G.S. 143-48.5 and G.S. 143-133.3**, 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

(3) **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.

(4) **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.

(5) **Pursuant to G.S. 143B-139.6C**, the undersigned hereby certifies that the Contractor will not use a former employee, as defined by G.S. 143B-139.6C(d)(2), of the North Carolina Department of Health and Human Services in the administration of a contract with the Department in violation of G.S. 143B-139.6C and that a violation of that statute shall void the Agreement.

(6) 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. 143-59.1and -59.2 shall be guilty of a Class I felony.

Contractor's Name: _____

Contractor's Authorized Agent: Signature _____ Date _____

Printed Name _____ Title _____

Witness: Signature _____ Date _____

Printed Name _____ Title _____

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

Appendix 16: 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.

Signature Reference only — Not for 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 17: Certification of Eligibility Under the Iran Divestment Act

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 18: Sample Ryan White / HOPWA Memorandum of Agreements

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 April 1, 2022 and end on March 31, 2023.

Community Care Services	**The Counseling Center**
BY: *Joe Jenkins*	BY: *Sally Mae*
TITLE: HIV Services Director	TITLE: Executive Director
DATE: April 1, 2022	DATE: April 1, 2022
Leroy Jones **Witness**	

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 must 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 January 1, 2022 and end on December 31, 2022.

Housing Coalition, Inc.	**The Counseling Center**
BY: *Joe Jenkins*	BY: *Sally Mae*
TITLE: HIV Services Director	TITLE: Executive Director
DATE: January 1, 2022	DATE: January 1, 2022

Leroy Jones **Witness**

Appendix 19: ITTS Project Objectives

Please use the template provided below to complete your Goals and Objectives and include it with your application. The objectives should be completed for one year only (June 1, 2022 – May 31, 2023.) Agencies providing Integrated Targeted Testing Services (ITTS) are required to conduct HIV and syphilis testing. Hepatitis C testing is required for agencies testing people who currently inject or have a history of injecting drugs. PrEP goals and objectives should follow the NC PrEP Criteria identified in Appendix 4. Agencies must focus other HIV/STD/HCV prevention goals and objectives towards the following priority populations:

- Men who have Sex with Men (MSM) of all races and ethnicities (with a focus on African American/Black gay and bisexual men)
- African American and Latino men and women
- Minority Youth ages 13 to 24 years
- Persons Who Inject Drugs (PWID)
- Transgender Persons (with a focus on HIV among African American/Black transgender women)

Goal 1: Reduce the incidence of HIV/STDs in *(add County/s or Region)* by increasing the number of persons aware of their HIV/STD/HCV status.	
Testing Objective/s:	
1.	By May 31, 2023, (Enter Agency Name) will conduct (#___) HIV tests among N.C. identified priority populations by providing HIV counseling, testing, referral, and linkage to care in (add County/s or Region).
2.	By May 31, 2023 (Agency Name) will conduct (#__) HIV tests among young African American MSM by providing HIV counseling, testing, referral and linkage to care in (add county/Region). Note: 25% of total tests.
3.	By May 31, 2023, (Agency Name) will conduct (#___) HIV tests among non-MSM youth by providing by providing HIV counseling, testing, referral and linkage to care in (add county/Region). Note: 20% of total tests.
4.	By May 31, 2023, (Enter Agency Name) will conduct (#___) syphilis tests among N.C. identified priority populations by providing testing and referral to treatment in (add County/s or Region).
5.	By May 31, 2023, (Enter Agency Name) will conduct (#___) HCV tests among substance abusers by providing testing and referral to treatment in (add County/s or Region).
6.	By May 31, 2023, (Enter Agency Name) will conduct (#___) gonorrhea/chlamydia tests among N.C. identified priority populations by providing testing and referral to treatment in (add County/s or Region).
Goal 2: Increase condom availability and use among populations at risk for HIV/STD/HCV.	
Condom Distribution Objective/s:	
1.	By May 31, 2023, (Enter Agency Name) will establish and maintain a minimum of (#__) condom distribution sites and distribute (#_____) condoms among N.C. identified priority populations.
Goal 3: Increase PrEP access among populations at risk for HIV.	
PrEP Objective/s:	
1.	By May 31, 2023, (Enter Agency Name) will conduct (#___) PrEP referrals (make first appointment) using N.C. PrEP criteria in (add County/s or Region).
Goal 4: Increase information sharing through social media among populations at risk for HIV/STD/HCV.	
Social Media Objective/s:	
1d.	By May 31, 2022, (Enter Agency Name) will conduct (#___) social media activities on (Facebook, Grindr, SCRUFF) to boost testing among N.C. identified priority populations in (add County/s or Region).

Appendix 20: ITTS Projection Reports

Annual Projection for Funded Testing Program

Agency Name:							
Contract Period:							
Annual Contract Objectives:	**Number of persons tested for: _____HIV _____Syph _____GC/CT _____HCV** **Number of persons referred for PrEP: _____**						
	Agency Staff	County	Days/Hours	**Number of persons tested**		**Number of persons referred for PrEP**	
				Quarterly	Annually	Quarterly	Annually
Ex. Teeple's House	Mary K. Sole	Cumberland	Every Monday 1-3pm	25 HIV 25 Syphilis	100 HIV 100 Syphilis	10	50
TOTAL (for all sites)							

Appendix 21: ITTS Physician's Standing Orders

{Physician Letterhead}

Date

{Agency Name and address}

To Whom It May Concern:

The following are Standing Orders for {Name of Agency} regarding HIV, syphilis, hepatitis C, gonorrhea and chlamydia testing.

{Name of Director} is appointed the sole person responsible for ensuring that these standing orders are carried out in full on behalf and in the authority of {Name of Physician}.

Designated staff representing {Name of Agency} may collect appropriate specimens for HIV, syphilis, hepatitis C, gonorrhea and chlamydia testing at the specified site and at other nontraditional test sites in {Name of Counties} and during special targeted testing events.

Signed by {Name of Director}

Signed by {Name of Physician}

Appendix 22: 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.*

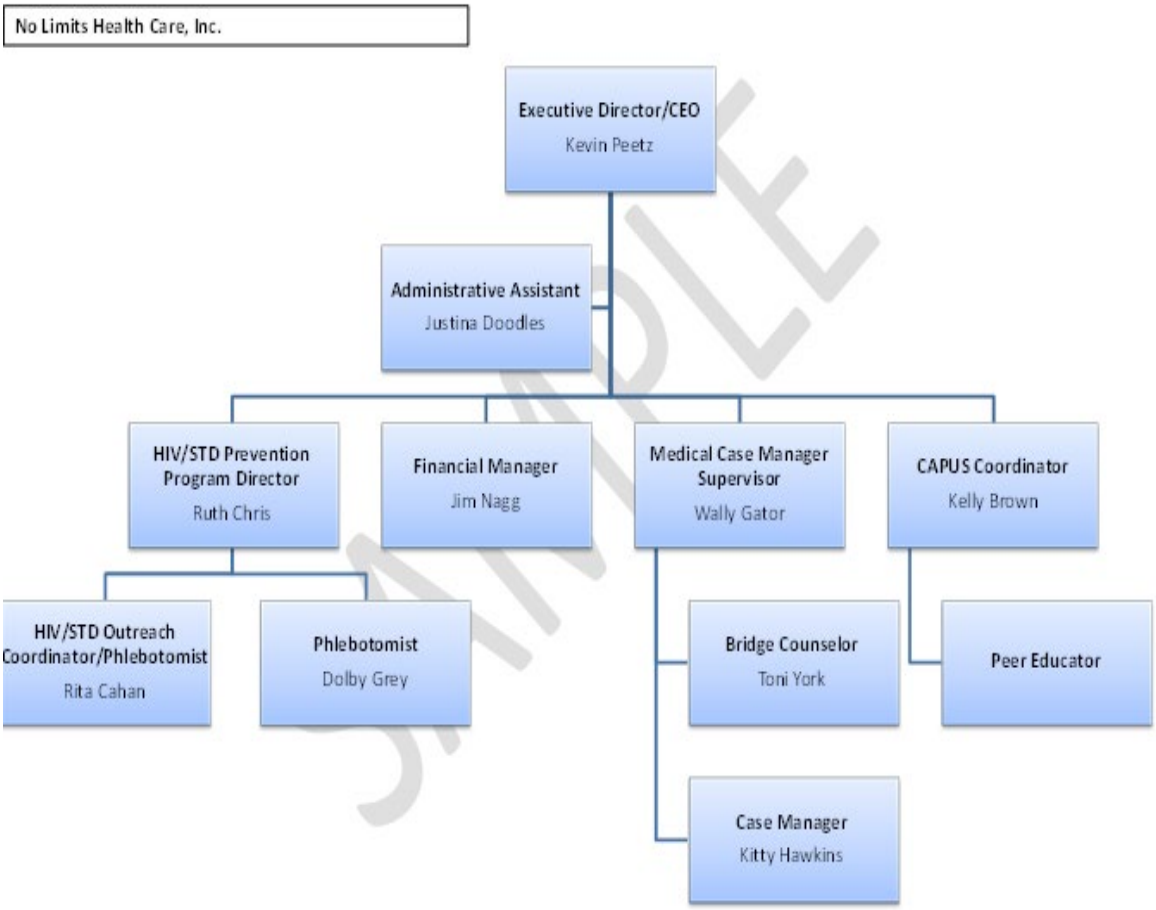
Step 5:
Move to the next box, which branches below the first. Type the name of the next-highest person. Most Word templates have three boxes on this branch. If you only have one or two people on this branch, click the box and press the "Delete" key. If you have more than three, click any box on the row, 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.

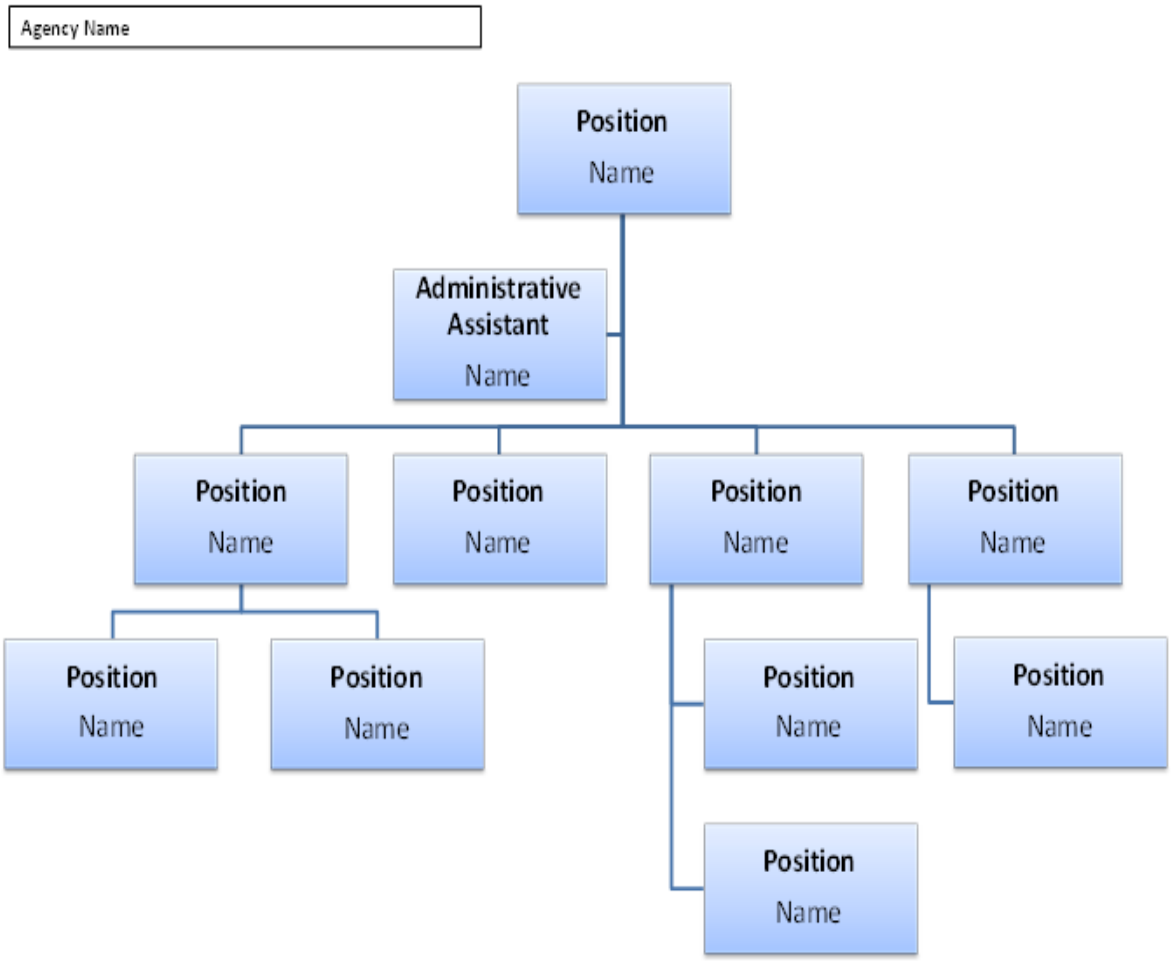
Step 6:
Click a box on the second row. Click the "Add Shape" menu and choose "Add Shape Below." This creates the next, lower level in the organizational hierarchy. Add boxes, names and titles for each person on this level of your company. Continue to add boxes and rows. Note that as you add boxes, Word 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.

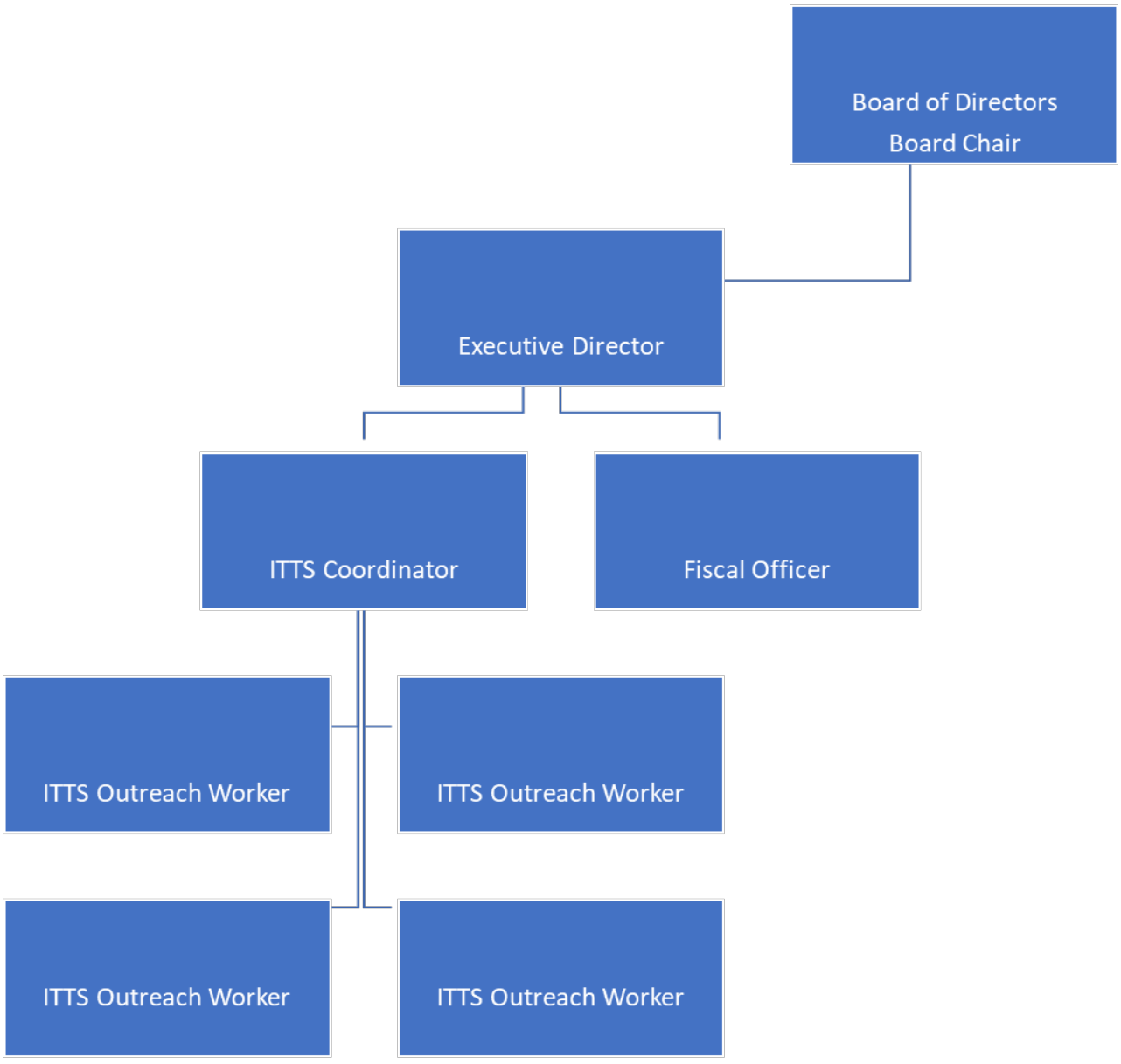
Step 8:
Click the "Change Colors" button on the ribbon. Choose a different set of hues from the default Word blue. You can also change individual colors in the chart. Click a box or click multiple boxes by holding down the "Ctrl" key and then clicking each box to change. Right-click any of the selected 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
Position
Name
Administrative
Assistant
Name
Position
Name
Position
Name
Position
Name
Position
Name
Position
Name
Position
Name
Position
Name
Position
Name

Agency Name


Board of Directors
Board Chair
Executive Director
ITTS Coordinator
Fiscal Officer
ITTS Outreach Worker
ITTS Outreach Worker
ITTS Outreach Worker
ITTS Outreach Worker

Appendix 23: Sample ITTS Budget

Estimated Budget ITTS Narrative - SAMPLE

No Limits Health Care, Inc. - Budget Detail Year 1			
Category	**Item**	**Narrative**	**Amount**
Salary/Wages		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, monitor the ITTS program budget, and develop and institute a quality management plan. She will also process, maintain, and prepare required reports for the State Communicable Disease Branch. 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, send specimens to the State Laboratory of Public Health (SLPH) and to LabCorp, make referrals for all clients that receive positive test results and make PrEP referrals for HIV negative clients. Data Manager/Phlebotomist, Dolby Grey, 0.25 FTE - Annual Salary = $25,840 x 0.25 FTE = ***$6,460*** The Data Manager/Phlebotomist will assist in planning, coordinating, and conducting counseling, testing and referrals at targeted sites for high-risk populations, send specimens to the State Laboratory of Public Health (SLPH) and to LabCorp, and, conduct post-test counseling and referrals for all clients that receive positive test results. He will also enter all data into EvaluationWeb and review all positive forms for accuracy prior to sending to the Prevention Program's Data Manager. Total FTEs: 0.50 + 1.0 + 0.25 = 1.75 FTEs Total Salary: $24,250 + 28,100 + $6,460 = $58,810	$58,810
Fringe Benefits		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)	$15,434

		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) Data Manager/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) Total Fringe: $5,277 + $8,178+ $1,979 = $15,434	
Supplies and Materials	Other	Office Supplies: General office supplies needed to support 1.75 FTE ITTS program staff in conducting the day to day program operations: 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 $7.49; 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. Total Supplies/Materials: $105 + $19.50 + $256.40 + $7.49 + $340 + $255 + $74.50 + $35.25 = $1,093	$1,093
Supplies and Materials	Other	Medical Supplies: Medical supplies necessary to conduct the testing requirements of the ITTS Program: 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. Total Supplies/Materials: $176 + $200 + $405 + $300 + $49.20 + $14 + $82.24 + $201.69 + $87 + $3,388 = $4,903	$4,903
Travel	Contractor Staff	Travel: Reimbursement for staff to travel throughout a five-county region to conduct testing and program activities. Also includes mileage to attend HIV/STD	$3,553

		Communicable Disease Branch required trainings and meetings. Program staff travels an estimated 515 miles per month. 528.79 x 12 = 6,345.48 miles x $0.56 per mile = $3,553.46 ($3,553)	
Utilities	Telephone	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; Data Manager/Phlebotomist 0.25 FTE x $60 = $15 per month x 12 = $180. $360 + $720 + $180 = $1,260	$1,260
Rent	Office Space	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. ft. x 12 mos. (June 1, 2017 to May 31, 2018). 315 x $2.05 = $645.75 per mo. x 12 mos. = $7,749	$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			**$100,217**

Estimated Budget ITTS Narrative - SAMPLE

Name: No Limits Health Care, Inc.	
Item Description	***Contract Amount***
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
Data Manager/Phlebotomist, Dolby Grey	$6,460
Fringe – Phlebotomist	$1,979
Total Salary and Fringe	**$74,244**

Operating Expenses	
Supplies and Materials – Office	$1,093
Supplies and Materials – Medical Supplies	$4,903
Travel/Contractor Staff	$3,553
Utilities – Telephone	$1,260
Rent – Office Space	$7,749
Professional Services – Payroll	$1,575
Operational Other – Incentives and Participants	$1,340
Total Operation Expenses	**$21,473**

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

Total Budget	**$ 100,217**

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

1. Complete the *Estimated Budget Breakdown Page* and *Estimated Budget Justification Page.* As shown in Appendix 23.

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/Wages – 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/Wages: 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 $75.10 = $150.02. 418 miles round trip from Greensboro, NC to Wilmington, NC for training x $0.560/mile = $234.08. 2 staff x (1 breakfast at $8.60 each + 2 lunches at $11.30 each + 2 dinners at $19.50 each) = $140.40. Total travel: $150.02 + $234.08 + $140.40= $524.50.

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 preformed. 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.

Appendix 24: Sample Ryan White Budget

Region 12 Network of Care
Chelsea Medical Center (CMC)
Ryan White Part B
BUDGET NARRATIVE
April 1, 2022 - March 31, 2023

Fairy Primary Health (FPH) is an Early Intervention Services (EIS) clinic owned and operated Chelsea Medical Center (CMC).

Fringe Schedule (8.65% paid by Part B) for all Employees, as indicated, includes:
FICA – 7.65%
Pension – 1%
Health Insurance - CMC pays $8,920 for traditional PPO plan and $7,691 for Consumer Driven Health Plan

Administration **$26,200**

Administration activities include:

- Manage CAREWare data collection, data entry, RSR and CLD;
- Fulfill state and Federal regulations, policies, guidance and all contractual obligations;
- Compile and submit required fiscal and program reports

Salary/Fringe: $26,200
The following staff will have responsibility for all administrative activities:

Ryan White Program Coordinator – J. Cook - (.1 FTE): $7,479
Annual Salary: $60,626 Part B: $6,063
Total Fringe: $1,416
Annual Health Insurance Premium: $8,920 Part B: $892
Fringe Benefits: 8.65% Part B: $524

Medical Case Management (MCM) Supervisor – K. Signal – (.18 FTE): $18,721
Annual Salary: $87,513 Part B: $15,752
Total Fringe: $2,969
Annual Health Insurance Premium: $8,920 Part B: $1,606
Fringe Benefits: 8.65% Part B: $1,363

Additional staff members enter client level data (CLD) but are not paid with RW Part B funds.

Quality Improvement **$18,941**

Quality Improvement activities include:

- Conduct Quality Improvement activities;
- Collect/report quality improvement performance indicators; and
- Actively participate in the Regional Quality Council (RQC) and associated National Quality Improvement Projects such as ECHO, etc.

Salary/Fringe: $17,631
The following staff will have responsibility for all Quality Improvement activities:

Ryan White Program Coordinator – J. Cook - (.08 FTE): $5,984
Annual Salary: $60,626 Part B: $4,850
Total Fringe: $1,134
Annual Health Insurance Premium: $8,920 Part B: $714
Fringe Benefits: 8.65% Part B: $420

Nurse Practitioner – L. Noles, ANP (.05 FTE): $7,040
Annual Salary: $121,384 Part B: $6,069
Total Fringe: $971
Annual Health Insurance Premium: $8,920 Part B: $446
Fringe Benefits: 8.65% Part B: $525

Clinical Manager – D. Harris, RN - (.055 FTE): $4,607
Annual Salary: $70,020 Part B: $3,851
Total Fringe: $756
Annual Health Insurance Premium: $7,691 Part B: $423
Fringe Benefits: 8.65% Part B: $333

Staff Travel: $1,310

Funds are requested for the Program Coordinator to attend Regional Quality Council (RQC) Meetings in Raleigh four times per year.

Overnight lodging (Raleigh)	$114.50 per RQC meeting x 4 meetings = ($75.10 hotel + $8.60 breakfast + $11.30 lunch + $19.50 dinner)	$458
Mileage	1,521.4 miles at $0.560 per mile =	$852

Planning and Evaluation **$34,264**

Planning and Evaluation activities include:
- Coordinate the Network, convene/facilitate quarterly Network meetings within the contract period;
- Coordinate Network services;
- Implement and update an Evaluation Plan for the Network;
- Annually review and update the Network Grievance Policy; and
- Annual client satisfaction survey

Salary/Fringe: $34,264

The following staff will have responsibility for all P/E activities:

Ryan White Program Coordinator – J. Cook - (.18 FTE): $13,463
Annual Salary: $60,626 Part B: $10,913
Total Fringe: $2,550
Annual Health Insurance Premium: $8,920 Part B: $1,606
Fringe Benefits: 8.65% Part B: $944

Medical Case Management (MCM) Supervisor – K. Signal – (.2 FTE): $20,801
Annual Salary: $87,513 Part B: $17,503
Total Fringe: $3,298
Annual Health Insurance Premium: $8,920 Part B: $1,784
Fringe Benefits: 8.65% Part B: $1,514

Note: *M. Lucy, Assistant VP is assisting with the update of the Network Client Grievance Policy and facilitation of quarterly Network meetings. However, she is paid with other funding sources.*

Core Medical Services: $156,542

Outpatient/Ambulatory Medical Care **$116,221**

Outpatient/Ambulatory Health Services (OA) are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Allowable activities include: medical history taking; physical examination; diagnostic testing (including laboratory testing); treatment and management of physical and behavioral health conditions; behavioral risk assessment, subsequent counseling, and referral; preventive care and screening; pediatric developmental assessment; prescription, and management of medication therapy; treatment adherence provided during the OA visit; education and counseling on health and prevention issues; and referral to and provision of specialty care related to HIV diagnosis.

Clinical Manager position is responsible for ordering of vaccines, OTC medications and medical supplies. This position monitors and discards all out of date supplies and medications on a monthly basis and also serves as clinical support based on patient volume.

An estimated 400 Outpatient/Ambulatory services will be provided to 150 clients at Medicaid rates.

Salary/Fringe: $71,400

Nurse Practitioner – L. Noles, ANP (.40 FTE): $56,322
Annual Salary: $121,384 Part B: $48,554
Total Fringe: $7,768
Annual Health Insurance Premium: $8,920 Part B: $3,568
Fringe Benefits: 8.65% Part B: $4,200

Clinical Manager – D. Harris, RN - (.18 FTE): $15,078
Annual Salary: $70,020 Part B: $12,604
Total Fringe: $2,474
Annual Health Insurance Premium: $7,691 Part B: $1,384
Fringe Benefits: 8.65% Part B: $1,090

Operating Expenses: $44,821

Laboratory and Diagnostic Services $31,821
CMC will reimburse laboratories and hospitals to perform all the laboratory and diagnostic tests required to deliver high-quality medical care. The estimated cost of laboratory expense per patient, per test, per year is as listed below.

Lab Test	Unduplicated Pts	Units/Pt/Year	Total Units per Year	Cost per Unit	Total Cost
HIV-1 Antibody	40	1	40	$30.53	$1,221.20
HIV VL RNA by PCR	62	2	124	$29.61	$3,671.64
CD4 Count	60	2	120	$33.02	$3,962.40
HCV Screen	60	1	60	$40.17	$2,410.20
HCV Viral Load	60	2	120	$30.24	$3,628.80
HBV Screen	60	1	60	$14.36	$861.60
Metabolic Panel	60	2	120	$10.42	$1,250.40
Lipid Panel	60	1	60	$16.53	$991.80
CBC/Diff	60	2	120	$9.58	$1,149.60
RPR	60	1	60	$22.18	$1,330.80
HIV-1 Genotype	60	1	60	$96.26	$5,775.60
Various radiology tests	52	2	104	~$53.524	$5,566.50
Total	**694**		**1,048**		**$31,820.54 (Rounded to $31,821)**

Medical Supplies $3,000

This line item includes the following consumable supplies: disposable gloves; personal protective equipment (e.g., eyeglasses/face shields); alcohol swabs; disinfectants/ sterilizers, gauze, disposable exam robes, examination table paper, etc. Medical supply costs (partial costs) are based on historical experience and are estimated at $5 patient encounter x 600 patient encounters per year. ($5 x 600 = $3,000)

Specialty Medical Services

Professional Services (Various Private Practices) $10,000

This line item is budgeted to reimburse medical providers for specialty consultations (e.g., cardiology, gastroenterology, neurology, ophthalmology, etc.). These services are required to provide Part B patients comprehensive outpatient/ambulatory medical care. Reimbursement will be on a fee-for-service basis using the Medicaid fee schedule. Based on prior experience, Part-B patients will need at least 80 specialty consultations during the year at an average cost of $125/visit. ($125 x 80 = $10,000)

Oral Health Care **$16,000**

Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services (including prosthetics) by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants. Services provided at Medicaid rates on a fee-for-service basis by dental providers throughout the region.

40 clients @ 2 visit/client = 80 @ $200/visit = $16,000

Mental Health **$6,000**

Mental Health services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such

professionals typically include psychiatrists, psychologists, and licensed clinical social workers. Services are provided at Medicaid rates on a fee-for-service basis.
25 clients @ 3 visit/client = 75 @ $80/visit = $6,000

Substance Abuse Outpatient Care ***$0***
Substance Abuse services are paid with other funding sources such as 340B funds and RW Part C funding based on client need.

Medical Case Management **$8,321**
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include: initial assessment of service needs; development of a comprehensive, individualized care plan; timely and coordinated access to medically appropriate levels of health and support services and continuity of care; client monitoring to assess the efficacy of the care plan; re-evaluation of the care plan at least every six months with adaptations as necessary; ongoing assessment of the client's and other key family members' needs and personal support systems; treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; client-specific advocacy and/or review of utilization of services.

CMC 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 include the initial assessment of service needs. She 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. She will ensure coordination and follow-up of medical treatments.
K. Signal does not perform additional duties under MCM scope as she does not carry a client case load.

85 clients for intake assessments x 1 assessment = 85 visits. **This number of clients was derived following review of actual CAREWare data from FY 2018 and FY 2019 to date.

Salary/Fringe: $8,321

Medical Case Management (MCM) Supervisor – K. Signal – (.08 FTE): $8,321
Annual Salary: $87,513 Part B: $7,001
Total Fringe*:* $1,320
Annual Health Insurance Premium: $8,920 Part B: $714
Fringe Benefits: 8.65% Part B: $606

Health Insurance Premium & Cost-Sharing Assistance for Low Income Individuals
$10,000
Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. (Health Insurance also includes standalone dental insurance). Allowable services include: paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients; paying standalone dental insurance premiums to provide

comprehensive oral health care services for eligible clients; and paying cost sharing on behalf of the client.

Eligible Ryan White patients will be expected to participate in the opportunities of the Affordable Care Act. A total of 60 clients will be served. 10 clients will receive assistance with cost-sharing assistance for Qualified Health Plans through the Federally Facilitated Marketplace (FFM) and COBRA premiums. 60 will receive assistance with provision of cost sharing assistance. There will be overlap as some clients will need both types of assistance.
50 clients @ 2 payments = 100 @ $100/payment = $10,000

Support Services: $8,361

Psychosocial Support **$4,161**
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. 180 clients x 2 visits = 360 visits.

Salary/Fringe: $4,161

Medical Case Management (MCM) Supervisor – K. Signal – (.04 FTE): $4,161
Annual Salary: $87,513 Part B: $3,501
Total Fringe*:* $660
Annual Health Insurance Premium: $8,920 Part B: $357
Fringe Benefits: 8.65% Part B: $303

Medical Transportation **$1,200**
FPH 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. A total of 25 clients will be served (other transportation assistance).
40 clients @ 100 miles (4 trips per client) = 4,000 @ $0.30/mile = $1,200

Emergency Financial Assistance **$3,000**
FPH 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. A total of 12 clients will be served (6 clients will receive EFA for utility assistance and 6 clients will receive EFA for general expenses).
12 clients @ $250/payment = $3,000

Contracted Services

Fringe Schedule (18.65%) for all Employees includes:
FICA - 7.65%
Health Insurance – 13% Total salary funded by RW Part B = $79,917. Total health insurance billed to RW Part B = $10,896. $10,896/$79,717 = 0.13.

Administration **$10,158**

Administration activities include:

- CAREWare data collection, data entry, and RSR;
- Adhere to State and Federal regulations, policies, guidance and all contractual obligations;

- Compile and submit required fiscal and program reports;
- Process requests for payment of services;
- Assist with contract record keeping;
- Monitor budget and expenditures to assure that contract guidelines are met;
- Locate and maintain providers and assist in obtaining memoranda of Understanding agreements for the region;
- Process and paycheck requests from providers;
- Complete and submit monthly billing and reports; and
- Monitor budget and maintain contract records.

Salary/Fringe: $10,158
The following staff will have responsibility for all administrative activities:

HSO Lead Medical Case Manager – M. Buttons – (.08 FTE): $3,373
Annual Salary: $42,162 Part B: $3,373

HSO Chief Financial Officer – Q. Ganny - (.13 FTE): $6,785
Annual Salary: $52,189 Part B: $6,785

Fringe benefits are not being charged to Ryan White Part B for Administration.
Total Projected Part B Salary: $10,158 ($3,373 + $6,785)
Total Projected Part B Fringe: $0.00

Planning and Evaluation **$4,155**

Planning and Evaluation activities include:
- Coordinate Network services;
- Assist with implementation and updates of an Evaluation Plan for the Network;
- Annually review and update the Network Grievance Policy; and
- Annual client satisfaction survey.

Salary/Fringe: $4,155
The following staff will have responsibility for all P/E activities:

HSO Lead Medical Case Manager – M. Buttons – (.08 FTE): $4,155
Annual Salary: $42,162 Part B: $3,373
Total Fringe*:* $782
Annual Health Insurance Premium: $6,547 Part B: $524
Fringe Benefits: 7.65% Part B: $258

Medical Case Management **$98,482**
HSO Medical Case Managers (MCM)
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include: initial assessment of service needs; development of a comprehensive, individualized care plan; timely and coordinated access to medically appropriate levels of health and support services and continuity of care; client monitoring to assess the efficacy of the care plan; re-evaluation of the care plan at least every six months with adaptations as necessary; ongoing

assessment of the client's and other key family members' needs and personal support systems; treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; client-specific advocacy and/or review of utilization of services.
An estimated 1,010 Medical Case Management services will be provided to 101 clients.

Salary/Fringe: $98,482

Case Manager – L. Jank (.77 FTE): $35,363
Annual Salary: $37,086 Part B: $28,556
Total Fringe: $6,807
Annual Health Insurance Premium: $6,003 Part B: $4,622
Fringe Benefits: 7.65% Part B: $2,185

Case Manager – E. Dubb (.51 FTE): $18,914
Annual Salary: $37,086 Part B: $18,914
Total Fringe: $0.00
Annual Health Insurance Premium: (health insurance is being paid by another funding source for F. Walker)
Fringe Benefits: (fringe benefits are being paid by another funding source for F. Walker)

Case Manager – M. Buttons (.20 FTE): $10,386
Annual Salary: $42,162 Part B: $8,432
Total Fringe: $1,954
Annual Health Insurance Premium: $6,547 Part B: $1,309
Fringe Benefits: 7.65% Part B: $645.00

Case Manager – R.Candy (.82 FTE): $33,819
Annual Salary: $33,280 Part B: $27,290
Total Fringe: $6,529
Annual Health Insurance Premium: $5,416 Part B: $4,441
Fringe Benefits: 7.65% Part B: $2,088

Support Services: $40,658

Psychosocial Support Services **$2,108**
HSO Psychosocial Support Manager (PSM)
Position will provide HIV support group facilitation and nutritional counseling by a non-dietician. This will include guidance on nutritional intake and support group facilitation at least 1 x per month. Key activities include: initial assessment of service needs and development of a comprehensive plan for the support group and each individual clients nutritional need, and ongoing assessment of the client's and other key family members' needs and personal support systems.
An estimated 64 Psychosocial Support services will be provided to 8 clients.

Salary: $2,108

Case Manager – M. Buttons (.05 FTE): $2,108
Annual Salary: $42,162 Part B: $2,108

Fringe benefits and health insurance are not being charged to Ryan White Part B for Non-Medical Case Management.

Medical Transportation (Support) **$15,220**

HSO 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 and HSO staff members to transport clients to medical appointments. Note: Clients will not be eligible for direct mileage reimbursement.
53 clients x 2.24 medical case managers = 119 transports x 10 visits/services per client = 1,190
A total of 53 clients will be served.

275 trips @ 181.87 miles @ $0.30/mile = $15,004.28

6 clients @ 16 dial a ride bus/van tickets @ $2.25/ticket = $216

Food Bank (Support) **$7,980**

HSO will purchase food vouchers for clients when clients complete annual and quarterly reviews of their care plan, medication adherence and demographic information, and experience emergency food shortages.
150 clients @ $9.50/voucher @ 5.6 vouchers/client = $7,980

Emergency Financial Assistance (Support) **$15,350**

HSO 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.
139 clients @ $110.43/payment = $15,349.77 (rounded to $15,350)

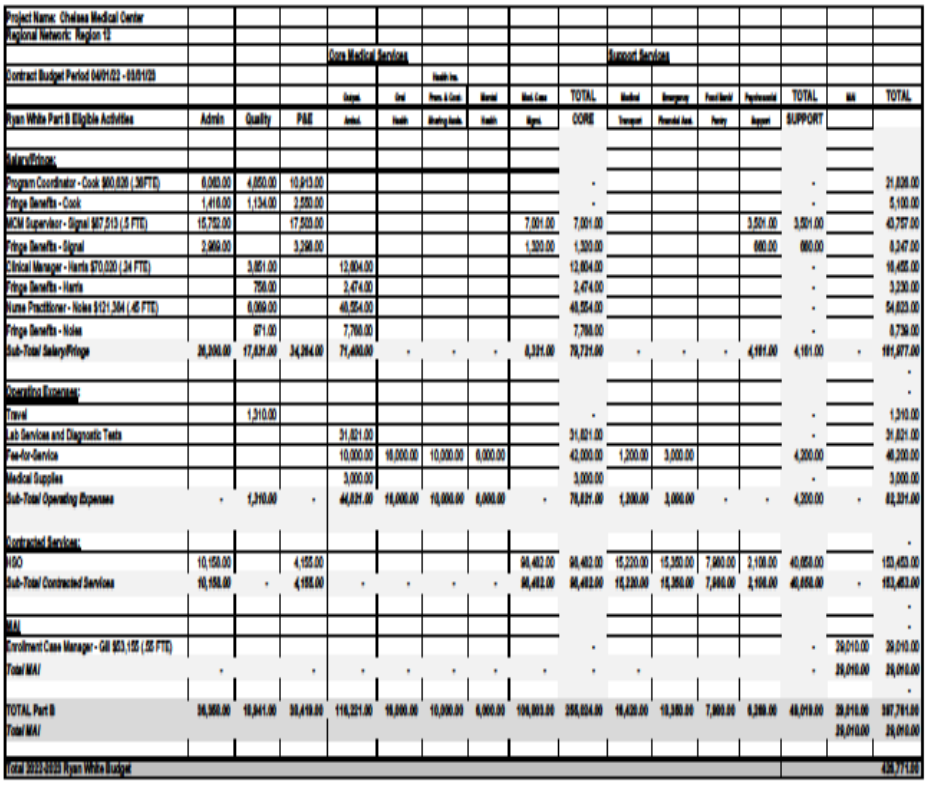
Minority AIDS Initiative: **$29,010**

Minority AIDS Initiative (MAI) services provide assistance in increasing minority client enrollment in HMAP. This position will also provide vigorous pursuit of healthcare coverage, enrollment services for patients including coverage to care assistance and pharmacy enrollment, especially targeting minorities to ensure that Ryan White is the payor of last resort.
An estimated 600 Minority AIDS Initiative services will be provided to 200 clients.

Salary/Fringe: $29,010

Enrollment Case Manager – R. Gill (.54576 FTE): $29,010
Annual Salary: $53,155 Part B: $29,010
Fringe benefits for MAI salary will be paid by CMC/program income.
Health Insurance will be paid from CMC/program income.

Total Part B	**$397,761**
Total MAI	**$29,010**
TOTAL RYAN WHITE	**$426,771**



Project Name: Chelsea Medical Center																
Regional Network: Region 12																
				Core Medical Services						Support Services						
Contract Budget Period 04/01/22 - 03/31/23																
					Oral Health	Prim. & Cond. Manag Assis.	Mental Health	Med. Case Mgmt.	TOTAL CORE	Medical Transport	Emergency Financial Asst.	Food Bank/ Pantry	Psychosocial Support	TOTAL SUPPORT	MA	TOTAL
Ryan White Part B Eligible Activities	Admin	Quality	P&E	Outpat. Ambul.												
Salary/Fringe:																
Program Coordinator - Cook $60,828 (.36FTE)	6,083.00	4,050.00	10,913.00						-					-		21,026.00
Fringe Benefits - Cook	1,416.00	1,134.00	2,550.00						-					-		5,100.00
MCM Supervisor - Signal $67,513 (.5 FTE)	15,752.00		17,503.00					7,001.00	7,001.00				3,501.00	3,501.00		43,757.00
Fringe Benefits - Signal	2,969.00		3,298.00					1,320.00	1,320.00				660.00	660.00		8,247.00
Clinical Manager - Harris $70,020 (.34 FTE)		3,851.00		12,604.00					12,604.00					-		16,455.00
Fringe Benefits - Harris		758.00		2,474.00					2,474.00					-		3,230.00
Nurse Practitioner - Noles $121,304 (.45 FTE)		6,069.00		48,554.00					48,554.00					-		54,623.00
Fringe Benefits - Noles		971.00		7,786.00					7,786.00					-		8,756.00
Sub-Total Salary/Fringe	26,220.00	17,831.00	34,264.00	71,490.00	-	-	-	8,321.00	79,721.00	-	-	-	4,161.00	4,161.00	-	161,877.00
																-
Operating Expenses:																-
Travel		1,310.00							-					-		1,310.00
Lab Services and Diagnostic Tests				31,821.00					31,821.00					-		31,821.00
Fee-for-Service				10,000.00	10,000.00	10,000.00	6,000.00		42,000.00	1,200.00	3,000.00			4,200.00		46,200.00
Medical Supplies				3,000.00					3,000.00					-		3,000.00
Sub-Total Operating Expenses	-	1,310.00	-	44,821.00	10,000.00	10,000.00	6,000.00	-	76,821.00	1,200.00	3,000.00	-	-	4,200.00	-	82,331.00
Contracted Services:																-
HSO	10,158.00		4,155.00					98,482.00	98,482.00	15,220.00	15,350.00	7,960.00	2,108.00	40,658.00		153,453.00
Sub-Total Contracted Services	10,158.00	-	4,155.00	-	-	-	-	98,482.00	98,482.00	15,220.00	15,350.00	7,960.00	2,108.00	40,658.00	-	153,453.00
																-
MAI																-
Enrollment Case Manager - Gill $53,155 (.55 FTE)									-					-	29,010.00	29,010.00
Total MAI	-		-	-	-	-	-	-	-	-				-	29,010.00	29,010.00
																-
TOTAL Part B	36,378.00	19,141.00	38,419.00	116,311.00	10,000.00	10,000.00	6,000.00	106,803.00	258,024.00	16,420.00	18,350.00	7,960.00	6,268.00	48,018.00	29,010.00	337,791.00
Total MAI															29,010.00	29,010.00
Total 2022-2023 Ryan White Budget																436,771.00

Appendix 25: Sample HOPWA Budget

HIV Care Network (Region 12)
Apple Health Services
Housing Opportunities for People with AIDS (HOPWA)
Budget Narrative
January 1, 2022 – December 31, 2022

Fringe Schedule (0%) for all Employees includes:
All fringe benefits will be paid from operational program income or other grant sources and will not be covered under HOPWA funding.

Administration $21,302

Administration activities include:

- CAREWare data collection
- CAPER reporting
- Adhere to State and Federal regulations, policies, guidance
- Ensure all contractual obligations are fulfilled
- Compile and submit required fiscal and program reports
- Ensure HOPWA services are available in all counties of the Network
- Monitor sub-contracted providers
- Assess client satisfaction with HOPWA services received and implement programmatic improvements as needed based on results of satisfaction assessments
- Ensure the Network Grievance Policy is distributed to all HOPWA clients
- Conduct Quality Improvement (QI) and collect and report QI performance indicators

Salary: $21,302
The following staff will have responsibility for all administrative activities:

Network Administrator – Lisa Selma (.25 FTE): $16,721
Annual Salary: $66,882
HOPWA: $16,721
Total Fringe: $0

Health Information Technician – Yvonne Parks (.125 FTE): $4,581
Annual Salary: $36,646
HOPWA: $4,581
Total Fringe: $0

Housing Information $12,349

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

It is estimated that 55 households will receive 2 services resulting in 110 services.

Salary: $12,349

Housing Specialist – Lamar Hager (.25 FTE) $12,349
Annual Salary: $49,394
HOPWA Annual Salary: $12,349
Total Fringe: $0

Resource Identification $3,744

Resource Identification services include the establishment, coordination and development of housing assistance resources for eligible persons, including conducting preliminary research and making expenditures necessary to determine the feasibility of specific housing related initiatives.
It is estimated that 55 households will receive 2 services resulting in 110 services.

Travel Reimbursement: $3,744

The Housing Specialist will travel throughout the 18 counties of the Network service area to locate housing units, meet with landlords and clients, conduct outreach, and attend housing meetings and trainings to establish, coordinate and develop housing resources for eligible clients. Estimated mileage is 557 miles per month at a rate of $0.56 per mile.
(557.1 miles x 12 months x $0.56 per mile = $3,744)

Tenant Based Rental Assistance (TBRA): $415,151

TBRA is a rental subsidy used to help participants obtain permanent housing in the private rental housing market that meets housing quality standards and is rent reasonable. TBRA pays the difference between the Fair Market Rent or "reasonable rent" and the tenant's portion of the rent. With TBRA, rental payments are made directly to property owners. The HOPWA subsidy covers a portion of the full rent and the tenant pays a portion based on their adjusted income or gross income. This service includes the completion of client intakes/assessments, verification of client/household income, verification of client medical status, completion of initial and annual housing inspections, conducting annual recertification of eligibility, mediation of client/landlord concerns, preparation of program termination documentation, and the issuance of monthly rental and utility assistance checks.
It is estimated that 50 HOPWA beneficiaries will receive approximately 600 units of service.

TBRA Program Cost (salary): $41,627

Housing Specialist – Lamar Hager (.75 FTE) $37,046
Annual Salary: $49,394
HOPWA Annual Salary: $37,046
Total Fringe: $0

This position completes client intake and service needs assessments, reviews client household income, performs initial and annual housing inspections to ensure housing meets Housing Quality Standards (HQS) and Fair Market Rent (FMR) standards, conducts annual client recertifications, handles client and/or landlord concerns, prepares and maintains TBRA termination documentation, and works with accounting/data staff to prepare monthly rental assistance checks.

TBRA Rental Subsidy Payments (WNCCHS): $373,524

Apple Health Services will provide tenant-based rental assistance to clients living throughout the 18 counties of the Network.
Based on updated rental costs, the average monthly rent and utilities allowance subsidy per household is $622.54 x 50 households per year.
($622.54 x 12 months x 50 households = $373,524).

Support Services $4,266

Permanent Housing Placement (PHP) $4,266

Permanent Housing Placement (PHP) services are used to help eligible persons establish a new residence where ongoing occupancy is expected to continue. Allowable costs include application fees, credit checks, security deposits, fees for housing services or activities designed to assist individuals or families in locating suitable housing, including tenant counseling, assisting individuals and families to understand leases, secure utilities, making moving arrangements, pay for representative payee services for persons who use such services to better manage their own finances, and mediation services related to neighbor/landlord issues that may arise. Placement costs cannot exceed the value of two month's rent in the new unit. Funds used must be returned to the program when clients vacate the unit and these returned funds should be recorded as program income and used to further program purposes.
4 unduplicated clients will receive 4 units of service each at $266.62 per service. ($266.62 x 4 clients x 4 services = $4,266).

Contracted Services

Short-Term Rental/Mortgage and Utility Assistance (STRMU) $27,613

One Step HIV Project
STRMU provides sort-term interventions that help maintain stable living environments for households who are experiencing a financial crisis and the potential loss of their housing arrangement. Allowable costs include overdue and ongoing rent, mortgage, or utility payments including late fees associated with overdue rent, mortgage and utility payments intended as a bridge to more permanent housing solutions, such as obtaining long-term rental assistance, increasing household income, or helping a household resolve a short-term crisis. STRMU assistance is limited to 21 weeks of assistance in a 52-week period.

Based on prior experience, One Step HIV Project will provide STRMU to at least 40 unduplicated clients (and their household members) per year, resulting in at least 135 units of service. The average amount per household per year is $690.32.
($690.32 x 40 clients = $27,613).

Total HOPWA $484,425

Apple Health Services, Inc.							
HOPWA Region Twelve January 1, 2022 - December 31, 2022 Budget							
	Admin	**Short-Term Rent Mortgage & Utility**	**Tenant Based Rental Assistance**	**RI**	**PHP**	**HI**	**Total**
Salary and Fringe:							
Selma, Network Administrator - $66,882 (.25 FTE)	16,721						16,721
Parks, Health Information Technician - $36,646 (.25 FTE)	4,581		4,581				9,162
Hager, Housing Specialist - $49,394 (1.00 FTE)			37,046			12,349	49,395
Operating Expenses:							
Tenant Based Rental Assistance (TBRA)			373,524				373,524
Resource Identification (Travel)				3,744			3,744
Permanent Housing Placement					4,266		4,266
Contracted Services							
One Step HIV Project		27,613					27,613
Total	**21,302**	**27,613**	**415,151**	**3,744**	**4,266**	**12,349**	**484,425**

Appendix 26: Additional Budget Guidance

1. 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 to this rate. The current state mileage reimbursement rate is 56 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 Manual[1] or adopted by means of an OSBM Budget Memo[2].

Current Rates for Travel and Lodging

Meals			**In State**	**Out of State**
	Breakfast		$8.60	$8.60
	Lunch		$11.30	$11.30
	Dinner		$19.50	$22.20
	Per Diem		$39.40	$42.10
Lodging		(Maximum)	$75.10	$88.70
Total			**$114.50**	**$130.80**
Mileage		$0.560 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.

2. Indirect Cost

Indirect cost is the cost incurred for common or joint objectives, which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. Regulations restricting the allocation of indirect cost vary based on the funding source.

Prevention (ITTS) Federally Funded

Where the applicant has a Federal Negotiated Indirect Cost Rate (FNICR) and there are no funding source restrictions, the applicant organization may request up to the federally negotiated rate. The total modified direct cost identified in the applicant's FNICR shall be applied. A copy of the FNICR must be included with the applicant's budget.

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[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

If the applicant does not have an FNICR, a 10% indirect cost rate (known as the *de minimis* rate) may be used on the total, modified direct cost as defined in 2 CFR 200.68, *Modified Total Direct Cost (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 minimis rate, or some part thereof. Applicants who do not wish to claim any indirect cost should enter "No indirect cost requested" in the indirect cost line item of the budget narrative.

Prevention (ITTS) State Funded
NC Division of Public Health policy limits indirect cost to 10%.

HIV Care/ R Part B and HOPWA
Per Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (commonly referred to as the Omni-circular), Indirect [facilities & administrative (F&A)] costs means those costs incurred for a common or joint purpose benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved. To facilitate equitable distribution of indirect expenses to the cost objectives served, it may be necessary to establish a number of pools of indirect (F&A) costs. Indirect (F&A) cost pools must be distributed to benefitted cost objectives on bases that will produce an equitable result in consideration of relative benefits derived. [78 FR 78608, Dec. 26, 2013, as amended at 79 FR 75880, Dec. 19, 2014.]

To simplify, Indirect Costs (IDCs) are those costs incurred by the project in support of general business operations, but which are not attributable to a specific funded project.

Indirect Costs + Direct Costs = Total Project Costs.

For all HCP Programs who choose to include IDCs in their contract, the Indirect Cost Rate MUST be calculated on a Modified Total Direct Cost (MTDC) basis, meaning some unallowable costs are exempted when the Indirect Costs are calculated.

Modified Total Direct Cost (MTDC) is determined by adding together all direct costs (-) minus any items which are exempt from IDC costs.

If an HCP grantee has a federally approved Indirect Cost Rate, these projects may charge their federally approved Indirect Cost Rate on all Ryan White and HOPWA contracts up to the respective allowable aggregate administrative cap. (Currently, the Ryan White administrative cap is 10% and the HOPWA administrative cap is 7%.)

(MTDC) x (Federally Negotiated Indirect Cost Rate) = Total Indirect Costs.

A portion of the Total Indirect Costs (calculated using the formula above) may be charged to Ryan White Contracts up to 10% of expenditures.

A portion of the Total Indirect Costs (calculated using the formula above) may be charged to HOPWA Contracts up to 7% of expenditures.

Appendix 27: Acronyms and Abbreviations

AA – Agreement Addendum
ACA – Affordable Care Act
ACS – AIDS Care Services
ADAP – AIDS Drug Assistance Program
AED – Academy for Educational Development
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
Branch – Communicable Disease Branch
BRAT – Behavioral Risk Assessment Tool
CADR – CARE Act Data Report
CAF – Contract Approval Form
CAPER – Consolidated Annual Performance and Evaluation Report (for HOPWA)
CARE Act - Ryan White Treatment Modernization Act of 2009
CBA – Capacity Building Assistance
CBO – Community Based Organization
CCME – Carolinas Center for Medical Excellence
CDB – Communicable Disease Branch
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
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
CW – CAREWare
CY – Calendar Year
DEBI – Diffusion of Evidence-Based Interventions
DHHS – Department of Health and Human Services
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
EtE – Ending the Epidemic
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
GAGAS – Generally Accepted Government Auditing Standards
HAART – Highly Active Antiretroviral Therapy
HAB – HIV/AIDS Bureau
HCBC – Home and Community Based Care
HCFA – Health Care Financing Administration (now CMS)
HCP – HIV Care Program
HCV – Hepatitis C
Hep A – Hepatitis Virus A
Hep B – Hepatitis Virus B
Hep C – Hepatitis Virus C
HETC – HIV Education and Training Center
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
HMAP – HIV Medication Assistance Program
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)
IDC – Indirect Cost
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
MTDC – Modified Total Direct Cost
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
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
PCAP – Premium and Copayment Assistance Program
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)
PHP – Permanent Housing Placement
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
RI – Resource Identification
RNCP – Regional Networks of Care and Prevention
RSR – Ryan White Program Services Report
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)
SSP – Syringe Services Program
STA – Short Term Assistance
STD – Sexually transmitted disease
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)
Unit – HIV/STD Prevention, Care and Viral Hepatitis Unit
UMAP – Uninsured/Underinsured Medication Assistance Program
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 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.

Bridge Counselor: a field service interventionist who provides brief (1-2 contacts) for linkage of newly diagnosed persons with HIV and reengagement of persons living with HIV (PLWH) who were not in care.

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 alterative 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 Network 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 (CPLOT): 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. 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 act.

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.

Ending the Epidemic: A plan under development by the North Carolina Communicable Disease Branch with community participation to end the HIV epidemic in North Carolina.

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.

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 Disparity: a higher burden of illness, injury, disability, or mortality experienced by one group relative to another

Health Equity: Everyone has a fair and just opportunity to be as healthy as possible.

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.

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

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 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.

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.

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 is 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.

Peer Navigator: Role models who provide reliable and relevant information to help clients overcome barriers that may prevent engagement, retention, or re-engagement in treatment.

People who Inject Drugs (PWID): people who are at risk for HIV infection through the use of equipment used to inject drugs, e.g., syringes, needles, cookers, spoons, etc.

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.

Pre-Exposure Prophylaxis (PrEP): a daily medication taken to prevent **HIV** infection.

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 ART: Initiation of HIV medication therapy within seven days of diagnosis.

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; influential.

Statewide Coordinated Statement of Need (SCSN): the Ryan White CARE Act requires all CARE Act Networks 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.

Stigma: negative attitudes and beliefs about people living with **HIV**

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.

Syringe Services Program: community-based prevention programs that can provide a range of services, including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for infectious diseases.

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.

Transitional Grant Area (TGA): an area reporting 1,000 to 1,999 AIDS cases in the most recent five years with 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.

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 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.

Viral Suppression: the amount of HIV in the body is reduced to a very low level, which keeps the immune system working, prevents illness, and helps prevent transmission to others.

Voluntary HIV testing: HIV testing that is offered free of coercion. With voluntary HIV testing, participants can accept or refuse HIV testing.