REQUEST FOR PROPOSALS

DEPARTMENT OF STATE HEALTH SERVICES
HIV/STD PREVENTION AND CARE BRANCH

RYAN WHITE PART B
APRIL 1, 2023 - MARCH 31, 2024
&
STATE HEALTH AND SOCIAL SERVICES PROJECTS
SEPTEMBER 1, 2023 - AUGUST 31, 2024

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.
500 LOVETT BLVD, SUITE 100
HOUSTON, TEXAS 77006
PHONE: (713) 526-1016
FAX: (713) 526-2369

LETTERS OF INTENT ARE REQUIRED
(SEE NEXT PAGE FOR GUIDELINES)
DUE DATE: THURSDAY, NOVEMBER 03, 2022
5:00 P.M., CENTRAL STANDARD TIME
NO PROPOSALS WILL BE REVIEWED WITHOUT
A CORRESPONDING LETTER OF INTENT!

PROPOSAL DUE DATE
THURSDAY, NOVEMBER 17, 2022
5:00 P.M., CENTRAL STANDARD TIME
NO LATE PROPOSALS WILL BE REVIEWED!

500 LOVETT BLVD, SUITE 100
HOUSTON, TEXAS 77006

SUBMIT ONE (1) ORIGINAL AND SEVEN (7) COPIES OF PROPOSAL
ON OR BEFORE INDICATED DUE DATE

LETTERS OF INTENT ARE REQUIRED!

Please submit a letter on agency letterhead addressed to Yvette Garvin, Executive Director, which includes the following information:

1. Applicant's name.
2. HSDA Applicant is applying for services in.
3. Service category(s) in which applicant will submit a proposal. Include all service categories that you will submit proposals for. Failure to submit the specific service category on your letter of intent prohibits your agency from applying in that category.
4. List the dollar amount ($) the applicant will apply for in each category.
5. Authorized signature.

DUE DATE: Thursday, November 03, 2022
5:00 P.M., Central Standard Time
NO EXCEPTIONS! NO EXCEPTIONS!

You must submit a separate letter of intent for each HSDA that you are applying in.

Email your letter of intent to Yvette Garvin (ygarvin@hivtrg.org) your letter; **HOWEVER**, it is **YOUR** responsibility to ensure receipt of the letter.

REMINDER: If you do **NOT** submit your letter of intent, your proposal(s) will **NOT** be reviewed.

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HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP
REQUEST FOR PROPOSALS (RFP)
DEPARTMENT OF STATE HEALTH SERVICES
RYAN WHITE PART B &
HIV HEALTH AND SOCIAL SERVICES PROJECTS (STATE SERVICES)

I. INTRODUCTION

Applications are requested for five HIV Service Delivery Areas (HSDAs): Paris/Texarkana, Tyler/Longview, Lufkin/Nacogdoches, Beaumont/Port Arthur, and Galveston. See Appendix D for a list of the counties cover by each HSDA.

The Houston Regional HIV/AIDS Resource Group, inc. (TRG) is the administrative agency for the five HSDAs in this Request for Proposal (RFP) and will be administering both the 2023-2024 Ryan White Part B Grant and the .2023-2024 State HIV Health and Social Services Projects Grants (hereafter referred to as DSHS State Services).

Any and all requirements contained in the RFP are subject to change pending any changes issued by the Department of State Health Services and its HIV/STD Prevention and Care Branch.

II. LEGAL AUTHORITY

TRG is requesting applications under Texas Health and Safety Code Chapter 12 and Chapter 85, Subchapter A, Section 85.031.

The Ryan White HIV/AIDS Program (RWHAP) is authorized and funded under Title XXVI of the Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009). The legislation was first enacted in 1990 as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. It has been amended and reauthorized four times: in 1996, 2000, 2006, and 2009. Ryan White Part B is administered: 1) at the local level by the Houston Regional HIV/AIDS Resource Group, Inc. (The Resource Group) through a grant from the HIV/STD Prevention and Care Branch, Department of State Health Services and 2) at the state level by the Department of State Health Services (DSHS) through a grant from the Division of Service Systems, HIV/AIDS Bureau (HAB), Health Resources and Services Administration (HRSA), Public Health Service (PHS), U.S. Department of Health and Human Services (HHS).

III. ELIGIBLE APPLICANTS

Eligible applicants for this program are governmental, public, and private non-profit entities located within the five HSDAs: Paris/Texarkana, Tyler/Longview, Lufkin/Nacogdoches, Beaumont/Port Arthur, and Galveston. Eligible entities may include but not limited to city and/or county health departments or districts; non-profit community-based organizations; and public or private non-profit hospitals. **For-profit entities may be funded if such entities are the ONLY available provider of quality HIV care in the area**. **Individuals are not eligible to apply. No funded agency may refuse service to any eligible PLWH who resides in the HSDA. No funded agency may serve PLWHPLWH who reside outside the designated HDSA without an**

approved waiver from The Houston Regional HIV/AIDS Resource Group, Inc.

IV. Purpose Of Project Grants

TRG is contracted by DSHS's TB/HIV/STD Prevention and Care Unit to administer its federal RW Part B funds and State general revenue to provide discretely defined direct services and housing assistance for people living with HIV in Texas. In order to have local access points of care and services, allow for local leadership, and to prevent duplication of services, DSHS awards grants to Administrative Agencies across the State to assist in providing appropriate and prioritized services to people living with HIV in the HIV Service Delivery Areas (HSDA) they serve. TRG receives and distributes funds for services for people living with HIV by contracting with Subrecipients in its assigned HSDAs through a competitive process. The purpose of this RFP is to provide financial assistance to improve the quality, availability and organization of health care and support services for individuals and families living with HIV in the five HSDAs: Paris/Texarkana, Tyler/Longview, Lufkin/Nacogdoches, Beaumont/Port Arthur, and Galveston.

V. Available Funds

This RFP announces funding for the following grants for the five HIV Service Delivery Areas (HSDAs): Paris/Texarkana, Tyler/Longview, Lufkin/Nacogdoches, Beaumont/Port Arthur, and Galveston.

- Ryan White Part B 4/1/2023 – 3/31/2024
- DSHS State Services 9/1/2023 – 8/31/2024

The Department of State Health Services has NOT yet made funding awards for these grants. The allocations contained in this RFP are based on level funding. Once the DSHS makes the final funding awards for these grants, the amount allocated for each service may be increased or decreased.

VI. Description/Funding Of Service Components

TRG is issuing a single RFP for ALL services funded under DSHS State Services and Ryan White Part B. All contracts resulting from this RFP will be for twelve (12) months as follows:

- Ryan White Part B 4/1/2023 – 3/31/2024
- DSHS State Services 9/1/2023 – 8/31/2024

Appendix A (DSHS State Services) and Appendix B (Ryan White Part B) have been generated for each HSDA and contain a listing of those services in the HSDA that have been funded through the community planning process and approved by DSHS. Funds awarded through this RFP will ONLY fund services contained in the Appendix A and B that applies to each HSDA.

Applicants may apply for more than one service contained in this RFP. However, applicants must submit a **separate** application (Section I) for each service proposed for funding. Applicants are required to submit ONLY one (1) Section II. NOTE: <u>If an applicant is applying for multiple HSDAs, a separate application (Section I) must be submitted for each service category in each HSDA. When applying in multiple HDSAs, applicants must submit a **Section II** for each HSDA in which they are applying.</u>

VII. Financial Requirements

Applicants are required to adhere to Federal principles for determining allowable costs. Such costs are determined in accordance with the cost principles of OMB Circular A-87 *Cost Principles for State, Local and Indian Tribal Governments*, OMB Circular A-110 *Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations,* and OMB Circular A-122 *Cost Principles for Non-Profit Organizations;* OMB Circular A-21, which have been incorporated into the Code of Federal Regulations (2 CFR Parts 215, 220, 225, and 230);

A. USE OF FUNDS

1. Allowable Use of Funds
   DSHS funds may be used for costs directly related to providing core medical and support services for individuals with HIV within the HSDA. For the purposes of health insurance premiums, contract funds may be used for the payment of insurance premiums, deductibles, co-insurance payments, and related administrative costs. All costs are subject to negotiation with TRG and DSHS.

2. Administrative Costs
   The Ryan White HIV/AIDS Treatment Extension Act of 2009 mandates a 10% aggregate cap on administrative costs. This cap applies to the total award to the HSDA, not specifically to individual applicants. However, to meet this requirement for the HSDA, each applicant will be expected to stay within the 10% administrative cost limit. Administrative activities include:
   - Usual and recognized overhead although TRG does not accept usage of an established indirect cost rate without prior approval. Usual and recognized overhead includes items such as rent, utility, telephone, and other expenses related to administrative staff; expenses such as liability insurance and audit expenses.
   - Management and oversight of specific programs funded under this RFP. This includes salaries, fringe benefits, and travel expenses of administrative staff, including financial management staff. This includes direct supervision of program staff. *This includes salaries and fringe benefits of staff solely devoted to TCT data entry or management.*

   While there is not a state mandated administrative cap on State Services funds, applicants for State Services funds are also required to stay within the 10% administrative cap requirements of Part B applicants.

   Applicants must comply with the requirements applicable to these funding sources as cited in the *Uniform Administrative Requirements, Cost Principles, and Audit Requirements* for Federal Awards (2 CFR Part 200); the Texas Grant Management Standards (TxGMS) (previously the *Uniform Grant Management Standards (UGMS)*), and all statutes, requirements, and guidelines applicable to this funding.

   If the applicant expends $750,000 or more in total federal funds and $500,000 in state funds awarded during their fiscal year, the applicant shall have a single audit or program specific audit in accordance with the 2 CFR 200.501 and UGMS, State of Texas Single Audit Circular. Audits must be done by an independent certified public accountant and

must be in accordance with the applicable OMB Circular, Government Auditing Standards, and UGCMS, which is accessible on the DSHS website. Costs of this audit can be charged to this budget according to the agency's standard cost allocation plan. If the applicant is not required to have a Single Audit, TRG and the DSHS will provide the Applicant with written audit requirements if a limited scope audit will be required.

3. Disallowed Use of Funds

Program funds may not be used for the following:

a. Inherently religious activities such as prayer, worship, religious instruction or proselytization;
b. Lobbying;
c. Any portion of the salary of, or any other compensation for, an elected or appointed government official;
d. Vehicles or equipment for government agencies that are for general agency use and/ordo not have a clear nexus to terrorism prevention, interdiction, and disruption (i.e., mobile data terminals, body cameras, in-car video systems, or radar units, etc. for officers assigned to routine patrol);
e. Weapons, ammunition, tracked armored vehicles, weaponized vehicles, or explosives(exceptions may be granted when explosives are used for bomb squad training);
f. Admission fees or tickets to any amusement park, recreational activity, or sporting event;
g. Promotional gifts;
h. Food, meals, beverages, or other refreshments, except for eligible per diem associatedwith grant-related travel or where pre-approved for working events;
i. Membership dues for individuals;
j. Any expense or service that is readily available at no cost to the grant project;
k. Any use of grant funds to replace (supplant) funds that have been budgeted for the same purpose through non-grant sources;
l. Fundraising;
m. Acquiring or constructing facilities or permanent improvements of any building or other facility;
n. Making payments for any item or service to the extent that payment has been made,or can reasonably be expected to be made under an insurance policy, or under any federal or State health benefits program and other specified payment sources;
o. Making cash payments to intended PLWH
p. Clothing;
q. Employment and employment-readiness services, except in limited, specified instances (e.g., non-medical case management services or rehabilitation services);
r. Funeral and burial expenses;
s. Property taxes;
t. Pre-exposure prophylaxis;
u. Non-occupational post-exposure prophylaxis;

v. Materials, designed to promote or encourage, directly, intravenous drug use or sexualactivity, whether homosexual or heterosexual.
w. International travel;
x. The purchase or improvement of land; and
y. Any other prohibition imposed by federal, State, or local law.

B. PAYER OF LAST RESORT/MEDICAID

The costs of delivering services should be reasonably shared by the state and federal governments, private health insurers, and, to the extent possible, by the person with an HIV-related condition. To maximize the limited program funds, Ryan White funds should be considered payer of last resort. Applicants must comply with Payer of Last Resort requirementsfound at the following URLs:

- https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-21-02-determining-eligibility-polr.pdf

Applicants must agree to bill third party payers for applicable (where the cost of the service is reimbursable from any third-party source) services provided, at no cost to the PLWH, with the exception of co-payments required by third party payers. These potential payers include private insurance carriers, Medicaid, other available federal, state, local, and private funds, etc. Applicants must have a policy and procedure to govern the processes around Payor of Last Resort. The policy should include a process by which the agency surveys each PLWH to:

a. Determine what employment-based medical insurances each PLWH currently holds;
b. Determine what publicly funded medical insurance benefits (e.g., Medicaid) each PLWH receives;
c. And conduct a financial assessment to determine if the PLWH is eligible for any publicly funded medical insurance benefit program.

Furthermore, the policy will require the agency to create a priority list of all publicly funded medical insurance benefits held within the caseload or that individual PLWHPLWH are potentially eligible for, plus all employment-based medical insurances held by PLWHPLWH with the agency caseload. The policy will require an enrollment process for PLWHPLWH who are potentially eligible for Medicaid and/or other publicly funded health insurance benefit program(s). The policy shall establish a system for charging, collecting, and tracking PLWH monies, including insurance co-payments and PLWH contributions to their own medical care whether on a sliding scale or flat fee basis.

Applicants shall maximize efforts to obtain payment from Medicaid and all other available sources. Applicants who provide Medicaid reimbursable services are required to become Medicaid providers for applicable program activities. Where applicable, applicants must establish the ability to bill private insurance including private health insurance, employer insurance plans, marketplace (ACA) plans and prepaid health plans.

The applicant cannot bill this grant for the provision of eligible services to a Medicaid eligible PLWH. Applicants cannot bill this grant for the provision of eligible services to an individual

who has private insurance including private health insurance, employer insurance plans, marketplace (ACA) plans and prepaid health plans.

C. PLWH CHARGES FOR SERVICES

All applicants must have a sliding-fee schedule in place that uses as its premise the latest Federal Poverty Guidelines. Persons with an annual gross family income at or below 100% of the Federal Poverty Guidelines shall not be charged for any services covered by this funding. In accordance with Title 25 Texas Administrative Code §1.91, no one shall be denied services due to their inability to pay.

PLWH with income exceeding 300% (except in the services category of Health Insurance and Cost Sharing Assistance and Food Pantry) of the federal poverty guidelines cannot be served with these funds. Additional income limitations are included in the individual service categories (see Appendix A – Ryan White Part B and Appendix B –DSHS State Services) if applicable.

Please refer to the following chart for allowable charges:

INDIVIDUAL/FAMILY MODIFIED ADJUSTED GROSS INCOME (MAGI)	TOTAL ALLOWABLE ANNUAL CHARGES TO PLWHPLWH
Equal to or below the official poverty line	No charges permitted
101 to 200 percent of the official poverty line	5 percent or less of MAGI
201 to 300 percent of the official poverty line	7 percent or less of MAGI
301 to 500 percent of the official poverty line	10 percent or less of MAGI

The 2022 HHS Poverty Guidelines are as follows:

SIZE OF FAMILY UNIT	POVERTY GUIDELINE
1	$ 13,590
2	$18,310
3	$23,030
4	$27,750
5	$32,470
6	$37,190
7	$41,910
8	$46,630

For family units with more than 8 members, add $4,720 for each additional member.

*Applicants are required to utilize the **most current** Federal Poverty Guidelines in determination of potential allowable charges. Applicants are required to adopt Modified Adjusted Gross Income (MAGI) for determination of income. Additional resources on MAGI can be located at https://www.dshs.texas.gov/hivstd/magi*

D. PROGRAM INCOME

All revenues received for services provided by these funds are considered program income. Any revenues generated from third-party reimbursements/private insurance, Medicaid, Medicare or 340b pharmacy constitute program income. Applicant must report how such program income is used by the Subrecipients to advance the objectives of the HIV/AIDS program. All program income generated as a result of program funding must be used for allowable current costs, and the income shall be budgeted and expended during the budget period in which it is realized. The receipt and expenditure of all program income shall be reported on the monthly expense report and the quarterly financial report. Please refer to the 2/5/2018 Texas Health and Human Services GTAG (at https://dshs.texas.gov/contracts/gtag.aspx) and the 2017 HHSC Uniform Terms and Conditions, Version 2.15 (at https://apps.hhs.texas.gov/PCS/HHS0000310/Exhibit-B-UTC-Grantee.pdf) for detailed requirements for program income.

Within thirty (30) days of the executed contract, submit to DSHS an annual forecast of all program income, including but not limited to, 340B-generated revenue expected to be earned by 340B-covered entities as program income from Ryan White Part B activities. AAs must also make available documentation to show how all program income is allocated and expended during annual AA monitoring visits or upon request.

Track and report the use of program income that is generated by services and activities provided by Applicant and funded by the RWHAP, as required.

E. FINANCIAL MANAGEMENT STANDARDS

Applicants are required to follow *Uniform Administrative Requirements, Cost Principles, and Audit Requirements* for Federal Awards (2 CFR Part 200); the Texas Grant Management Standards (TXGMS) (previously the *Uniform Grant Management Standards (UGMS)*), and all statutes, requirements, and guidelines applicable to this funding. The Uniform Guidance can be reviewed at http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl and the TXGMS can be found at https://comptroller.texas.gov/purchasing/grant-management/ Technical assistance in the application of these procedures is available from the Finance Department of TRG upon award of grant.

Applicants will develop, implement, and maintain financial management and control systems that meet or exceed the requirements of TXGMS. Those requirements include at a minimum:

1. Financial planning including the development of budgets that adequately reflect all functions and resources necessary to conduct authorized activities and the adequate determination of costs;

2. Financial management system including accurate, correct, and complete payroll, accounting, and financial reporting records; cost source documentation, effective internal and budgetary controls; determination of reasonableness, allowability, and allocability of costs; and timely and appropriate audits and resolution of any findings; and,
3. Billing and collection policies including a charge schedule, a system for discounting or adjusting charges based on a person's income and family size, and a mechanism capable of billing and making reasonable efforts to collect from patients and third parties.

VIII. General Requirements

A. Confidentiality

Strict confidentiality of all records is essential. Applicants must have a system, including detailed policies and procedures, in effect to protect primary service records and all other documents deemed confidential by law that are maintained in connection with the activities funded under this grant. All disclosures or transfers of protected information must be done in full compliance with applicable laws, including appropriately signed release of information forms, where applicable. All release of confidential information forms must comply with TRG's policy on Exchange/Release of Information (available upon request).

All applicant agencies must be in full compliance with the current regulations and rules of the Health Insurance Portability and Accountability Act (HIPAA).

The "Health and Safety Code" of the State of Texas provides for both civil and criminal penalties against anyone who violates the confidentiality of persons protected under the law. All employees, volunteers, and members of the Board of Directors of applicant agencies are required to sign statements of confidentiality assuring compliance with applicable laws.

B. Protocols and Standards

Applicants are required to adopt applicable written protocols based on the latest medical knowledge for the care and treatment of people living with HIV. These clinical protocols include, but are not limited to the most current version of the following:

- DSHS' HIV and STD Program Operation Procedures and Standards:

- Chapter 6A (Public Health Service) of Title 42 (The Public Health and Welfare) of the United States Code, as amended:
    - http://www.fda.gov/RegulatoryInformation/Legislation/ucm148717.htm

- Chapters 81 and 85 of the Texas Health and Safety Code:
    - http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.81.htm
    - http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.85.htm

- Clinical Manual for Management of the HIV-Infected Adult 2006 Edition, or latest edition. AIDS Education Training Center.
    - http://www.aids-ed.org/pdf/AETC-CM_071007.pdf

- Department of State Health Services Standards for Public Health Clinic Services

- DSHS Program's HIV/STD Clinical Resources Standards for Case Management Services

- Public Health Service Task Force Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmissions in the United States – July 31, 2012, or latest version
    - http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf

- Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents, February 12, 2013, or latest version; as developed by the DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents- a working group of the Office of AIDS Research and Advisory Council (OARAC)
    - http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf

- Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection; Health Resources and Services Administration (HRSA) and National Institutes of Health (NIH), November 1, 2012, or latest version; as developed by the Working Group on Antiretroviral Therapy and Medical Management of HIV-Infected Children convened by the National Resource Center at the Francois-Xavier Bagnoud Center, UMDNJ. The Health Resources and Services Administration (HRSA) and National Institute of Health (NIH).
    - http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf

- Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents): Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America
    - http://aidsinfo.nih.gov/contentfiles/Adult_OI.pdf (added)

- Guidelines for Prevention and Treatment of Opportunistic Infections among HIV-Exposed and HIV-Infected Children – September 4, 2009, or latest version. Recommendations from Centers for Disease Control and Prevention, the National Institutes of Health, the HIV Medicine Association of the Infectious Diseases Society of America, the Pediatric Infectious Diseases Society, and the American Academy of Pediatrics:
    - http://aidsinfo.nih.gov/contentfiles/Pediatric_OI.pdf

- Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis - September 30, 2005:
    - http://aidsinfo.nih.gov/contentfiles/HealthCareOccupExpoGL.pdf

- Incorporating HIV Prevention into the Medical Care of Persons Living with HIV – July 18, 2003, or latest version. Recommendations of the CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America:

- http://aidsinfo.nih.gov/contentfiles/HIVPreventionInMedCare_TB.pdf

- Prevention and Treatment of Tuberculosis Among Patients Infected with Human Immunodeficiency Virus: Principles of Therapy and Revised Recommendations. Center For Disease Control (CDC) Morbidity & Mortality Weekly Report (MMWR) 1998; 47(No RR-20), 1-51:
  - http://www.cdc.gov/mmwr/Preview/mmwrhtml/00055357.htm

- Perspectives in Disease Prevention and Health Promotion Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Blood-borne Pathogens. Center for Disease Control (CDC) Morbidity & Mortality Weekly Report (MMWR) June 24, 1988/ 37(24); 377-388:
  - http://www.cdc.gov/mmwr/preview/mmwrhtml/00000039.htm

- DSHS Program's Universal Precautions Preventing the Spread of HIV, Tuberculosis, and Hepatitis B in Employees of HIV/STD Funded Programs

- DSHS' STD Standards of Care and Monitoring Guidelines

- Sexually Transmitted Diseases Treatment Guidelines, 2006, or latest version. Morbidity and Mortality Weekly Report August 4, 2006
  - http://www.cdc.gov/std/treatment/2006/rr5511.pdf

- Child Abuse Reporting Requirements for DSHS Contractors/Providers

- Guidelines and Recommendations for the Prevention of Perinatal HIV Transmission in Texas. HIV testing of Pregnant Woman in Texas. 2010
  - https://www.texmed.org/template.aspx?id=16401

- Additional guidelines for HIV Treatment:
  - https://aidsinfo.nih.gov/guidelines

C. ASSURANCES & CERTIFICATIONS

Applicants must submit current, signed, and annually dated assurances adhering to the following (a copy of these forms is included in the Forms Section):
Applicants must submit current, signed, and annually dated assurances adhering to the following (a copy of these forms is included in the Forms Section):

- Form E-2: DSHS Assurances and Certifications
- Form E-3: HIV Contractor Assurances
- Form E-4: Nonprofit Board Member and Executive Officers Assurance
- Form E-5: General Provisions for Grant Agreement Assurances

D. Required Documents

ALL applicants must submit the following CURRENT documents:

- Form: E-6: Renewal Option Form (if electing to seek funding renewal for additional four years)
- Board of Directors List
- Articles of Incorporation
- Board of Director's Bylaws
- IRS Non-Profit Determination Letter
- Current Financial Audit in accordance with the OMB Circular A-133 or most recent financial audit **or** DSHS Single audit waiver form for agency's not required to complete a single audit.

Copies of ALL *Assurances, Certifications,* and *Required Documents* MUST be kept on-file at the applicant's business office for review by Resource Group staff at annual on-site reviews. Required documents should be sent to The Resource Group when revised and/or altered.

Non-compliance with all *Assurances, Certifications,* and *Required Documents* could result in the suspension or termination of funding; therefore, it is imperative that the applicant read, understand, and comply with these documents.

E. Policies of the Texas Department of State Health Services

All applicants must agree to abide by all applicable policies adopted by the Texas Department of State Health Services. All Policies located at https://www.dshs.texas.gov/hivstd/policy/

F. Federal Ryan White Policy Notices

Applicants applying for Ryan White Part B funding must agree to abide by all applicable policies adopted by the HRSA HIV/AIDS Bureau. All Policy Notices located at https://ryanwhite.hrsa.gov/grants/policy-notices

G. Program Reporting

1. Quality management reporting

In an effort to evaluate the quality of services being provided, funded agencies will be required to collect and report information in accordance with the established outcome measures for each HSDA. Quarterly updates on quality management activities are reported as part of the Unified Quarterly Report.

2. Unified Quarterly Report

Funded agencies will be required to collect and maintain relevant data documenting the progress toward the contract goals and objectives as well as any other data requested by The Resource Group. Such data is reported in the Unified Quarterly Report. This report consists of narrative updates on various requirements and expectations conducted during the period. Funded agencies will need to respond thoroughly and thoughtfully to each

question of the report, as applicable. This report is required to be submitted quarterly according to the schedule below:

Quarter	First	Second	Third	Fourth
Period Covered	Jan-March	April-June	July-Sept	Oct-Dec
Due Date	April 20th	July 20th	October 20th	January 20th

Failure to comply with the deadlines and content requirements will result in an interruption of monthly reimbursements.

3. DATA IMPROVEMENT PLAN

The Resource Group requires that all funded agencies submit a Data Improvement Plan that outlines how they will ensure that the PLWH-level and service utilization data being entered is complete and accurate. The plan will identify specific data elements and, areas of improvement to be addressed in each quarter and establish quantifiable benchmarks to achieving improvement. The plan will be monitored as part of the Unified Quarterly Report.

4. CLIENT -LEVEL DATA REPORTING

The Resource Group requires that funded agencies submit the required client-level data (CLD) through the approved CLD system to support its monthly reimbursements. CLD includes, but is not limited to, PLWH served per provider/service, basic demographic information, relevant medical markers and co-morbidities, and service encounters. The approved CLD system for the DSHS State Service and Ryan White Part B funding is the Take Charge Texas (TCT) system. Applicants will be required to obtain access to TCT within thirty (30) days of the contract start date and maintain access through the term on the contract. CLD should be entered/updated within five (5) days of service encounter unless otherwise instructed in less time according to the Agency Protocol. On a monthly basis, applicants will be required to submit a TCT Statistical Analysis Report (STAR) with its monthly expense reports.

5. RYAN WHITE SERVICE REPORT

The Resource Group requires that all Part B funded agencies submit the required Ryan White Services Report (RSR) that includes de-identified PLWHCLD reporting for PLWHPLWH served per provider into two reports, the Data Improvement Plan, and the Ryan White Completeness Report quarterly. These reports will follow the Unified Quarterly schedule for submission. Annually, the RSR is required to be submitted into the Health Resources and Services Administration (HRSA) Electronic Handbook (EHB) for all data from the previous year. This data includes basic demographic information, relevant medical markers and co-morbidities, minority composition of entity's board and/or staff, amounts and types of services provided, PLWHPLWHPLWH, amount of HIV/AIDS funding by source and information on numbers. By February 15 of each year, all Part B Applicants must submit reports to The Resource Group summarizing activities from January through December of the previous calendar year (i.e., the 2023 RSR includes data from January 1, 2022, through December 31, 2022). The Resource Group will provide the required format for submission of the RSR.

H. FINANCIAL REPORTING

1. MONTHLY EXPENSE REPORTS

Monthly Expense Reports which include the budget versus actual (expense incurred) report are required no later than 10 days after the end of each month. The A TCT Star Report must accompany the monthly expense reports. Monthly Expense Reports submitted late will be paid on the last business day of the following month. TRG will provide contractors with forms to use for this report. These reports are to be mailed or delivered to Finance Department, Houston Regional HIV/AIDS Resource Group, 500 Lovett Blvd, Suite 100, Houston, Texas 77006. A Monthly Expense Report must be submitted whether program funds have been expended during the month or not.

2. VARIANCE REPORTS

The Finance Department will issue a variance report to any applicant that is ten (10%) percent below or above the targeted spending level for each funded service category after six, nine and eleven months. TRG will send emails with deadline and report to complete. A response to the report is required by deadline established in the communication. Failure to submit these reports can result in a hold placed on monthly reimbursement or automatic reduction in award amount.

3. QUARTERLY FINANCIAL REPORTS (FSR 269A)

Quarterly financial reports are required no later than 30 days after the end of each grant quarter for agencies. The report will show actual agency expenses for the quarter, number of units of service provided, and program income, if any. The purpose of the report is to determine whether the reimbursement rate is in excess of the agency's actual unit cost. Agencies are not permitted to make a profit with grant funds. When the final FSR is submitted, and a refund needs to be made of excess monies if costs incurred were less than funds received. A check for excess monies received must accompany the final financial report.

4. FINAL EXPENSE REPORT

A final expense report must be submitted no later than 15 days after the end of the budget period if all allowable costs have not been recovered. No expenses will be considered for reimbursement unless submitted by this deadline.

I. PARTICIPATION IN THE COMMUNITY PLANNING PROCESS

Applicants applying for funding must agree to participate in all applicable Community Planning processes mandated by DSHS, including, but not limited to the following:

a. Coordinate community input procedures as needed, including publicizing relevant meetings, establishing stakeholder panels, etc.
b. Participate in meetings to establish and update service category priorities for the allocation of funds based on data collected by the Administrative Agencies and through planning activities;

c. Participate in the establishment and/or updating of allocation plans for each service category based on data collected by the Administrative Agencies and through planning activities;
d. Participate in meetings and correspondences to develop and update a regional comprehensive service delivery plan that coordinates and integrates HIV health and support services for people living with or at risk for HIV and families affected by HIV;
e. Collaborate with The Resource Group in planning for and implementing a comprehensive assessment of HIV/AIDS service needs for the planning area every three years and supplemental needs assessment activities in the interim years;
f. Collaborate with The Resource Group in conducting needs assessment activities in each HSDA in accordance with requirements of DSHS and the Health Resources and Services Administration (HRSA).

J. MEANINGFUL ENGAGEMENT

Applicants applying for funding must agree to encourage the meaningful participation of people living with HIV in the planning, implementation, and evaluation of services, including, but not limited to the following:

a. Develop and maintain an Advisory Board of at least five PLWH who provide feedback quarterly.
b. Document and report all activities (i.e., duties, opportunities, training, workshops, and consumer meetings) that occur to engage with PLWH, including but not limited to Advisory Board meetings and focus groups.
c. Actively engage PLWH in developing, implementing, and evaluating the service funded under the RFP.
d. Document and provide information on PLWH concerns or complaints and how they are addressed. Develop and maintain evidence and documentation of identified problems, barriers, and topics related to service delivery changes and the improvements made to systems based on this information.
e. Actively engage PLWH as partners in their care and treatment planning.

K. CONTINUUM OF HIV CARE/TREATMENT CASCADE

Identifying persons living with HIV and linking them to HIV primary care with initiation and long-term maintenance of life-saving antiretroviral treatment (ART) are important public health steps toward the elimination of HIV in the United States. The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is referred to as the Continuum of HIV Care or Care Treatment Cascade. 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 HIV viral load suppression.

Applicants must ensure that funded services support the Continuum of HIV Care.

L. GUIDING DOCUMENTS

1. HEALTHY PEOPLE 2030

The Healthy People initiative began in 1979 when Surgeon General Julius Richmond

issued a landmark report titled "Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention." Then, in 1980, ODPHP released Healthy People 1990 — the first set of ambitious, measurable 10-year objectives for improving health and well-being nationwide. Every decade, the Healthy People initiative develops a new set of evidence-based objectives with the goal of improving health and well-being nationwide. Healthy People 2030 is the fifth iteration of the initiative and addresses the latest public health priorities. The Mission of Healthy People 2030 is to promote, strengthen, and evaluate the nation's efforts to improve the health and well-being of all people.

Foundational Principles of Healthy People 2030

- The health and well-being of all people and communities is essential to a thriving, equitable society.
- Promoting health and well-being and preventing disease are linked efforts that encompass physical, mental, and social health dimensions.
- Investing to achieve the full potential for health and well-being for all provides valuable benefits to society.
- Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.
- Healthy physical, social, and economic environments strengthen the potential to achieve health and well-being.
- Promoting and achieving health and well-being nationwide is a shared responsibility that is distributed across the national, state, tribal, and community levels, including the public, private, and not-for-profit sectors.
- Working to attain the full potential for health and well-being of the population is a component of decision-making and policy formulation across all sectors.

Overarching Goals of Healthy People 2030

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to act and design policies that improve the health and well-being of all.

Applicants must ensure that funded services support the goals and objective of Healthy People 2030.

2. NATIONAL HIV/AIDS STRATEGY (NHAS)/HIV NATIONAL STRATEGIC PLAN

In January 2021, the U.S. Department of Health and Human Services (HHS) released the HIV National Strategic Plan for the United States: A Roadmap to End the HIV Epidemic (2021-2025). The vision of the NHAS calls for the United States to

"become a place where new HIV diagnosis are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance will have unfettered access to high-quality, life extending care, free from stigma and discrimination." The NHAS is the nation's first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved. The National HIV/AIDS Strategy (NHAS) has three primary goals: (1) reducing the number of persons who become diagnosed with HIV; (2) increasing access to care and optimizing health outcomes for persons living with HIV; and (3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for persons living with HIV (PLWH) to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care, and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify persons who are living with HIV but do not know their serostatus and reduce stigma and discrimination against persons living with HIV.

Applicants must align funded services, within the parameters of the RWHAP statute and program guidance, with these strategies.

3. **THE SEXUALLY TRANSMITTED INFECTIONS (STI) NATIONAL STRATEGIC PLAN**
   The *Sexually Transmitted Infections National Strategic Plan* - PDF (STI Plan) is a groundbreaking, first-ever, five-year plan that aims to reverse the recent dramatic rise in STIs in the United States. The STI Plan sets a vision as well as goals, objectives, and strategies to respond to this STI epidemic. It also includes indicators with measurable targets to track progress. The STI Plan aims to provide a roadmap for a broad range of stakeholders—including public health, health care, government, community-based organizations, educational institutions, researchers, private industry, and academia—to develop, enhance and expand STI prevention and care programs at the local, state, tribal and national levels over the next five years.

   Applicants must align funded services, within the parameters of the RWHAP statute and program guidance, with the STI National Strategic Plan.

4. **VIRAL HEPATITIS STRATEGIC PLAN**
   The *Viral Hepatitis National Strategic Plan: A Roadmap to Elimination 2021-2025* (Viral Hepatitis Plan, Plan) - PDF provides a framework to eliminate viral hepatitis as a public health threat in the United States by 2030. The Viral Hepatitis Plan focuses on hepatitis A, hepatitis B, and hepatitis C—the three most common hepatitis viruses that have the most impact on the health of the nation. The Plan is necessary as the nation faces unprecedented hepatitis A outbreaks, progress on preventing hepatitis B has stalled, and hepatitis C rates nearly tripled from 2011 to 2018. The Plan provides goal-oriented objectives and strategies that can be implemented by a broad mix of stakeholders at all levels and across many sectors, both public and private, to reverse the rates of viral hepatitis, prevent new infections, improve care and treatment, and ultimately eliminate

viral hepatitis as a public health threat in the United States.

Applicants must align funded services, within the parameters of the RWHAP statute and program guidance, with the Viral Hepatitis National Strategic Plan.

5. ENDING THE HIV EPIDEMIC

In February 2019, the Ending the HIV Epidemic in the United States (EHE) initiative was launched to further expand federal efforts to reduce HIV diagnoses. This 10-year initiative seeks to achieve the important goal of reducing new HIV diagnoses in the United States to fewer than 3,000 per year by 2030. The initiative promotes and implements four strategies to substantially reduce HIV transmissions – Diagnose, Treat, Prevent, and Respond. The initiative is a collaborative effort among key U.S Department of Health and Human Services (HHS) agencies, primarily HRSA, the Centers for Disease Control and Prevention (CDC), the National Institutes of Health(NIH), the Indian Health Service (IHS), and the Substance Abuse and Mental HealthServices Administration (SAMHSA).

For the RWHAP, the EHE initiative expands the program's ability to meet the needs of PLWH specifically focusing on linking people with HIV who are either newly diagnosed, diagnosed but currently not in care, or are diagnosed in care but not yet virally suppressed to the essential HIV care and treatment and support services needed to help them achieve viral suppression.

Applicants must align funded services, within the parameters of the RWHAP statute and program guidance, with Ending the HIV Epidemic.

6. ACHIEVING TOGETHER (TEXAS HIV PLAN)

Achieving Together is a road map for preventing new HIV diagnoses in Texas and ensuring that individuals living with HIV have access to systems of care. Achieving Together offers a comprehensive approach to reducing HIV based on public health principles, advances in science and research, and the continuum of HIV care. The continuum provides the range of possible engagement, beginning with awareness of HIV status, spanning a range of engagement levels, and ending with people fully engaged in medical care and virally suppressed.

The goals and accompanying strategies in this plan were developed with input from persons living with HIV (PLWH) and other stakeholders across Texas. This plan is intended to prioritize actions and coordinate the use of resources across individuals and organizations in communities and groups affected by HIV, to identify common goals, and align strategies and evaluation. The Plan is meant to enrich local action rather than specifically direct it. By seeing specific actions and programs as part of this broad spectrum of HIV engagement, organizations and programs can amplify the effects of their response by connecting with others whose work may be up or down stream from theirs. Linked arms bridge gaps and form strong barricades against viral encroachment.

Applicants must align funded services, within the parameters of the RWHAP statute and

program guidance, with Achieving Together.

M. USING DATA EFFECTIVELY

HRSA and CDC's Division of HIV/AIDS Prevention support integrated data sharing, analysis, and utilization for the purposes of program planning, conducting needs assessments, determining unmet need estimates, reporting, quality improvement, enhancing the HIV care continuum, and public health action. Integrated data sharing, analysis, and utilization of HIV data by state health departments can help further progress toward reaching the HIV National Strategic Plan goals and improve outcomes on the HIV care continuum.

Applicants should:

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

N. DSHS DATA USE AGREEMENT

If this application is funded, the Applicant will be required to execute a Data Use Agreement (DUA) with DSHS and TRG. The purpose of this DUA is to facilitate access to, creation, receipt, maintenance, use, disclosure, or transmission of Confidential Information and describe Applicant's rights and obligations with respect to the Confidential Information and the limited purposes for which the Applicant may create, receive, maintain, use, disclose or have access to Confidential Information. This DUA also describes remedies in the event of Applicant's noncompliance with its obligations under this DUA. This DUA applies to both business associates, as "business associate" is defined in the Health Insurance Portability and Accountability Act (HIPAA), and subcontractors who are not business associates, who create, receive, maintain, use, disclose or have access to Confidential Information.

The Data Use Agreement is available to review upon request.

O. LOCAL RESPONSIBLE PARTY (LRP)

The Applicant will designate a Local Responsible Party (LRP) from its staff who is responsible for ensuring the security of the TB/HIV/STD PHI maintained by the Applicant as part of the activities required under this contract. The LRP will

1. Ensure appropriate policies/procedures are in place for handling PHI, for releasing confidential PHI data, and for any rapid response due to suspected breaches of protocol and/or confidentiality.
2. Ensure security policies are reviewed periodically for efficacy, and monitor evolving technology (e.g., new methods hackers are using to illegally access PHI; new technologies for keeping PHI protected from hacking) on an ongoing basis to ensure that PHI remain as secure as possible.
3. Approve any Applicant staff requiring access to PHI. The LRP will grant authorization to staff who have a work-related need (i.e., work under this contract) to view TB/HIV/STD PHI.

4. Approve access to required PLWH-level data systems, ensure required trainings (data security/confidentiality, cybersecurity) are completed and documentation submitted to TRG, and verifies the data system permissions assigned to staff correspond to their role under this contract.
5. Ensure Applicant staff with access to PHI are trained on federal and State privacy laws and policies before access to PHI is granted. This training will be renewed once each year.
6. Thoroughly and quickly investigate all suspected breaches of confidentiality in consultation with the TRG LRP to remain in compliance with the TRG's Breach of Confidentiality Response Policy.

P. CLIENT-LEVEL DATA (CLD) SYSTEM TRAINING REQUIREMENT:
As per House Bill 3834 (86R), Applicant staff requiring access to an HHS computer system or database is required to complete a DIR certified Cybersecurity training program during the initial term of the contract and each renewal period. For additional information see the HHS Webpage at https://hhs.texas.gov/doing-business-hhs/contracting-hhs/vendor-resources (Under "Information Security Resources") and the DIR Webpage at https://dir.texas.gov/View-About-DIR/Information-Security/Pages/Content.aspx?id=154. In addition to the DIR certified Cybersecurity training, CLD system users must complete the Data Security and Confidentiality training via the TRAINTexas annually. Certificates of completion for both trainings must be submitted to TRG when requesting access to the CLD system. Trainings certificates must be submitted annually thereafter.

Q. ELIGIBILITY FOR SERVICES
Applicant will ensure that all PLWH are eligible to receive services at least every six (6) months including an annual certification (conducted based on PLWH's birthdate) and six-month attestation conducted six months after the PLWH's certification (conducted based on the PLWH's half-birth month). Eligibility that must be assessed includes HIV diagnosis, income, residency, and potential third-party payers. Documentation of HIV diagnosis, income, residency, and third-party screening must be maintained in the Applicant's primary service record for all PLWH served by the Applicant and comply with the policy referenced above.

R. CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)
Applicants receiving funding must take steps to ensure that people with Limited English Proficiency (LEP) can meaningfully access health andsocial services. A program of language assistance should provide for effective communication between the service provider and the person with LEP to facilitateparticipation in, and meaningful access to, services. The obligations of recipientsare explained on the Office for Civil Rights (OCR) website at https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html. Additionally, obligations of Applicants are explained on theOCR website at http://www.hhs.gov/civil-rights/index.html.

Applicants will provide services in accordance with the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (https://thinkculturalhealth.hhs.gov/).

S. COLLABORATION IN DELIVERY OF HIV/AIDS SERVICES REQUIREMENTS

Applicant must ensure services funded under this contract,include either direct service provision by the Applicant or by Applicant referral, for:

a. Screening, diagnosis, and treatment of sexually transmitted diseases (STDs);
b. Screening, diagnosis, and treatment of hepatitis A, B, and/or C;
c. Screening, diagnosis, and treatment of tuberculosis (TB); and
d. Mental health and substance abuse services, as deemed appropriate by the providerwho performs the screening.

Services under this category must offer HIV/STD risk reduction services, education, and partner services in conjunction with local STD programs. If such care is obtained through a referral, Applicants must attempt to eliminate any barriers PLWH may have to seeking care prior to making referrals. Applicants is responsible for tracking referrals to HIV/STD care and for completion of services rendered.

Applicants must develop and establish a mechanism to facilitate collaboration with other agencies and individuals with expertise in the delivery of HIV/AIDS services and with knowledge of the target population(s) needs.

Applicant must, within thirty (30) days of the effective date of this contract,establish a Memorandum of Agreement with each local health department (or DSHS regional office, in an area without a local health department) within its service area. The memorandum must be designed to facilitate linking individuals who meet Ryan White eligibility criteria to local STD and TB programs, so that those individuals may receive appropriate services from the local programs.

Applicant must lead the establishment of formal systems and standing procedures for linking PLWH to primary care, so that all PLWH have a provider for non-HIV related illnesses. Applicants must maintain referral relationships with mental health entities in their service area that can serve as key points of access to the health care system for people livingwith HIV and provide referrals into the care system. Finally, Applicant must collaborate with hospital discharge planners to strengthen efforts for linking people living with HIV to HIV-related medical care.

T. GRANTS MONITORING

All funds issued must be monitored to ensure stewardship and compliance with all applicable Federal, State, and local requirements. Monitoring is accomplished through various mechanisms such monthly expenditure reporting and required supporting documentation, fiscal reporting, data reporting, progress reports (i.e., Unified Quarterly report), and quality compliance review (QCR) visits. QCR visits are conducted at a minimum annually (and more often, if necessary) and are designed to verify observance of applicable rules and regulations for the funded service(s). QCRs focus on issues of administrative, clinical (if applicable), consumer involvement, data management, fiscal, HOPWA (if applicable), staff and consumer interviews, programmatic and quality management.

In light of the COVID-19 pandemic, TRG has moved to virtual monitoring to reduce the potential spread of the disease. This transition to virtual monitoring will continue beyond the current health crisis. Virtual monitoring reduces the burden of monitoring on the Applicant and TRG. Therefore, the Applicant should establish policies and/or procedures that allow for virtual monitoring to the greatest extent possible.

Applicant must comply with all monitoring systems and ensure funded services delivered in a manner consistent with monitoring standards. TRG monitoring tools are available upon request (email plmartin@hivtrg.org for electronic copies).

U. EMPLOYING BEST PRACTICES IN SERVICE DELIVERY

HRSA has a number of projects and resources that may assist Applicants with program implementation. These include a variety of HRSA cooperative agreements, contracts, and grants focused on specific technical assistance (TA), evaluation, and intervention activities. A list of these resources is available on TargetHIV. Applicants should be familiar with these resources and are encouraged to use them as needed to support their program implementation.

Additionally, the RWHAP Recipient Compilation ofBest Practices Intervention Strategies (Best Practices Compilation) includes strategies that have been implemented in real world settings and that improve outcomes along the HIV care continuum. The Best Practices Compilation is an easily searchable resource to support Applicants' work and the needs of the people served by the RWHAP.

V. SOCIAL DETERMINANT OF HEALTH

Social determinants of health (SDOH) are conditions in which people are born, grow,live, work, and age. SDOH include factors like socioeconomic status, education, neighborhood and physical environment, community violence, employment, and social support networks, as well as access to health care. Applicants should screen for SDOH and address them in the course of service delivery to increase service outcomes.

W. INTIMATE PARTNER VIOLENCE

In 2017, HRSA launched its Strategy to Address IPV, an effort to address this critical social determinant of health through agency-wide collaborative action. The Strategy includes four priority areas including (1) Training the nation's health workforce, (2) Building partnerships to raise awareness, (3) Increasing access to quality care, and (4) Addressing gaps in knowledge about IPV risks, impacts, and interventions. Applicants are encouraged to consider one or more of these priority areas, as relevant, in the development and measurement of their initiative.

X. TREATMENT AS PREVENTION

Applicants should incorporate HHS Guidelines on Antiretroviral Therapy to Prevent Sexual Transmission of HIV (Treatment as Prevention) and the Centers for Disease Control's Recommendations for HIV prevention with adults and adolescents with HIV in the United States, 2014: Summary for clinical providers. These guidelines include new and longstanding federal guidance on biomedical, behavioral, and structural interventions that

can decrease HIV transmission from persons with HIV by promoting adherence to antiretroviral therapy (ART) and reducingtheir HIV viral load.

IX. GRANT APPLICATION INSTRUCTIONS

This section contains instructions for writing your application. Forms specified have been included in the Forms Section of this announcement and should be inserted in the application as noted. **Omission of any or all forms may be cause to reject your proposal in its entirety.** Your completed application must follow this outline with the required information provided in the ORDER shown. **All proposals are to be submitted in two separate sections.**

Section I contains Items A-F listed. There must one (1) original and seven (7) copies of Section I submitted or the proposal will not be reviewed.

Section II contains only Item G (Other Required Documents) listed below. Only one (1) original copy of Section II must be submitted. Please number this section separately from Section I.

All proposals must be in English. All proposals must be typewritten using standard size **black** Times New Roman font no smaller or larger than 12-point (color printing is **not** allowed) on 8 1/2" by 11" paper. Text must be double-spaced ***(only forms may be single spaced)*** and have margins of one inch on all sides. **All pages must include typewritten or computer-generated page numbers on ALL pages** (including all forms, title pages, and all appendices); and printed only on one side of each page. Brochures, pamphlets, booklets, etc. included in Appendices are not bound by these restrictions but must be identified by a single page number on the cover of that item and that entire item is considered as a single page. Any such items that cannot go into a typewriter may have a neat and legible handwritten page number. Section dividers or title pages included in the proposal must also have a consecutive page number. Proposals must be received on time.

Proposals without the required number of copies and/or not received on time will not be reviewed. Do not submit double-sided copies. Do not use photo-reduction.

A. APPLICATION FOR FINANCIAL ASSISTANCE

Use **Form A-1** provided. ALL sections of this form must be completed! UIN not DUNS

B. APPLICATION CHECKLIST

Use **Form A-2** provided. Use the application checklist to ensure that all required information has been included in the application. Page numbers must be included. This serves as a table of contents.

C. AGENCY CONTACT LIST

Use **Form A-3: Agency Contact List** provided. Designate a staff contact for each grant function. If the proposed service is not a core medical service (see Appendix D), your agency is not required to have a clinical services contact.

D. PROJECT NARRATIVE

The Project Narrative must provide all of the following information in the order listed below about the applicant and the proposed project. Narrative answers/statements must be self-explanatory and understandable to members of the independent review panel who may read, evaluate, and score your proposal. Assume that those individuals are unfamiliar with your agency and its programs, and that they have little information about your target population.

The Project Narrative must not exceed thirty (30) double-spaced, typewritten or computer-generated pages**. Please repeat each question and answer each question separately and in order. When referencing Forms and Appendices in your response to a question, please include the page of that document within your application.** FORMS DO NOT COUNT TOWARDS YOUR 30 PAGES LIMIT.

1. DESCRIPTION OF THE ORGANIZATION

a. Describe the history of your agency including your agency's overall mission. Describe your agency's historical experience in providing services to People Living with HIV (PLWH) in the Designated HSDA. If your agency has not provided services to PLWH in the past, please describe why you are applying to start serving PLWH.

b. Briefly describe your agency's structure. Provide a narrative of the organizational structure, such as management and other key staff positions; board of directors and its components (i.e., officers, advisory councils, and/or committees). Include an **organizational chart** in the appendices. Also include **job descriptions and resumes** for **every** position listed in your budget. Include resumes (not to exceed 2 pages) for **all existing staff** listed in the budget in the appendices. Job description title **must** match the position title listed in the Line-Item Budget & Categorical Budget Justification Forms (Form D-4).

c. Describe all of your agency's **current programs and activities**, especially those targeted to PLWH in the applicable HSDA.

d. Describe your agency's Information Technology (IT) support infrastructure; including qualifications and experience of staff assigned to IT duties. Please note if IT support is provided via contract. Describe how your agency ensures confidentiality of protected health and other data.

e. Discuss how the National HIV/AIDS Strategy (https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025) and the HIV Continuum of Care (i.e. the Treatment Cascade) has been integrated into your agency's programs and activities. Include description of systems to identify those PLWH who are out of medical care and link PLWH back into care.

2. DESCRIPTION OF THE PROPOSED SERVICE

a. Describe how this **proposed** service fits into your agency's overall mission statement. Describe your agency's plan for delivering the proposed service. Using **Form B-1, Work Plan** - create a work plan that includes the key action steps for providing the proposed service. The work plan should contain S.M.A.R.T. objectives including the number of unduplicated PLWH and units to be provided. If the proposed service will be new to your agency, include realistic timeframes for the implementation of the

service. Describe in detail how each objective and its key action step will be accomplished in a manner that ensures PWLH will receive quality services.

b. Describe how the proposed service will be delivered to the population outlined in the most currently published version of the ***HSDA's Epidemiological (Epi) Profile*** (**see Appendix E).**

c. Complete **Form B-2 Proposed PLWH to Be Served** that outlines the specific number of PLWHPLWH, units and counties for the proposed service. Indicate numbers, not percentages you propose to serve in each demographic category. You also must include licensure information.

d. Describe in detail the methods of informing PLWH about your agency and funded services. PLWH Describe activities that your agency performs to ensure services are provided to the targeted subpopulations listed in the Epi Profile.

e. **All services have some sort of barriers.** Describe the **CHALLENGES** which PLWH may encounter **IN ACCESSING** this service (i.e., stigma, travel, childcare, diverse cultural beliefs/practices, systemic racism, etc.). How does your agency eliminate or minimize these barriers?

3. COLLABORATION AND REFERRAL

a. Applicants are expected to collaborate with other services providers (both Ryan White funded and non-RW funded) to deliver its services within a continuum of care. These collaborations should be formal written agreements to work together in a cooperative effort toward specific and agreed upon objectives. Each agreement should identify the shared staff, workspace and services exchanged. Complete **Form B-3 Collaborative Agreements with Other Service Provider**s outlining established collaborative agreements as they relate to the proposed service. Describe the duties that each agency provides under the collaboration.

b. All applicants are expected to link clients who are newly diagnosed or are out of medical care back into medical care. In narrative form, describe your agency's procedures for determining whether a client is in medical care. Describe your agency's Linkage to Care system to connect clients who are newly diagnosed or reconnect "out of care" clients with a medical provider.

c. In narrative form, describe your agency's procedures (step by step) to handle incoming and outgoing referrals for the service for which you are applying. Include how your agency will verify clients received the services in which they are referred (your referral and follow-up system).

4. QUALITY MANAGEMENT AND EVALUATION OF THE PROPOSED SERVICE

a. Describe in detail your agency's continuous quality improvement (CQI) process for improving the quality of service for the PLWH you are proposing to serve. Describe your quality management committee. Describe how the proposed service will be evaluated through your CQI process. **Include a copy of your agency's current Quality Management Plan in the Appendices.**

b. Describe how your agency manages grievances including the agency staff designated to manage grievances. Describe how grievances and their resolutions are incorporated

in the agency's CQI process. **Include a copy of your policy for agency PLWH grievance process procedure.**

c. Describe your PLWH feedback survey process for the proposed service and how your agency will ensure that all PLWH of the proposed service will be given the opportunity to fill out a survey at least annually. Specifically address the availability, frequency, and method of distributing/collecting surveys. Include the methods of informing PLWHPLWH of satisfaction survey results. **Include a copy of your agency's latest PLWH feedback survey for the proposed service along with tabulated results.**

5. MEANINGFUL ENGAGEMENT OF PLWH

All applicants are expected to include consumers in the design, implementation and evaluation of proposed services. Consumers should receive support, education and training from agency staff that increases their health literacy and improves their ability to be partners in their own care. Applicants should include consumers in the recruitment and retention of consumers in care. **Complete Form C-1: Meaningful Engagement Action Plan** to outline systems at the agency that will address these expectations outlining goals, opportunities and activities for obtaining consumer feedback. Include the following activities (if any)

- Consumer Advisory Boards,
- Consumer-specific Board of Director positions,
- Consumer participation in evaluation of services,
- Consumer focus groups or committee,
- Health literacy programs,
- Peer-facilitated patient education and mentoring programs, and/or
- Other consumer initiatives at your agency.

6. BUDGET INFORMATION

a. Agencies are expected to have a diversity of funding. Describe in narrative form your agency's experience in grants and contracts management. Provide specific details of what other funding sources your agency has and for what services. Complete Form **D-1 Current Funding and Contracts.**

b. Describe the applicant's process and procedure for ensuring clients have been screened for eligibility for Medicaid, Medicare, Veterans benefits, private health insurance or other state or federal programs to ensure that Ryan White Program funds are the payer of last resort. List the name of the software application or third-party service used to perform such verifications. Simply asking clients about their third-party coverage is not adequate. **Applicants must have (in place) a viable methodology to verify insurance coverage @ each patient visit if service is eligible for third party coverage.**

c. If the proposed service is covered by Medicaid, Medicare, or other third-party payment, describe whether your agency is currently able to bill for those services. If your agency is not, include a realistic plan for how your agency will implement third party billing within the first ninety (90) days of the grant period. Complete **Form D-2: Licensures, Permits and Certifications**. Provide applicant's Medicaid and

Medicare certification numbers on Form D-2. Include copies of applicant's applicable licensures, permits, and certification (including Medicaid and Medicare certification notifications) in Section II. Failure to provide the required information on Form D-2 and copies of Applicant's documentation in the applicable categories may result in the disqualification of the submitted proposal.

d. Describe the financial management staff (describe the who, what positions, and experience), including any financial management conducted by outside accountant/accounting firm, if applicable.
e. If your organization is a not-for-profit agency, describe the role your Board of Directors takes in each of the following activities (must address all activities listed):
   1.Describe the trainings (specific topics) provided to the BOD and how often trainings are conducted?
   2. How often does the BOD meet, when and where?
   3. List the specific information/reports provided to the BOD at each meeting?
   4. Describe the procedure/process utilized by the BOD to:
      i. Approve/amend annual agency budgets – when/how often?
      ii. Approve variances – describe process of approval of budget variances
      iii. Describe the process for determining the salary level for the Executive Director' annual evaluation and subsequent increases.
   5. Describe the fundraising activities and/or events conducted by the BOD.

F. BUDGET FORMS

The project budget must be submitted in the format provided. All applicants must submit a line-item budget and categorical budget justification. All final budgets for applicants awarded funds will be negotiated and approved by the Houston Regional HIV/AIDS Resource Group prior to contract execution.

A list of "allowable" and "unallowable" expenses is included in **Appendix C** for your reference. Providers are not allowed to bill for "no shows" or missed appointments.
The following information/forms are required:

1. Form D-1: Current Funding and Grants Form must be completed by all applicants. Use the form provided.
2. Form D-2: Licensures, Permits, & Certifications Form must be completed by all applicants. Use the form provided.
3. Form D-3: Line Item & Categorical Budget Justification must be created by all applicants. Instructions and examples for a categorical budget justification are in the forms section. Please separate administrative and program costs. Use the Excel form provided. Do not change the formatting of Form D-3. Do not submit budgets in any other format than Form D-3.
4. Form D-4: Proposed Subcontracting of Services Form must be completed by all applicants who incorporated any subcontracting of the proposed services in Form D-3. Use the form provided. If your agency is not proposing any subcontracting, enter "NA" in the Page Number column on Form A-2: Subcontractor Checklist & Table of Contents.

G. REQUIRED APPENDICES

The applicant should place the items requested in the Narrative in order in this section.

Those items are as follows:
1. Organizational Chart
2. Job Descriptions (for all positions)
3. Resumes (for existing staff)
4. Required Narrative (Series B) Forms
5. Quality Management Plan
6. PLWH Grievance Process Policy
7. Tabulated Results
8. Required Form C-1: Meaningful Engagement Action Plan
9. Required Financial (Series D) Forms

H. ADDITIONAL APPENDICES

The applicant should use additional appendices to add any necessary reference or supporting materials to the application (such as legal agreements between agencies, brochures, etc.). **The appendices should be included with Section I, not Section II and should be numbered in sequence with Section I, not Section II. Applicants are limited to 15 pages of additional appendices.**

I. OTHER REQUIRED DOCUMENTS (SECTION II)

The following documents are required in order for the application to be considered for funding. Documents must be arranged in the application in the order shown. Use the enclosed "Section II Cover Sheet" as a cover sheet for Section II. Where indicated, forms are provided in the Forms Section of the RFP. [Forms are also available upon request on computer diskette.] This section should be page numbered separately. Please restart this section with Page 1.

Submit ONLY one (1) copy of Section II, regardless of how many different service applications you are submitting; additional copies of Section II are NOT required. Submit Section II separate from Section I (have a separate clip on these two sections.)

Reviewers will **NOT** see Section II. **DO NOT** include additional items in Section II that you want Reviewers to see or that you reference in your Narrative. Include any additional documents that you want reviewers to see in the Appendices of Section I.

1. Form E-2: DSHS Assurances and Certifications (use form provided)
2. Form E-3: HIV Contractor Assurances (use form provided)
3. Form E-4: Non-profit Board Member and Executive Officers Assurance (use form provided)
4. Form E-5: General Provisions for Grant Agreement Assurances (use form provided)
5. Board of Director's List – must include name, occupation, address, and phone number of ALL Board members. Board officers MUST be indicated. Please note: place of employment is NOT acceptable for occupation. Government agencies are exempt from this requirement.
6. Article of Incorporation – must be a certified (by the Secretary of State) copy. Government agencies are exempt from this requirement.
7. By-Laws – A current copy of the By-Laws adopted by the Board of Directors. Government agencies are exempt from this requirement.

8. IRS Non-Profit determination letter – the current letter from the IRS giving notification of non-profit status.
9. Current Financial Audit in accordance with OMB Circular A-133 or most recent financial audit.

X. TECHNICAL ASSISTANCE

A. WEBINAR

A technical assistance webinar (link below) will be offered on **Thursday, October 27th, 2022, 9:00 a.m.** Potential applicants, especially new applicants, are encouraged to attend. The webinar presentation slides, and Q & A will be posted on The Resource Group website (www.hivtrg.org) at 1 p.m. on October 28th.

RFP TA Webinar Link: https://meet.goto.com/670917629
Access Code: 670-917-629

B. TECHNICAL ASSISTANCE QUESTIONS

ALL technical assistance questions and request for webinar participation MUST be submitted in writing to both Yvette Garvin and Patrick Martin.

Contact Information	
Yvette Garvin Executive Director The Resource Group 500 Lovett Blvd., Suite 100 Houston, TX 77006 ygarvin@hivtrg.org	Patrick L. Martin Program Development Director The Resource Group 500 Lovett Blvd., Suite 100 Houston, TX 77006 plmartin@hivtrg.org

All technical assistance questions received at The Resource Group by 12 Noon on October 20th, 27th and November 3, and 10th will be posted, with answers, on The Resource Group website (www.hivrtrg.org) by 12 Noon of the Friday following each of these Thursdays. NO technical assistance questions will be answered after Friday, November 11th.

XI. APPLICATION SUBMISSION

The original and seven (7) copies of Section I and one (1) original copy of Section II of the application must be received by the Houston Regional HIV/AIDS Resource Group on or before Thursday, November 17th @ 5:00 P.M. Central Standard Time.

LATE PROPOSALS OR PROPOSALS SUBMITTED WITHOUT ONE (1) ORIGINAL AND SEVEN (7) COPIES OF SECTION I AND ONE (1) ORIGINAL COPY OF SECTION II WILL NOT BE REVIEWED FOR FUNDING.