New York State
Department of Health
Division of HIV and Hepatitis Health Care
Bureau of Ambulatory Care Services
And
Health Research Inc.

Request for Applications
RFA # 20185
Internal RFA # 22-0005

Grants Gateway #: DOH01-AHEA-2023, DOH01-AHEB-2023, DOH01-AHEC-2023

Advancing Health Equity through Comprehensive Community-Based HIV Ambulatory Care Services

This procurement encompasses three (3) components. In order to apply for any of the three (3) components, eligible applicants must be prequalified in the New York State Grants Gateway, unless exempt, and submit the application via the New York State Grants Gateway.

Applicants may submit more than one application as per the guidance specific to the component.

Component A: Retention and Adherence Program (RAP) - Applicants may submit one application per site
Component B: Centers for Young Adults - Applicants may submit one application per region
Component C: Family-Focused Health Care for Women - Applicants may submit one application per region

KEY DATES

RFA Release Date: July 21, 2022
Questions Due: August 4, 2022, by 4:00 PM
Questions, Answers and Updates Posted: (on or about) August 18, 2022
Applications Due: September 8, 2022, by 4:00 PM

DOH Contact Name & Address:
Margaret Smalls, Bureau Director
NYS Department of Health/AIDS Institute
Bureau of HIV Ambulatory Care Services
Email: 2022.AHE.RFA@health.ny.gov
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I. INTRODUCTION

The New York State Department of Health AIDS Institute (NYSDOH AI) and Health Research Inc. (HRI) announces the availability of $15,232,877 annually for five (5) years in state and federal funding to provide services to improve health outcomes and address health disparities experienced by people living with HIV/AIDS (PLWH/A) in NYS.

This Request for Applications (RFA) contains the following three distinct components:

- Component A: Retention and Adherence Program (RAP)
- Component B: Centers for Young Adults (CYA)
- Component C: Family-Focused Health Care for Women (FFHC)

Applicants not previously funded by the NYSDOH AI are encouraged to apply.

A. Background/Intent

As a national leader in the fight to End the HIV epidemic, the NYSDOH AI has invested significant resources to increase access to high quality HIV prevention, care, and treatment services designed to eliminate the transmission of HIV and improve the medical outcomes of people living with diagnosed HIV (PLWDH). The success of these interventions is demonstrated by a declining number of new HIV diagnoses, increases in linkage to, and retention in care, with higher percentages of patients achieving sustained viral load suppression.

In NYS, the number of persons newly diagnosed with HIV has decreased 51% from 2011 to 2020 (3,971 to 1,933). Other notable gains during the period include a 16% reduction in HIV-related deaths and a 25% increase in viral load suppression.

Though progress has been achieved through current programming efforts to end the HIV epidemic, success has not been equitable across all age groups and communities, especially among Black, Indigenous, and People of Color (BIPOC) communities. NYS HIV Surveillance confirms that the HIV epidemic continues to disproportionately impact women, adolescents and young adults, and men who have sex with men (MSM) from BIPOC communities.

In 2020, non-Hispanic Black/African American people represented 14.1% of the population of NYS but accounted for 46% of new HIV diagnoses and Hispanic persons represented 19% of the population of NYS yet constituted 29.7% of new HIV diagnoses. The severity of this disparity is confirmed when rates among those newly diagnosed with HIV are compared by race/ethnicity. The rate of new HIV diagnoses among non-Hispanic Black individuals was 8.1 times higher than the rate for non-Hispanic White individuals and the rate for Hispanic individuals was 3.9 times higher than the rate for non-Hispanic White individuals. The prevalence rate of HIV among non-Hispanic Black individuals was 7.8 times higher than their non-Hispanic White counterparts, and similarly among Hispanic individuals, the prevalence rate was 4.1 times higher than their non-Hispanic White counterparts.
2020 surveillance data highlights include:

- Adolescents and young adults ages 13 - 29 represented 36.8% of new HIV diagnoses;
- Persons ages 30 - 39 represented 31% of new diagnoses and 31.7% of concurrent diagnoses;
- MSM represented 49.9% of new HIV diagnoses and 39.6% of concurrent diagnoses;
- Non-Hispanic Black/African American people represented 46% of individuals newly diagnosed with HIV and 44.7% of concurrent diagnoses;
- Hispanic people accounted for 29.7% of new HIV diagnoses and 28.7% of concurrent diagnoses. BIPOC women experience disproportionately higher rates of new and concurrent HIV/AIDS diagnoses four to six times higher than their White counterparts; and
- Non-Hispanic Black Women continue to have significantly higher rates of AIDS diagnoses and morbidity when compared against all racial/ethnic counterparts.

These data are stark confirmation of the disproportionate burden and HIV health inequity faced by BIPOC communities, adolescents/young adults, men who have sex with men, and BIPOC women of child-bearing age who are prioritized to receive services through this RFA.

The NYSDOH AIDS Institute (AI) is committed to achieving health equity by identifying and responding to the social determinants identified through funded programming, employing cross-sector partnerships to address the non-medical needs of patients more effectively, and by addressing institutional and structural racism to promote equal access and care for all.

Health equity is the fair and just opportunity for everyone to achieve optimal holistic health and well-being regardless of social position or other social or structural determinants of health (SDOH). HIV health disparities are inextricably linked to a complex blend of social determinants that impact the outcomes of HIV direct and supportive services. Community health centers are well positioned to assess and address their patients’ SDOH because primary care is a natural point of integration among clinical care, public health, behavioral health, and community-based services.

To effectively improve health outcomes, it is important to look at both disparities and social determinants of health to identify and address the root causes (i.e., racism, classism, sexism). Funded programs should proactively address intersectional factors impacting racial and ethnic disparities using a health equity framework.

This RFA intends to improve HIV health equity through the delivery of funded services and development of clinical-community partnerships designed to address the non-medical social needs identified. Funded services will occur in community-based ambulatory care settings by multidisciplinary teams that incorporate sexual health, health equity, and social determinants principles and frameworks to deliver “person-centered” services responsive to the complex clinical and non-clinical needs of the priority populations, with the goals of reducing health disparities and health inequities. Successful applicants will provide integrated and innovative interventions that effectively promote linkage to, retention in, and re-engagement in care,
address barriers experienced by consumers, and increase the use of Antiretroviral therapy (ART) among BIPOC communities. Proposed models of care should be community driven and address HIV and medical treatment beliefs, racism, SDOH, patient-provider relationships, stigma, and trauma.

In June 2014, NYS announced a three-point plan to end the AIDS epidemic in NYS. This plan provided a roadmap to significantly reduce HIV infections to a historic low by the end of 2020, with the goal of achieving the first ever decrease in HIV prevalence. The plan also aimed to improve the health of all HIV positive New Yorkers and was the first jurisdictional effort of its kind in the U.S. The three points highlighted in the plan are:

1) Identify persons with HIV who remain undiagnosed and get them linked to care.
2) Link and retain persons diagnosed with HIV in health care to maximize viral suppression; and
3) Increase access to Pre-Exposure Prophylaxis (PrEP) for persons who are HIV negative.

NYS has been laying the groundwork for ending the AIDS epidemic since the disease emerged in the early 1980s. NYS’s response to the HIV/AIDS epidemic has involved the development of comprehensive service delivery systems that evolved over time in sync with the evolution of AIDS from a terminal illness to a manageable chronic disease. This strategy enabled the state to implement new technologies as they were introduced, including new treatments, new diagnostic tests and, PrEP. By building upon each individual success and relying on a strong administrative infrastructure, the state was able to roll out innovative programs quickly to achieve the greatest impact. Ending the epidemic in NYS is within reach, thanks to aggressive and systematic public health initiatives that have made it possible to drive down rates of new infections. The State’s Ending the Epidemic (ETE) initiative was launched with visionary leadership and extensive stakeholder leadership and participation.

The components contained in this RFA address these ETE Blueprint (B.P.) recommendations:

BP3: Address acute HIV infection
BP4: Improve referral and engagement
BP5: Continuously act to monitor and improve rates of viral suppression
BP7: Use client-level data to identify and assist patients lost to care or not virally suppressed
BP8: Enhance and streamline services to support the non-medical needs of all persons with HIV
BP13: Create a coordinated statewide mechanism for persons to access PrEP and nPEP and prevention focused care
BP26: Provide HCV testing to persons with HIV and remove restrictions to HCV treatment access based on financial considerations for individuals co-infected with HIV and HCV
BP28: Equitable funding where resources follow the statistics of the epidemic
BP29: Expand and enhance the use of data to track and report progress

The ETE BP continues to guide all ETE efforts. The ETE Addendum Report is a written report that provides an overview of the past five years of New York State’s ETE initiatives, as well as a
summary of the community feedback sessions that were conducted in 2020 to assist in identifying areas of focus for ETE beyond 2020.

The ETE BP and the ETE Addendum report are available on the NYSDOH website at: www.health.ny.gov/endingtheepidemic

In November 2021, NYS released its plan to eliminate hepatitis C as a public health problem in NYS by 2030. To achieve the goal of hepatitis C elimination, concerted efforts are needed to ensure access to timely diagnosis, care, and treatment for all people with hepatitis C. NYS plans to eliminate hepatitis C by:

- Enhancing hepatitis C prevention, testing and linkage to care services for people who inject drugs, people who are incarcerated, men who have sex with men, and other populations disproportionately impacted by HCV infection;
- Expanding hepatitis C screening and testing to identify people living with hepatitis C who are unaware of their status and link them to care;
- Providing access to clinically appropriate medical care and affordable hepatitis C treatment without restrictions and ensure the availability of necessary supportive services for all New Yorkers living with hepatitis C;
- Enhancing NYS hepatitis C surveillance, set and track hepatitis C elimination targets, and make this information available to the public; and
- Addressing social determinants of health (SDOH).

Other relevant resources are the National HIV/AIDS Strategy (NHAS) and the NYS Prevention Agenda. The NHAS is a five-year plan that details principles, priorities, and actions to guide our collective national response to the HIV epidemic. Information on the NHAS and updates to the strategy through 2025 can be found at: National HIV/AIDS Strategy (2022-2025) | HIV.gov. The NYS Prevention Agenda is the blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability and low socioeconomic groups, as well as other populations who experience them. The NYS Prevention Agenda can be found on the following website: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/.

B. Available Funding

Up to $15,232,877 annually in State and HRI funding is available to support Components A, B and C through this RFA. The awards allocated per component will not exceed the annual amounts listed in the table below.

**Component A: Retention and Adherence Program (RAP)**

Up to $8,757,877 in HRI funding is available annually to fund up to 35 awards for Component A. Funding for Component A will be allocated to applicants as stated in the chart below.

<table>
<thead>
<tr>
<th>NYSDOH Region</th>
<th>Maximum Annual Award Amount</th>
<th>Number of Awards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central New York: Cayuga, Herkimer,</td>
<td>$250,000</td>
<td>0 to 2</td>
</tr>
</tbody>
</table>
Applicants for Component A may submit one application per site. A separate application must be submitted for each additional site proposed. Applications for Component A that are multi-site or propose rendering services in non-Article 28 settings will be deemed ineligible and disqualified from further consideration.

- Awards will be made to the highest scoring applicants in each region, up to the minimum number of awards indicated for that region. Remaining funding will be awarded to the next highest acceptable scoring applicant(s) from any region until the remaining funding is exhausted or awards have been made to all acceptable scoring applicants.

- If there is an insufficient number of acceptable applications (scoring 70 or above) received from any region, HRI/NYSDOH AI reserves the right to:
  - Fund an application scoring in the range of (60-69) from a region and/or
  - Apply unawarded funding to the next highest scoring applicant(s) in other region(s) until the maximum number of awards per region is met.

- If there is an insufficient number of fundable applications in a region, the maximum number of awards may not be met for that region. HRI/NYSDOH AI reserves the right to re-solicit any region where there are an insufficient number of fundable applications.

- If funding remains available after the maximum number of acceptable scoring applications is awarded to each region, HRI/NYSDOH AI reserves the right to exceed the

<table>
<thead>
<tr>
<th>Region</th>
<th>Counties</th>
<th>Funding: $250,000</th>
<th>Awards: 1 to 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finger Lakes</td>
<td>Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates</td>
<td></td>
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<tr>
<td>Long Island</td>
<td>Nassau and Suffolk</td>
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<td></td>
</tr>
<tr>
<td>Lower Hudson Valley</td>
<td>Putnam, Rockland, and Westchester counties</td>
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<td></td>
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<tr>
<td>Mid-Hudson Valley</td>
<td>Dutchess, Orange, Sullivan, and Ulster counties</td>
<td></td>
<td></td>
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<tr>
<td>Southern Tier</td>
<td>Broome, Chenango, Chemung, Cortland, Delaware, Otsego, Tompkins, and Tioga</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western New York</td>
<td>Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming</td>
<td>$250,000</td>
<td>1 to 3</td>
</tr>
<tr>
<td>New York City - Bronx</td>
<td></td>
<td>$250,000</td>
<td>0 to 4</td>
</tr>
<tr>
<td>New York City - Brooklyn</td>
<td></td>
<td>$250,000</td>
<td>0 to 4</td>
</tr>
<tr>
<td>New York City - Manhattan</td>
<td></td>
<td>$250,000</td>
<td>0 to 3</td>
</tr>
<tr>
<td>New York City - Queens/Staten Island</td>
<td></td>
<td>$250,000</td>
<td>0 to 2</td>
</tr>
</tbody>
</table>
maximum number of awards. Remaining funding will be awarded to the next highest acceptable scoring applicant(s) from any region until the remaining funding is exhausted or awards have been made to all acceptable scoring applicants.

- HRI/NYSDOH AI reserves the right to revise the award amounts as necessary due to changes in availability of funding.

- HRI/NYSDOH AI reserves the right to shift funding from one Component of the RFA to another Component should there be an insufficient number of fundable applications received in any Component.

Should additional funding become available, the NYSDOH AI and HRI may select an organization from the pool of applicants deemed not funded, due to limited resources. If it is determined that the needed expertise/services are not available among these organizations, the NYSDOH AI and HRI reserve the right to establish additional competitive solicitations.

Current Contractors: If you choose to not apply for funding, the NYSDOH AI highly recommends notifying your community partners of your intent. This will ensure community members and providers are aware of the discontinuation of the program and services.

Ryan White funding is the “payer of last resort”. Please see Ryan White Guidance for Part B Direct Service Subcontractors for funding restrictions. (Attachment 1)

Funds under this RFA are considered dollars of “last resort” and can only be used when there are no options for other reimbursement. Grant funding cannot be used to reimburse for services that are able to be billed to a third party (i.e., Medicaid, ADAP, PrEP-AP, private health insurance, Gilead patient assistance, co-pay assistance programs, etc.). A provider cannot use grant funds in lieu of billing for services to a third party.
Component B: Centers for Young Adults (CYA)

Up to $4,400,000 in State and HRI funding is available to annually fund up to 14 awards for Component B applicants. Applicants must meet the minimum caseload requirements stated in the chart below.

<table>
<thead>
<tr>
<th>NYSDOH Region</th>
<th>Maximum Annual Award Amount</th>
<th>Minimum Caseload Requirement</th>
<th>Number of Awards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central New York: Cayuga, Herkimer,</td>
<td>$250,000</td>
<td>25+</td>
<td>0 to 1</td>
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<tr>
<td>Jefferson, Lewis, Madison, Oneida,</td>
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<tr>
<td>Ónondaga, Oswego, St. Lawrence,</td>
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<tr>
<td>Broome, Chenango, Chemung, Cortland,</td>
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<tr>
<td>Delaware, Otsego, Tompkins, and Tioga.</td>
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</tr>
<tr>
<td>Finger Lakes: Livingston, Monroe,</td>
<td>$250,000</td>
<td>25+</td>
<td>0 to 1</td>
</tr>
<tr>
<td>Ontario, Schuyler, Seneca, Steuben,</td>
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<td></td>
<td></td>
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<tr>
<td>Wayne, and Yates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hudson Valley: Dutchess, Orange,</td>
<td>$250,000</td>
<td>25+</td>
<td>0 to 1</td>
</tr>
<tr>
<td>Putnam, Rockland, Sullivan, Ulster,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Westchester</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long Island: Nassau and Suffolk</td>
<td>$362,500</td>
<td>50+</td>
<td>0 to 1</td>
</tr>
<tr>
<td>Northeastern New York: Albany,</td>
<td>$250,000</td>
<td>25+</td>
<td>0 to 1</td>
</tr>
<tr>
<td>Columbia, Fulton, Greene, Montgomery,</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rensselaer, Saratoga, Schenectady,</td>
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<td></td>
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<tr>
<td>Schoharie, Warren, Washington,</td>
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<tr>
<td>Clinton, Essex, Franklin, and Hamilton</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western New York: Allegany, Cattaraugus,</td>
<td>$250,000</td>
<td>25+</td>
<td>0 to 1</td>
</tr>
<tr>
<td>Chautauqua, Erie, Genesee, Niagara,</td>
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<td></td>
<td></td>
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<tr>
<td>Orleans, and Wyoming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York City - Bronx</td>
<td>$362,500</td>
<td>50+</td>
<td>1 to 2</td>
</tr>
<tr>
<td>New York City - Brooklyn</td>
<td>$362,500</td>
<td>50+</td>
<td>1 to 2</td>
</tr>
<tr>
<td>New York City - Manhattan</td>
<td>$362,500</td>
<td>50+</td>
<td>2 to 3</td>
</tr>
<tr>
<td>New York City – Queens/Staten Island</td>
<td>$362,500</td>
<td>50+</td>
<td>0 to 1</td>
</tr>
</tbody>
</table>

Applicants may submit one (1) application per region. A separate application must be submitted for each additional region proposed. Applications for Component B that are multi-site or propose rendering services in non-Article 28 settings will be deemed ineligible and disqualified from further consideration.

- Awards will be made to the highest scoring applicants in each region, up to the minimum number of awards indicated for that region. Remaining funding will be awarded to the next highest acceptable scoring applicant(s) from any region until the remaining funding is exhausted or awards have been made to all acceptable scoring applicants.

- If there is an insufficient number of acceptable applications (scoring 70 or above) received from any region, HRI/NYSDOH AI reserves the right to:
  - Fund an application scoring in the range of (60-69) from a region and/or
  - Apply unawarded funding to the next highest scoring applicant(s) in other region(s) until the maximum number of awards per region is met.
• If there are an insufficient number of fundable applications in a region, the maximum number of awards may not be met for that region. HRI/NYSDOH AI reserves the right to re-solicit any region where there are an insufficient number of fundable applications.

• If funding remains available after the maximum number of acceptable scoring applications is awarded to each region, HRI/NYSDOH AI reserves the right to exceed the maximum number of awards. Remaining funding will be awarded to the next highest acceptable scoring applicant(s) from any region until the remaining funding is exhausted or awards have been made to all acceptable scoring applicants.

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• HRI/NYSDOH AI reserves the right to shift funding from one Component of the RFA to another Component should there be an insufficient number of fundable applications received in any Component.

Should additional funding become available, the NYSDOH AI and HRI may select an organization from the pool of applicants deemed not funded, due to limited resources. If it is determined that the needed expertise/services are not available among these organizations, the NYSDOH AI and HRI reserve the right to establish additional competitive solicitations.

**Current Contractors:** If you choose to not apply for funding, the NYSDOH AI highly recommends notifying your community partners of your intent. This will ensure community members and providers are aware of the discontinuation of the program and services.

Ryan White funding is the “payer of last resort”. Please see Ryan White Guidance for Part B Direct Service Subcontractors for funding restrictions. (Attachment 1)

Funds under this RFA are considered dollars of "last resort” and can only be used when there are no options for other reimbursement. Grant funding cannot be used to reimburse for services that are able to be billed to a third party (i.e., Medicaid, ADAP, PrEP-AP, private health insurance, Gilead patient assistance, co-pay assistance programs, etc.). A provider cannot use grant funds in lieu of billing for services to a third party.
Component C: Family-Focused Health Care for Women (FFHC)

Up to $2,075,000 in HRI funding is available annually to fund up to six (6) awards for Component C. The allocation method used for this component is based on the statewide incidence of perinatal HIV infection.

<table>
<thead>
<tr>
<th>NYSDOH Region</th>
<th>Maximum Annual Award Amount</th>
<th>Number of Awards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest of State (ROS)*</td>
<td>$200,000</td>
<td>1</td>
</tr>
<tr>
<td>New York City regions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronx</td>
<td>$375,000</td>
<td>1 to 1</td>
</tr>
<tr>
<td>Brooklyn</td>
<td>$375,000</td>
<td>0 to 1</td>
</tr>
<tr>
<td>Manhattan</td>
<td>$375,000</td>
<td>1 to 2</td>
</tr>
<tr>
<td>Queens/Staten Island</td>
<td>$375,000</td>
<td>0 to 1</td>
</tr>
</tbody>
</table>


Applicants may submit one (1) application per region. A separate application must be submitted for each additional region proposed. **Proposed program services must be provided at the funded location. Applications for Component C that are multi-site or propose rendering services in non-Article 28 settings will be disqualified from further consideration.**

- Awards will be made to the highest scoring applicants in each region, up to the minimum number of awards indicated for that region. Remaining funding will be awarded to the next highest acceptable scoring applicant(s) from any region until the remaining funding is exhausted or awards have been made to all acceptable scoring applicants.

- If there is an insufficient number of acceptable applications (scoring 70 or above) received from any region, HRI/NYSDOH AI reserves the right to:
  - Fund an application scoring in the range of (60-69) from a region and/or
  - Apply unawarded funding to the next highest scoring applicant(s) in other region(s) until the maximum number of awards per region is met.

- If there are an insufficient number of fundable applications in a region, the maximum number of awards may not be met for that region. HRI/NYSDOH AI reserves the right to re-solicit any region where there are an insufficient number of fundable applications.

- If funding remains available after the maximum number of acceptable scoring applications is awarded to each region, HRI/NYSDOH AI reserves the right to exceed the maximum...
number of awards. Remaining funding will be awarded to the next highest acceptable scoring applicant(s) from any region until the remaining funding is exhausted or awards have been made to all acceptable scoring applicants.

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**II. WHO MAY APPLY**

**A. Minimum Eligibility Requirements**

**Applicants for Component A must meet the following eligibility requirements:**

- Applicants must be prequalified in the New York State Grants Gateway, if not exempt, on the date applications are due.
- Applicant must be licensed by the New York State Department of Health under Article 28 of the Public Health Law with proposed services rendered in Article 28 sites;
- Possess current not-for-profit 501© (3) Tax-Exempt Status;
- Applicant must utilize an electronic health record system (EHR). Applicants must complete Attachment 2 - [Electronic Health Records (EHR) Assessment](Attachment 2) must be uploaded to the Grants Gateway in the Pre-Submission Uploads section of the online application.
- Applicant must have the capacity to collect Social Determinants of Health (SDOH) and Sexual Orientation Gender Identity (SOGI) data within the EHR;
Applicant must demonstrate experience providing HIV, primary care, and supportive services to PLWH/A that incorporates the diverse ethnic, cultural, and social experiences specific to the populations prioritized to receive services through this RFA; and
Applicant must submit Attachment 3 - Statement of Assurances signed by the Chief Executive Officer (CEO) or Designee to certify the organization meets all criteria listed on Attachment 3. Attachment 3 must be uploaded to the Grants Gateway in the Pre-Submission Uploads section of the online application.

Applicants for Component B must meet the following eligibility requirements:

- Applicants must be prequalified in the New York State Grants Gateway, if not exempt, on the date applications are due;
- Applicant must be licensed by the New York State Department of Health under Article 28 of the Public Health Law with proposed services rendered in Article 28 sites;
- Possess current not-for-profit 501© (3) Tax-Exempt Status;
- Applicant must utilize an electronic health record system (EHR). Applicants must complete Attachment 2 - Electronic Health Records (EHR) Assessment. Attachment 2 must be uploaded to the Grants Gateway in the Pre-Submission Uploads section of the online application;
- Applicant must have electronic capacity to collect Social Determinants of Health (SDOH) and Sexual Orientation Gender Identity (SOGI) data within the EHR;
- Applicant must demonstrate experience providing HIV, primary care, and supportive services to PLWH/A that incorporates the diverse ethnic, cultural, and social experiences specific to the populations prioritized to receive services through this RFA;
- Applicant must propose to serve an annual minimum caseload of 50 adolescents/young adults living with HIV in New York City. Applicants from regions outside of New York City must propose to serve a minimum caseload of 25 adolescents/young adults who are living with HIV; and
- Applicant must submit Attachment 3 - Statement of Assurances signed by the Chief Executive Officer (CEO) or Designee to certify the organization meets all criteria listed on Attachment 3. Attachment 3 must be uploaded to the Grants Gateway in the Pre-Submission Uploads section of the online application.

Applicants for Component C must meet the following eligibility requirements:

- Applicants must be prequalified in the New York State Grants Gateway, if not exempt, on the date applications are due;
- Applicant must be licensed by the New York State Department of Health under Article 28 of the Public Health Law with proposed services rendered in Article 28 sites;
- Possess current not-for-profit 501© (3) Tax-Exempt Status;
- Applicant must utilize an electronic health record system (EHR); Applicants must complete Attachment 2 - Electronic Health Records (EHR) Assessment. Attachment 2 must be uploaded to the Grants Gateway in the Pre-Submission Uploads section of the online application;
Applicant must have the electronic capacity to collect Social Determinants of Health (SDOH) and Sexual Orientation Gender Identity (SOGI) data within the EHR;

Applicant must demonstrate experience providing HIV, primary care, and supportive services to PLWH/A that incorporates the diverse ethnic, cultural, and social experiences specific to the populations prioritized to receive services through this RFA;

Applicant must provide co-located HIV primary care and supportive services for individuals who are planning a pregnancy, birthing, persons of childbearing age, are pregnant, or are the primary caregiver to their dependent children and are living with HIV; and

Applicant must submit Attachment 3 - Statement of Assurances signed by the Chief Executive Officer (CEO) or Designee to certify the organization meets all criteria listed on Attachment 3. Attachment 3 must be uploaded to the Grants Gateway in the Pre-Submission Uploads section of the online application.

III. PROJECT NARRATIVE/WORK PLAN OUTCOMES (ALL COMPONENTS)

This RFA aims to improve HIV health equity and reduce HIV disparity by delivering health care services modeled to ensure quality HIV clinical care and systemic practices that mitigate the impact of racism and address the social determinants of health experienced by community health center patients.

To achieve these aims, RFA applicants must provide comprehensive, patient-centered health service models that utilize a health equity lens, incorporate the Bureau of HIV Ambulatory Care RFA Guiding Principles (Attachment 4), and routinely collect and analyze SDOH data. Successful models use SDOH data to develop tailored clinical-community partnerships responsive to the spectrum of non-medical social needs that contribute to health inequity. Additionally, programs implement self-correcting strategies to ensure efforts target those disproportionately impacted.

Successful applicants will demonstrate current organizational engagement with the priority population for the component applied using HIV surveillance, cascade, and disparity data for the selected region.

The RFA components in this solicitation are flexible with opportunities for applicants to present innovation-based programs tailored to the needs and service gaps identified through organizational community needs assessments, demonstrated experience with the priority population, and feedback obtained from PLWH/A. In addition, applicants may propose innovative or evidence-based services not outlined in the scope of services consistent with the outcomes, guiding principles, and eligible costs as stipulated in this RFA.
<table>
<thead>
<tr>
<th>Component A</th>
<th>Retention and Adherence Program</th>
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</thead>
<tbody>
<tr>
<td><strong>Priority Population(s)</strong></td>
<td>PLWH/A, BIPOC, LGBTQ, or other communities experiencing disparate HIV outcomes</td>
</tr>
<tr>
<td><strong>Client Eligibility</strong></td>
<td>Eligible clients are individuals living with HIV who meet Ryan White eligibility criteria (Attachment 1: Ryan White Guidance for HRI Direct Service Subcontractors), and are newly diagnosed, out-of-care or not regularly engaged in care or are not virally suppressed.</td>
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<tr>
<th>Component B</th>
<th>Centers for Young Adults</th>
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<tr>
<td><strong>Priority Population(s)</strong></td>
<td>Young adults ages (13-29) living with HIV, are BIPOC, LGBTQ, or other adolescent young adult communities experiencing disparate HIV outcomes.</td>
</tr>
<tr>
<td><strong>Client Eligibility</strong></td>
<td>Eligible clients are individuals living with HIV who meet Ryan White eligibility criteria (Attachment 1: Ryan White Guidance for HRI Direct Service Subcontractors), and are newly diagnosed, out-of-care or not regularly engaged in care or are not virally suppressed.</td>
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<tr>
<td><strong>Priority Population(s)</strong></td>
</tr>
<tr>
<td><strong>Client Eligibility</strong></td>
</tr>
</tbody>
</table>
SCOPE OF SERVICES: (ALL COMPONENTS)

The following are core service categories and apply to all components.

Medical Case Management provides a range of client-centered activities focused on improving health outcomes. Activities are provided by an interdisciplinary team that includes other specialty care providers. 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; continuous client monitoring to assess the efficacy of the care plan; re-evaluation of the care plan with adaptations as necessary; ongoing assessment of the clients’ and other key family members’ needs and personal support systems; treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; and client-specific advocacy and/or review of utilization of services. In addition, Medical Case Management will provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients’ partners and treatment as prevention; education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage); health literacy; and treatment adherence education.

Psychosocial Support Services provide group or individual support and counseling services to assist PLWH/A in addressing behavioral and physical health concerns.

Expected Outcomes: (ALL COMPONENTS)

The expected outcomes of this RFA are to improve access and engagement in quality HIV, STI and HCV services to reduce health inequities experience by PLWH/A by:

1. Increasing access and acceptability of HIV primary care, sexual health, behavioral health and supportive services;
2. Early identification of HIV and immediate access to treatment and medical care;
3. Increased viral load suppression and sustained suppression rates for PLWH/A to achieve good health outcomes;
4. Reduce incidence and transmission of HIV/STI/HCV;
5. Support elimination of perinatal HIV transmission;
6. Reengage PWLH/A who have stopped receiving medical care due to SDOH and other barriers;
7. Reduce racial and ethnic disparities for PLWH/A; and
8. Decrease rates of HIV morbidity and mortality.

A. Program Model Description: (ALL COMPONENTS)

Applicants for all Components are expected to integrate the Bureau of HIV Ambulatory Care Services Guiding Principles (Attachment 4) as part of the proposed model.

Proposed models will align with current AI priorities, ETE goals (ETE), and adherence to AIDS Institute Clinical Guidelines¹ including strategies intended to reduce racial and ethnic health disparities experienced by the priority population(s).

Applicants may subcontract components of the scope of work. For those applicants that propose subcontracting, it is preferable to identify subcontracting agencies during the application process. Applicants that plan to subcontract are expected to state in the application the specific components of the scope of work to be performed through subcontracts. Applicants should note that the lead organization (contractor) will have overall responsibility for all contract activities, including those performed by subcontractors, and will be the primary contact for the NYSDOH AI. All subcontractors should be approved by the NYSDOH AI.

An applicant with an established program funded by a source other than the AIDS Institute may apply for funding of one or more discrete services to supplement the existing program. In these cases, the applicant should demonstrate the program will be comprehensive with the addition of the requested service(s).

Demonstration of a Commitment to Health Equity

Health Equity (HE) is the fair and just opportunity for everyone to achieve optimal holistic health and well-being regardless of social position or other social or structural determinants of health. This requires addressing avoidable inequalities (e.g., access to affordable and high-quality food, housing, education, health care/services, and safe environments), historical and contemporary injustices (e.g., economic injustice/poverty, racism, classism, ableism, sexism, homophobia, transphobia, xenophobia, and other forms of oppression, discrimination, and/or stigma) and valuing health differences equally. We also acknowledge the historical and structural underpinnings of race, racism, and genocide in the United States that perpetuate many of the racial inequities we see manifested today. Because health equity can never truly be achieved without racial equity, we work toward achieving both.

The NYSDOH AI works closely with its community partners to identify and respond to current needs. The needs are wide and varied, but they center on addressing social determinants, socioeconomic status, education, housing, transportation, employment, cultural competence, access to healthcare services and discrimination.

The NYSDOH AI is committed to ensuring our funded programs and partners are equipped with the knowledge, skills, and expertise to adequately address health and social inequities. We are all

¹ https://www.hivguidelines.org/
accountable to pay attention to the intersections of race and health equity. We are committed to the implementation of new and tailored approaches to address the challenges faced by our Black/Brown, Indigenous, and People of Color (BIPOC) communities. In our mission to ensure that everyone has a fair chance to experience optimal health, we are employing the following health equity principles:

• Be Explicit;
• Identify and Effectively Address Racism and Racial Implicit Biases;
• Adopt a “Health in all Policies” Approach;
• Create an Internal Organization-Wide Culture of Equity;
• Respect and Involve Communities in Health Equity Initiatives; and
• Measure and Evaluate Progress in Reducing Health Disparities

**Component A: Retention and Adherence Program (RAP)**

**Program Description**

Retention and adherence is a multi-step process model conducted within community health settings to ensure timely access to and coordination of medical care and supportive services for PLWH/A. Retention and adherence programs use a patient-centered multidisciplinary team approach to support rapid engagement and retention in HIV primary care. RAP team members and primary care providers work collaboratively to coordinate clinical care and address the non-medical social determinants of health that contribute to health disparity.

In addition to the range of core services, program models may include evidence-based interventions that address the social determinants of health, barriers, and needs of PLWH/A to achieve sustained viral suppression and improved self-management.

The program model is implemented by a multidisciplinary team in a manner that employs a social justice/racial equity framework, affirms sexual and gender identity, incorporates a sexual health framework\(^2\), trauma informed practices\(^3\), and health literate care\(^4\). RAP team members and primary care providers work collaboratively to coordinate clinical care and to address the psychosocial and non-medical social determinants of health that contribute to disparate health outcomes experienced by this population.

In addition to the **Bureau of HIV Ambulatory Care Services Guiding Principles (Attachment 4)**, effective RAP models include linkage, navigation, multidisciplinary service coordination, peer services, systemic identification of medical and non-medical needs, including mental, behavioral health, and substance use services; PrEP and PEP education and partner screening, STI screening, referral follow up and tracking, and, tailored clinical-community partnerships that are responsive to the needs of the priority populations to be reached. Successful applicants will develop partnerships with community-based programs serving individuals to be reached through this solicitation to facilitate early identification and active entry and referrals to care.

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Peer services can play a key role in increasing linkage and retention in care, rates of viral suppression and preventing new infections. It is expected that peers will be included in proposed service models to the greatest extent possible. Programs models may also include evidence-based interventions that are responsive to the lived experiences, racism/racial discrimination, trauma, and stigma that disproportionately affects BIPOC, LGBTQ, young MSM or other communities experiencing disparate HIV outcomes.

To ensure a continuum of services that are responsive to the identified needs and social determinants of health experienced by the priority population(s) selected by the applicant, programs must develop and maintain streamlined referral processes and a tailored network of clinical-community partnerships to provide appropriate services not available at the funded location. Network partners should have a history serving the priority population(s), provide psychosocial and supportive services, and work collaboratively with the RAP multidisciplinary team.

Effective retention and adherence models include linkage, navigation, multidisciplinary service coordination, peer services, referral tracking, and routine assessment and identification of medical and non-medical needs, including behavioral health and substance use services.

 Applicants who use the following staffing pattern will be best prepared to administer successful programs. Please note that applicants are not required to have each of these positions in place to be eligible to apply:

**RAP required staffing:**
- One or more (1.0) Full-Time Equivalent (FTE) RAP Specialist/Medical Case Manager or equivalent must have a B.A. or B.S. with at least one (1) year of HIV or other chronic-illness related field experience, or an Associate degree and three (3) years of such experience, or five (5) years of such experience. This position is a dedicated FTE without shared responsibilities or funding from other sources; and
- One or more (1.0) Full-Time Equivalent (FTE) Peer Navigator(s) Navigator/Community Health Worker(s) or equivalent.

Additional staff to be considered include:
- Program Manager
- Clinical lead
- Data Entry
- Quality Improvement

**Funded programs will provide qualified program administrators, managers, direct service, data, and peers representative of the populations prioritized.**
Component B: Center for Young Adults (CYA)
Program Description

The Centers for Young Adults (CYAs), formally known as the Specialized Care Centers program, will provide comprehensive HIV primary care, sexual and behavioral health, medical case management, and supportive services tailored to the unique needs of adolescents and young adults living with HIV (ages 13-29). Applicants must demonstrate experience providing HIV clinical and primary care and supportive services to young adults ages 13 - 29, from BIPOC, LGBTQ, and other communities experiencing disparate HIV outcomes.

Component B applicants will provide the scope of services in a clinical setting that is young adult and/or adolescent focused. CYA programs are patient-centered models of service delivery and are designed to improve early diagnosis and linkage to HIV primary care, rapid initiation of ART, engagement in supportive and psychosocial services, and use a strengths-based approach to facilitate the transition of adolescents to adult care.

The program model is implemented by a multidisciplinary team in a manner that employs a social justice/racial equity framework, affirms sexual and gender identity, incorporates a sexual health framework, trauma informed practices, and health literate care. CYA team members and primary care providers work collaboratively to coordinate clinical care and to address the psychosocial and non-medical social determinants of health that contribute to disparate health outcomes experienced by this population.

In addition to the Bureau of HIV Ambulatory Care Services Guiding Principles (Attachment 4), effective CYA models include linkage, navigation, multidisciplinary service coordination, peer services, systemic identification of medical and non-medical needs, including mental, behavioral health, and substance use services; PrEP and PEP education and partner screening, STI screening, referral follow up and tracking, and, tailored clinical-community partnerships that are responsive to the needs of the priority populations to be reached. Successful applicants will develop partnerships with community-based programs serving individuals to be reached through this solicitation and those that serve youth at elevated risk to facilitate early identification and active entry and referrals to care.

Peer services can play a key role in increasing linkage and retention in care, rates of viral suppression and preventing new infections. It is expected that peers will be included in proposed service models to the greatest extent possible. Programs models may also include evidence-based

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7 https://www.ahrq.gov/health-literacy/publications/ten-attributes.html
interventions that are responsive to the lived experiences, racism/racial discrimination, trauma, and stigma that disproportionately affects BIPOC, LGBTQ, MSM or other adolescent young adult communities experiencing disparate HIV outcomes.

To ensure a continuum of services that are responsive to the identified needs and social determinants of health experienced by the priority population(s) selected by the applicant, programs must develop and maintain streamlined referral processes and a tailored network of clinical-community partnerships to provide age-appropriate services not available at the funded location. Network partners should have a history serving at-risk youth, provide age appropriate psychosocial and supportive services, and work collaboratively with the CYA multidisciplinary team.

Priority population served through this component may include adolescents and young adults who are BIPOC, MSM, LGBTQ, or gender non-conforming individuals. Additional determinants that negatively impact successful engagement and viral load suppression may include: homelessness or unstable housing; involvement in “street economy”, sex trafficking; substance use; having experienced physical, mental, and/or sexual abuse/trauma; gang-involvement; and/or involvement with the criminal justice system. These experiences should be considered when developing proposals.

**CYA Required Staffing**

Applicants who use the following staffing pattern will be best prepared to administer successful programs. Please note that applicants are not required to have each of these positions in place to be eligible to apply:

- One or more (1.0) Full-Time Equivalent (FTE) CYA Medical Case Manager or equivalent must have a B.A. or B.S. with at least one (1) year of HIV or other chronic-illness related field experience, or an Associate degree and three (3) years of such experience, or five (5) years of such experience;
- Employ or subcontract with a youth oriented mental health provider (Psychiatrist, Psychologist, Psychiatric Nurse Practitioner, licensed clinical social worker, licensed mental health counselor) to co-located services. This consultation position allows for a specialist to review patient charts and provide input into mental health care and treatment and should facilitate referrals to mental health providers. Programs may include up to 25% (NYC) or 10% (Rest of State) of one FTE psychologist/psychiatrist/psychiatric nurse practitioner employed as a mental health consultant; and
- Employ or subcontract with a substance use provider, experienced in the delivery of young adult-focused therapeutic services to individuals living with HIV, to deliver services at the funded location. This position allows for a specialist to review medical records, provide clinical input into substance use care and treatment plans, and facilitate referrals higher levels of substance use care and treatment when needed.

Additional staff to be considered include:

- Program Manager
- Clinical lead
- Social Worker
- Peer(s)
Funded programs will provide qualified program administrators, managers, direct service, data, and peers representative of the population(s) to be reached through the proposal.

**Component C: Family-Focused Health Care for Women**

**Program Description**

Family-Focused HIV Health Care Programs (FFHC) provide comprehensive HIV-related services for *BIPOC women and birthing individuals* 8 who are planning a pregnancy, pregnant, or are caregivers to dependent children (age 18 or younger) and are living with HIV (WLWH). FFHC’s will support efforts to achieve and maintain viral load suppression, reduce the potential of perinatal HIV transmission and transmission of HIV to sexual partners, and improve medical outcomes through facilitation of early access to and retention in care and early initiation of HIV treatment. Family Planning/Reproductive Health services must encompass pre- and inter-conception, pregnancy and postpartum care reduce the potential of perinatal transmission of HIV and the disparate health outcomes experienced by babies who are BIPOC or at increased risk for poor postnatal outcomes.

Agencies that seek funding for this component should propose evidence-based interventions and comprehensive models with co-located services to promote a holistic and family-focused approach to women’s health.

Family-focused care provides a framework for the care and treatment of women and birthing individuals in the context of family. HIV services are tailored to meet the needs of women and birthing individuals with dependent children to improve timely entry, access, and retention in care. Programs must have active involvement of clinicians (physicians, mid-level practitioners) in the development, delivery, and evaluation of the program model as well as patient services, and routine participation in multidisciplinary team meetings. Communication among team members and community partners is essential to ensure that service coordination and timely interventions occur.

A multidisciplinary team implements the program model in a manner that affirms sexual and gender identity, and incorporates a sexual health framework 9, trauma informed practices 10, and health literate care 11. FFHC team members and primary care providers work collaboratively to coordinate clinical care and to address the psychosocial and non-medical social determinants of health that contribute to disparate health outcomes experienced by this population.

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8 The additive use of the term “birthing individual” is a move toward gender-inclusive language that represents identity and inclusiveness. For the purposes of this RFA it is important to note that the term(s) “women” or “woman” encompasses both cisgender and transgender women and “birthing individual” refers to any transgender, gender non-conforming, gender nonbinary, pansexual, queer, two-spirit, intersex, gender fluid, and additional identities not listed who do not identify as a woman and for whom pregnancy can occur.


In addition to the **Bureau of HIV Ambulatory Care Services Guiding Principles (Attachment 4)**, effective FFHC models include linkage, navigation, multidisciplinary service coordination, Peer services, systemic identification of medical and non-medical needs, including mental, behavioral health, and substance use services; PrEP and PEP education and partner screening, STI screening, referral follow up and tracking, and, tailored clinical-community partnerships that are responsive to the needs of the priority populations to be reached. Successful applicants will develop partnerships with community-based programs that have existing relationships with the population(s) to be served through this solicitation at elevated risk of poor neo-natal outcomes and to facilitate early identification and active entry and referrals to care.

To reduce barriers to care and to prevent missed appointments or loss to care, essential elements of family-focused care guide the service delivery model. Programs should ensure that clinical oversight of care and treatment for infants exposed or infected with HIV is provided by, or in consultation with, an experienced HIV clinician. In addition, medical care and treatment appointments for the child bearer and infant should be co-located and coordinated.

Peer services can play a key role in increasing linkage and retention in care, rates of viral suppression and preventing new infections. It is expected that Peers will be included in proposed service models to the greatest extent possible. Programs models may also include evidence-based interventions that are responsive to the lived experiences, racism/racial discrimination, trauma, and stigma that disproportionally affects BIPOC women, birthing, and transgender individuals experiencing disparate HIV and child health outcomes.

**FFHC applicants must additionally:**
- Demonstrate experience in the provision of HIV clinical and primary care and supportive services to childbearing persons planning a pregnancy, are pregnant, or are the primary caregiver to dependent children and are also living with HIV; and
- Have OB/GYN services located at the funded location that are integrated with program services.

**FFHC Staffing Requirements**
Applicants with the following staffing will be best prepared to successfully administer programs. Please note that applicants are not required to have each of these positions in place to be eligible to apply:

- One or more (1.0) Full-Time Equivalent (FTE) Medical Case Manager or equivalent must have a B.A. or B.S. with at least One or more (1.0) Full-Time Equivalent (FTE) positions one (1) year of HIV or other chronic-illness related field experience, or an Associate degree and three (3) years of such experience;
- Employ or subcontract with a mental health provider (Psychiatrist, Psychologist, Psychiatric Nurse Practitioner, licensed clinical social worker, licensed mental health counselor) to deliver services co-located. This consultation position allows for a specialist to review patient charts, provide clinical input into mental health care and treatment, and should facilitate referrals higher levels of mental health care when needed. Programs may include up to 25% (NYC) or 10% (Rest of State) of one FTE
psychologist/psychiatrist/psychiatric nurse practitioner employed as a mental health consultant;

- Employ or subcontract with a substance use provider, experienced in the delivery of young adult-focused therapeutic services to individuals living with HIV, to deliver services co-located services. This position allows for a specialist to review medical records, provide clinical input into substance use care and treatment plans, and facilitate referrals higher levels of substance use care and treatment when needed; and
- Employ at least one peer navigator with experience working in the field of HIV/AIDS to support medical case management activities (e.g., program promotion, treatment adherence support, co-facilitate educational workshops/groups, etc.).

Additional staff to be considered include:

- Data Entry
- Quality Improvement
- Program Manager
- Clinical lead

Funded programs will provide qualified program administrators, managers, direct service, data, and peers representative of the population(s) to be reached through the proposal.

B. Requirements for ALL COMPONENTS

All applicants selected for funding will be required to:

1. Adhere to the Bureau of HIV Ambulatory Care Services RFA Guiding Principles Attachment 4;
2. Adhere to all Work Plan objectives, tasks and performance measures for the Component for which an application is submitted. Attachment 5: Component A Work Plan; Attachment 6: Component B Work Plan; and Attachment 7: Component C Work Plan;
3. Be actively engaged and have experience providing services to clients who are representative of the priority population within the selected community for the component applied;
4. Coordinate services with other HIV/STI/HCV health and human service providers and participate in local HIV-related planning groups;
5. Collaborate with local health departments, regional offices of the NYSDOH as well as other health and human service providers in identifying and responding to emerging trends;
6. Participate in a collaborative process with the NYSDOH AI to assess progress meeting the initiative standards and program outcomes and provide monthly narrative reports describing the program with respect to 1) model implementation, 2) client identification, engagement, and retention 3) success in meeting the workplan objectives, tasks and performance measures for the RFA component applied for, 4) data collection and reporting 5) significant accomplishments achieved, and 6) barriers encountered and plans to address noted problems;
7. Ensure funded staff receive a minimum of 12 hours of training annually specific to the scope of services provided through this RFA;

8. Submit statistical reports on clients served, and other data using the NYSDOH AIDS Institute Reporting System (AIRS). Successful applicants must demonstrate the capacity to collect and report all required data, both personnel and hardware-related using AIRS. AIRS is a data reporting system that is required by the NYSDOH AI to report client demographic information as well as program activities. NYSDOH AI requires maintenance and reporting of unduplicated client level data, including demographics and service histories, in accordance with applicable federal and/or state reporting requirements. NYSDOH AI provides and supports the AIRS software to enable providers to meet data submission requirements. Details on this software product may be obtained by accessing the following Internet address, www.airsny.org;

9. Have an electronic medical record system;

10. Address and assess the specific social and/or structural determinants of health. The unequal distribution of social and/or determinants can lead to disparities and ultimately inequities in health and health outcomes. Strategies should prioritize those populations that are most impacted, negatively, by social and structural determinants of health;

11. Adhere to the most current Standards of Care, including, but not limited to, those issued by the NYSDOH AI and the HRSA National Monitoring Standards as a condition of receiving Ryan White funds. (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/program-monitoring-faq.pdf);


13. Establish, implement, and update annually an agency-specific quality management plan and shall conduct quality improvement projects addressing the specific needs of Ryan White Part B-funded services utilizing a proven quality improvement framework, such as the Plan-Do-Study-Act (PDSA) model or equivalent;

14. Participate in NYSDOH AI supported Ryan White Part B Quality Management Program meetings and activities, including, but not limited to, the submission of an annual Ryan White Part B quality management plan and quality improvement project, the reporting of established performance measures and the presentations of quality improvement projects at quality meetings per the timeline established by the NYSDOH AI;

15. Provide documentation of quality assurance and improvement activities, including maintenance of client satisfaction surveys and other mechanisms as designated by the NYSDOH AI, and

16. Participate in Ryan White Part B Quality Management Program-specific quality improvement trainings to ensure that the Contractor staff is aware and capacitated to participate in agency-specific quality improvement projects.

17. Address and assess the specific social and/or structural determinants of health. The unequal distribution of social and/or determinants can lead to disparities and ultimately inequities in health and health outcomes. Strategies should prioritize those populations that are most impacted, negatively, by social and structural determinants of health. Please
see Attachment 8: Health Equity Definitions and Examples of social and structural determinants of health.

IV. ADMINISTRATIVE REQUIREMENTS

A. Issuing Agency

This RFA is issued by the New York State Department of Health AIDS Institute (NYSDOH AI), Division of HIV Hepatitis Health Care, Bureau of HIV Ambulatory Care Services and Health Research Inc. The Department and HRI are responsible for the requirements specified herein and for the evaluation of all applications.

B. Question and Answer Phase

All substantive questions must be submitted in writing via email to:

2022.AHE.RFA@health.ny.gov

To the degree possible, each inquiry should cite the RFA section and paragraph to which it refers. Written questions will be accepted until the date posted on the cover of this RFA. This includes Minority and Women Owned Business Enterprise (MWBE) questions and questions pertaining to MWBE forms.

Questions of a technical nature can also be addressed in writing at the email address listed above. Questions are of a technical nature if they are limited to how to prepare your application (e.g., formatting) rather than relating to the substance of the application.

All questions submitted should state “Advancing HE” in the subject line.

Some helpful links for questions of a technical nature are below. Questions regarding specific opportunities or applications should be directed to the DOH contact listed on the cover of this RFA.

- https://grantsmanagement.ny.gov/resources-grant-applicants
- Grants Gateway Videos: https://grantsmanagement.ny.gov/videos-grant-applicants
- Grants Gateway Team Email: grantsgateway@its.ny.gov
  Phone: 518-474-5595
  Hours: Monday thru Friday 8am to 4pm
  (Application Completion, Policy, Prequalification and Registration questions)
- Agate Technical Support Help Desk
  Phone: 1-800-820-1890
  Hours: Monday thru Friday 8am to 8pm
Prospective applicants should note that all clarifications and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the submission of an application.

This RFA has been posted on the NYS Grants Gateway website at: https://grantsgateway.ny.gov/IntelliGrants_NYSGG/module/nysgg/goportal.aspx and a link provided on the Department’s public website at: https://www.health.ny.gov/funding/. The RFA is also posted on HRI’s public website at: http://www.healthresearch.org/funding-opportunities.

Questions and answers, as well as any updates and/or modifications, will be posted on the Grants Gateway and HRI’s website. All such updates will be posted by the date identified on the cover of this RFA.

C. Letter of Intent

Letters of Intent are not a requirement of this RFA.

D. Applicant Conference

An Applicant Conference will not be held for this project.

E. How to File an Application

Applications must be submitted online via the Grants Gateway by the date and time posted on the cover of this RFA. Reference materials and videos are available for Grantees applying to funding opportunities on the NYS Grants Gateway. Please visit the Grants Management website at the following web address: https://grantsmanagement.ny.gov/ and select the “Apply for a Grant” from the Apply & Manage menu. There is also a more detailed “Grants Gateway: Vendor User Guide” available in the documents section under Training & Guidance; For Grant Applicants on this page as well. Training webinars are also provided by the Grants Gateway Team. Dates and times for webinar instruction can be located at the following web address: https://grantsmanagement.ny.gov/live-webinars.

To apply for this opportunity:

1. Log into the Grants Gateway as either a “Grantee” or “Grantee Contract Signatory”.
2. On the Grants Gateway home page, click the “View Opportunities” button”.
3. Use the search fields to locate an opportunity; search by State agency (NYSDOH) or enter the Grant Opportunity name <INSERT RFA NAME>.
4. Click on “Search” button to initiate the search.
5. Click on the name of the Grant Opportunity from the search results grid and then select the “APPLY FOR GRANT OPPORTUNITY” button located bottom left of the Main page of the Grant Opportunity.

Once the application is complete, prospective grantees are strongly encouraged to submit their applications at least 48 hours prior to the due date and time. This will allow sufficient opportunity for the applicant to obtain assistance and take corrective action should there be a technical issue with the submission process. Failure to leave adequate time to address issues identified during this process may jeopardize an applicant’s ability to submit their application. Both NYSDOH and Grants Gateway staff are available to answer applicant’s technical questions and provide technical assistance prior to the application due date and time. Contact information for the Grants Gateway Team is available under Section IV. B. of this RFA.

PLEASE NOTE: Although NYSDOH and the Grants Gateway staff will do their best to address concerns that are identified less than 48 hours prior to the due date and time, there is no guarantee that they will be resolved in time for the application to be submitted and, therefore, considered for funding.

The Grants Gateway will always notify applicants of successful submission. If a prospective grantee does not get a successful submission message assigning their application a unique I.D. number, it has not successfully submitted an application. During the application process, please pay particular attention to the following:

- Not-for-profit applicants must be prequalified on the due date for this application submission. Be sure to maintain prequalification status between funding opportunities. Three of a not-for-profit’s essential financial documents - the IRS990, Financial Statement and Charities Bureau filing - expire on an annual basis. If these documents are allowed to expire, the not-for-profit’s prequalification status expires as well, and it will not be eligible for State grant funding until its documentation is updated and approved, and prequalified status is reinstated.
- Only individuals with the roles “Grantee Contract Signatory” or “Grantee System Administrator” can submit an application.
- Prior to submission, the system will automatically initiate a global error checking process to protect against incomplete applications. An applicant may need to attend to certain parts of the application prior to being able to submit the application successfully. Be sure to allow time after pressing the submit button to clean up any global errors that may arise. You can also run the global error check at any time in the application process. (see p.68 of the Grants Gateway: Vendor User Guide).
- Grantees should use numbers, letters and underscores when naming their uploaded files. There cannot be any special characters in the uploaded file name. Also, be aware of the restriction on file size (10 M.B.) when uploading documents. Grantees should ensure that any attachments uploaded with their application are not “protected” or “pass-worded” documents.
The following table will provide a snapshot of which roles are allowed to Initiate, Complete, and Submit the Grant Application(s) in the Grants Gateway.

<table>
<thead>
<tr>
<th>Role</th>
<th>Create and Maintain User Roles</th>
<th>Initiate Application</th>
<th>Complete Application</th>
<th>Submit Application</th>
<th>Only View the Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegated Admin</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grantee</td>
<td></td>
<td>X</td>
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<tr>
<td>Grantee Contract Signatory</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Grantee Payment Signatory</td>
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<tr>
<td>Grantee System Administrator</td>
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<td>X</td>
<td></td>
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<tr>
<td>Grantee View Only</td>
<td></td>
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<td></td>
<td>X</td>
</tr>
</tbody>
</table>

PLEASE NOTE: Waiting until the last several days to complete your application online can be dangerous, as you may have technical questions. Beginning the process of applying as soon as possible will produce the best results.

Late applications will not be accepted. **Applications will not be accepted via fax, e-mail, hard copy or hand delivery.**

F. Department of Health’s and HRI’s Reserved Rights

The Department of Health and HRI reserve the right to:

1. Reject any or all applications received in response to this RFA.
2. Withdraw the RFA at any time, at the Department’s or HRI’s sole discretion.
3. Make an award under the RFA in whole or in part.
4. Disqualify any applicant whose conduct and/or proposal fails to conform to the requirements of the RFA.
5. Seek clarifications and revisions of applications.
6. Use application information obtained through site visits, management interviews and the state’s investigation of an applicant’s qualifications, experience, ability or financial standing, and any material or information submitted by the applicant in response to the agency’s request for clarifying information in the course of evaluation and/or selection under the RFA.
7. Prior to application opening, amend the RFA specifications to correct errors or oversights, or to supply additional information, as it becomes available.
8. Prior to application opening, direct applicants to submit proposal modifications addressing subsequent RFA amendments.
9. Change any of the scheduled dates.
10. Waive any requirements that are not material.
11. Award more than one contract resulting from this RFA.
12. Conduct contract negotiations with the next responsible applicant, should the Department or HRI be unsuccessful in negotiating with the selected applicant.
13. Utilize any and all ideas submitted with the applications received.
14. Unless otherwise specified in the RFA, every offer is firm and not revocable for a period of 60 days from the bid opening.
15. Waive or modify minor irregularities in applications received after prior notification to the applicant.
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer’s application and/or to determine an offerer’s compliance with the requirements of the RFA.
17. Negotiate with successful applicants within the scope of the RFA in the best interests of the State and HRI.
18. Eliminate any mandatory, non-material specifications that cannot be complied with by all applicants.
19. Award grants based on geographic or regional considerations to serve the best interests of the state and HRI.

G. Term of Contract

Any State contract resulting from this RFA will be effective only upon approval by the New York State Office of the Comptroller. Any HRI contract resulting from this RFA will be effective only upon approval by HRI. Refer to Attachment 9—General Terms and Conditions – Health Research Incorporated Contracts.

It is expected that NYS contracts resulting from this RFA will have the following multi-year time period: **July 1, 2023 – June 30, 2028**. Continued funding throughout this period is contingent upon availability of funding and state budget appropriations. NYSDOH also reserves the right to revise the award amount as necessary due to changes in the availability of funding.

A sample New York State Master Contract for Grants can be found in the Forms Menu once an application to this funding opportunity is started.

HRI funded contracts resulting from this RFA will be for 12-month terms. The anticipated start date of HRI contracts is July 1, 2023. However, depending on the funding source, the initial contract term could be for a shorter time period. HRI awards may be renewed for up to four (4) additional annual contract periods based on satisfactory performance and availability of funds. HRI reserves the right to revise the award amount as necessary due to changes in the availability of funding.
H. Payment & Reporting Requirements of Grant Awardees

1. The Department may, at its discretion, make an advance payment to not for profit grant contractors in an amount not to exceed twenty-five (25) percent. Due to requirements of the federal funder, no advance payments will be allowed for HRI contracts resulting from this procurement.

2. The grant contractor will be required to submit monthly invoices and required reports of expenditures to the State’s designated payment office (below) or, if requested by the Department, through the Grants Gateway:

   DHHHCFiscal@health.ny.gov

Grant contractors must provide complete and accurate billing invoices in order to receive payment. Billing invoices submitted to the Department must contain all information and supporting documentation required by the Contract, the Department and the Office of the State Comptroller (OSC). Payment for invoices submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner’s sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with OSC’s procedures and practices to authorize electronic payments. Authorization forms are available at OSC’s website at: http://www.osc.state.ny.us/epay/index.htm, by email at: epayments@osc.state.ny.us or by telephone at 855-233-8363. CONTRACTOR acknowledges that it will not receive payment on any claims for reimbursement submitted under this contract if it does not comply with OSC’s electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

Payment of such claims for reimbursement by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be: Contractor will be reimbursed for actual expenses incurred as allowed in the Contract Budget and Work Plan.

3. The funded grant contractor will be required to submit the following periodic reports at the address above or, to the State’s designated payment office (below) or, if requested by the Department, through the Grants Gateway:
   • A monthly narrative addressing program implementation, barriers and accomplishments.
   • Monthly client service and outcome data through the AIDS Institute Reporting System (AIRS). http://www.airsny.org/

For HRI contracts, contractors will be expected to submit voucher claims and reports of expenditures in the manner that HRI requires. Required forms will be provided with the contract package.
All payment and reporting requirements will be detailed in Attachment D of the final NYS Master Grant Contract. For HRI Contracts, payments and reporting requirements will be detailed in Exhibit “C” of the final contract.

I. Minority & Woman-Owned Business Enterprise Requirements

Pursuant to New York State Executive Law Article 15-A, the New York State Department of Health (“NYSDOH”) recognizes its obligation to promote opportunities for maximum feasible participation of certified minority- and women-owned business enterprises and the employment of minority group members and women in the performance of NYSDOH contracts.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title “The State of Minority and Women-Owned Business Enterprises: Evidence from New York” (“Disparity Study”). The report found evidence of statistically significant disparities between the level of participation of minority- and women-owned business enterprises in state procurement contracting versus the number of minority- and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority- and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that NYSDOH establish goals for maximum feasible participation of New York State Certified minority- and women-owned business enterprises (“MWBE”) and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs

For purposes of this solicitation, the New York State Department of Health hereby establishes a goal of 30% as follows:

1) For Not-for-Profit Applicants: Eligible Expenditures include any subcontracted labor or services, equipment, materials, or any combined purchase of the foregoing under a contract awarded from this solicitation.

2) For-Profit and Municipality Applicants: Eligible Expenditures include the value of the budget in total.

The goal on the eligible portion of this contract will be 15% for Minority-Owned Business Enterprises (“MBE”) participation and 15% for Women-Owned Business Enterprises (“WBE”) participation (based on the current availability of qualified MBEs and WBEs and outreach efforts to certified MWBE firms). A contractor (“Contractor”) on the subject contract (“Contract”) must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor
agrees that NYSDOH may withhold payment pending receipt of the required MWBE documentation. For guidance on how NYSDOH will determine “good faith efforts,” refer to 5 NYCRR §142.8.

The directory of New York State Certified MWBEs can be viewed at: https://ny.newnycontracts.com. The directory is found on this page under “NYS Directory of Certified Firms” and accessed by clicking on the link entitled “Search the Directory”. Engaging with firms found in the directory with like product(s) and/or service(s) is strongly encouraged and all communication efforts and responses should be well documented.

By submitting an application, a grantee agrees to complete an MWBE Utilization plan as directed in Attachment 10 of this RFA. NYSDOH will review the submitted MWBE Utilization Plan. If the plan is not accepted, NYSDOH may issue a notice of deficiency. If a notice of deficiency is issued, Grantee agrees that it shall respond to the notice of deficiency within seven (7) business days of receipt. NYSDOH may disqualify a Grantee as being non-responsive under the following circumstances:

a) If a Grantee fails to submit a MWBE Utilization Plan;

b) If a Grantee fails to submit a written remedy to a notice of deficiency;

c) If a Grantee fails to submit a request for waiver (if applicable); or

d) If NYSDOH determines that the Grantee has failed to document good-faith efforts to meet the established NYSDOH MWBE participation goals for the procurement.

In addition, successful awardees will be required to certify they have an acceptable Equal Employment Opportunity policy statement.

J. Vendor Identification Number

Effective January 1, 2012, in order to do business with New York State, you must have a vendor identification number. As part of the Statewide Financial System (SFS), the Office of the State Comptroller’s Bureau of State Expenditures has created a centralized vendor repository called the New York State Vendor File. In the event of an award and in order to initiate a contract with the New York State Department of Health, vendors must be registered in the New York State Vendor File and have a valid New York State Vendor ID.

If already enrolled in the Vendor File, please include the Vendor Identification number on the application cover sheet. If not enrolled, to request assignment of a Vendor Identification number, please submit a New York State Office of the State Comptroller Substitute Form W-9, which can be found on-line at: https://www.osc.state.ny.us/files/vendors/2017-11/vendor-form-ac3237s-fe.pdf.

Additional information concerning the New York State Vendor File can be obtained on-line at: http://www.osc.state.ny.us/vendor_management/index.htm, by contacting the SFS Help Desk at 855-233-8363 or by emailing at helpdesk@sfs.ny.gov.

K. Vendor Responsibility Questionnaire
The New York State Department of Health strongly encourages that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System. The Vendor Responsibility Questionnaire must be updated and certified every six (6) months. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at https://www.osc.state.ny.us/state-vendors/vendrep/file-your-vendor-responsibility-questionnaire or go directly to the VendRep system online at https://www.osc.state.ny.us/state-vendors/vendrep/vendrep-system.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the Office of the State Comptroller’s Help Desk at 866-370-4672 or 518-408-4672 or by email at ITServicedesk@osc.ny.gov.

Applicants opting to complete online should complete and upload the Vendor Responsibility Attestation (Attachment 11) of the RFA. The Attestation is located under Pre-Submission uploads and once completed should be uploaded in the same section.

Applicants opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website, www.osc.state.ny.us/vendrep, and upload it with their Application in the Pre-Submission uploads section in place of the Attestation.

L. Vendor Prequalification for Not-for-Profits

All not-for-profit vendors subject to prequalification are required to prequalify prior to grant application and execution of contracts.

Pursuant to the New York State Division of Budget Bulletin H-1032, dated July 16, 2014, New York State has instituted key reform initiatives to the grant contract process which requires not-for-profits to register in the Grants Gateway and complete the Vendor Prequalification process in order for applications to be evaluated. Information on these initiatives can be found on the Grants Management Website.

Applications received from not-for-profit applicants that have not Registered and are not Prequalified in the Grants Gateway on the application due date listed on the cover of this RFA cannot be evaluated. Such applications will be disqualified from further consideration.

Below is a summary of the steps that must be completed to meet registration and prequalification requirements. The Vendor Prequalification Manual on the Grants Management Website details the requirements and an online tutorial are available to walk users through the process.

1) Register for the Grants Gateway

- On the Grants Management Website, download a copy of the Registration Form for Administrator. A signed, notarized original form must be sent to the NYS Grants
Management office at the address provided in the submission instructions. You will be provided with a Username and Password allowing you to access the Grants Gateway.

If you have previously registered and do not know your Username, please email grantsgateway@its.ny.gov. If you do not know your Password, please click the Forgot Password link from the main log in page and follow the prompts.

2) Complete your Prequalification Application

- Log in to the Grants Gateway. If this is your first time logging in, you will be prompted to change your password at the bottom of your Profile page. Enter a new password and click SAVE.

- Click the Organization(s) link at the top of the page and complete the required fields including selecting the State agency you have the most grants with. This page should be completed in its entirety before you SAVE. A Document Vault link will become available near the top of the page. Click this link to access the main Document Vault page.

- Answer the questions in the Required Forms and upload Required Documents. This constitutes your Prequalification Application. Optional Documents are not required unless specified in this Request for Application.

- Specific questions about the prequalification process should be referred to your agency representative or to the Grants Gateway Team at grantsgateway@its.ny.gov.

3) Submit Your Prequalification Application

- After completing your Prequalification Application, click the Submit Document Vault Link located below the Required Documents section to submit your Prequalification Application for State agency review. Once submitted the status of the Document Vault will change to In Review.

- If your Prequalification reviewer has questions or requests changes you will receive email notification from the Gateway system.

- Once your Prequalification Application has been approved, you will receive a Gateway notification that you are now prequalified to do business with New York State.

Vendors are strongly encouraged to begin the process as soon as possible in order to participate in this opportunity.

M. General Specifications
1. By submitting the “Application Form”, each applicant attests to its express authority to sign on behalf of the applicant.

2. Contractors will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

3. Submission of an application indicates the applicant’s acceptance of all conditions and terms contained in this RFA, including the terms and conditions of the contract. Any exceptions allowed by the Department during the Question and Answer Phase (Section IV.B.) must be clearly noted in a cover letter included with the application.

4. An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.

5. Provisions Upon Default
   
a. The services to be performed by the Applicant shall be at all times subject to the direction and control of the Department as to all matters arising in connection with or relating to the contract resulting from this RFA.

b. In the event that the Applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFA, HRI and the Department acting for and on behalf of the State, shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the Applicant.

c. If, in the judgment of the Department and HRI, the Applicant acts in such a way which is likely to or does impair or prejudice the interests of the State and HRI, the Department and HRI acting on behalf of the State, shall thereupon have the right to terminate any contract resulting from this RFA by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgement of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

6. Applicant must maintain an active registration in the System for Award Management (SAM) at SAM.gov, have no exclusions or delinquent federal debt.
V. COMPLETING THE APPLICATION

A. Application Format and Content

Please refer to the Grants Gateway: Vendor User Guide for assistance in applying for this procurement through the NYS Grants Gateway. This guide is available on the Grants Management website at: https://grantsmanagement.ny.gov/vendor-user-manual. Additional information for applicants is available at: https://grantsmanagement.ny.gov/resources-grant-applicants.

Also, you must use Microsoft Edge to access the Grants Gateway. Using Chrome or Firefox causes errors in the Work Plan section of the application.

Please respond to each of the sections described below when completing the Grants Gateway online application. Your responses comprise your application. Please respond to all items within each section. When responding to the statements and questions, be mindful that application reviewers may not be familiar with the agency and its services. Therefore, answers should be specific, succinct and responsive to the statements and questions as outlined.

All applicants are required to complete and upload Attachment 12 (Application Cover Page). Attachment 12 should be submitted via the Grants Gateway in the Pre-Submission Uploads section of the online application.

Application Format for ALL COMPONENTS of the RFA

1. Program Abstract Not Scored
2. Community and Agency Description Maximum Score: 15 points
3. Health Equity Maximum Score: 15 points
4. Program Design and Implementation Maximum Score: 50 points
5. Budget and Justification Maximum Score: 20 points

1. Program Abstract Not Scored

Applicants should provide a program abstract with the following information:

1a) Describe the proposed program for the component for which you are applying. Include its purpose and design stating what will be completed and how.
1b) Describe the priority population(s) and specific needs of the priority populations of the component for which you are applying. Indicate the total projected number of unduplicated clients to be served annually.

1c) Describe the unmet service gaps or patient needs that the proposed program and funding will meet? What organizational systems are in place to ensure program services reach the priority populations experiencing the most significant disparate outcomes?

1d) State the goals and objectives of your program and outcomes your organization expects to achieve under the component for which you are applying.

1e) State how program success will be measured. Include anticipated challenges in providing services.

2. Community and Agency Description Total 15 Points

2a) Describe why the applicant is qualified to implement the proposed program model under the component for which you are applying. Describe the need for services within the community. Include both quantitative and qualitative evidence to address this question. Applicants are instructed to complete Attachment 13: Sites, Days, and Hours of Operations chart indicating the service location(s) within the proposed service area; and site accessibility for the priority population. Attachment 13 should be uploaded to the Grants Gateway in the Pre-Submission Uploads section of the online application.

2b) Describe your organization’s experience in serving the priority population and community identified for the program services for which you are applying. Include organizational strengths and experience related to the specific component for which you are applying. State how your previous efforts and successes have aligned with achieving the goals of improving health outcomes of PLWH/A. Applicants are instructed to complete Attachment 14: Service Delivery Experience Table indicating how many years of experience they have providing the listed services and an estimate of how many individuals received those services. Attachment 14 should be uploaded to the Grants Gateway in the Pre-Submission Uploads section of the online application.

2c) What are the other programs and agencies in the geographic area that are relevant to your proposed program model and component for which you are applying? Describe your partnership with these agencies and how you will leverage these programs to maximize benefit to the priority populations indicated in your proposal without supplanting other resources?

2d) Please describe prior grants your organization has received from the NYSDOH AI that are relevant to this proposal. Include the results of the program and successes. If your organization has not received funding from the NYSDOH AI, describe any similar types of programs that your organization has undertaken in the past; include the results of the program and successes in achieving those results.
3. **Health Equity**  

   **Total 15 Points**

3a) Which SDOH(s) barriers will you address with the priority population served by this funding?

3b) Please provide the most current data that you have used to identify the SDOH barriers affecting the population served by the funding.

3c) Describe how will you monitor and evaluate the immediate impact of your efforts to address the SDOH(s). (i.e., if you have offered nutrition or housing services, for example, to a client and they have responded, has it improved their adherence with treatment?)

3d) What is your organization’s policy around addressing SDOH(s)? What is the agency’s capacity (staff knowledge, staff training, support for collaboration and evaluation) at addressing this?

3e) How does the organization’s leadership reflect the population served?

4. **Program Design and Implementation**  

   **Total 50 Points**

4a) Describe the proposed program model design for the component for which you are applying. Include specific strategies for implementing the program services. Describe interventions or innovative strategies with supporting evidence or rationale for utilizing them to implement your program model. Include how your model reflects the Bureau of HIV Ambulatory Care RFA Guiding Principles (Attachment 4) and the work plan for the component applied.

4b) Describe how consumers and key representatives from the community and priority populations you are proposing to serve for the component you are applying were included in the program design process. Describe what steps you will take to ensure that representation from the priority population(s) is included in implementing and evaluating the proposed program services. Applicants are required to complete the **Program Implementation Timeline (Attachment 15)**. Attachment 15 should be uploaded in the Grants Gateway in the Pre-Submission Uploads section of the Grants Gateway online application.

4c) Describe how your program will ensure effective services across the HIV, STI, and HCV care continuum, including access, linkage, and engagement in needed services for the component you are applying. Describe the organization's processes to ensure the development of tailored internal and external referral partnerships that meet the priority population's needs. Describe how these referrals will be facilitated, coordinated, recorded, reported, and evaluated for outcomes. What are the proposed methods to evaluate the effectiveness of these referral partnerships and community collaborations and their impact on the SDOH experienced by the priority population(s)? Applicants are required to complete **Attachment 16: Accessibility, Referral, Navigation, and Services**
Continuum Assessment. Attachment 16 should be uploaded to the Grants Gateway in the Pre-Submission Uploads section of the online application.

4d) Provide a brief description of staff roles and responsibilities and how the proposed staffing plan meets the minimum requirement and innovations described in the program model. The descriptions should include the job qualifications, educational background, licensures, and experience required. The staffing detail should include staff responsible for AIRS activities (System administration, data entry, data quality control, and NYSDOH AI reporting) and any in-kind staff. Applicants are instructed to complete Attachment 17– Agency Capacity and Staffing Information. Applicants are also required to upload their Organizational Chart as Attachment 18 to demonstrate the management and supervisory structure for the proposed program. Attachments 17 and 18 should be uploaded to the Grants Gateway in the Pre-Submission Uploads section of the online application.

4e) Describe how your organization identifies, prioritizes, and responds to health disparities. Describe any systemic or programmatic changes that have resulted from this approach in the past two years.

4f) Describe the plan for initial and ongoing staff training and support. Describe the agency’s health equity training plan, current and proposed.

4g) Describe the agency’s processes of program monitoring and Quality Improvement. Include the program’s indicators for success and how these measures are tracked to assess the effectiveness of the proposed services and activities for which you are applying. Describe how you will ensure that indicators falling below targets are addressed and improved.

4h) Describe the data flow process from the point of service delivery to entry into the AIDS Institute Reporting System (AIRS). Include how your organization will collect, analyze, and report client-level quality programmatic data for the component for which you are applying. Explain how data is extrapolated from the EHR to AIRS and other tracking systems.

5. Budgets and Justifications  Total 20 Points

Complete and submit a budget following these instructions:

5a) Applicants are instructed to prepare an annual budget based on the maximum award as listed for the region in which they are applying. The budget for year one (July 1, 2023 – June 30, 2024) must be entered into the Grants Gateway. Refer to Grants Gateway Expenditure Budget Instructions - Attachment 19. All budget lines should be calculated as whole dollar amounts. All costs should be related to the proposed activities, as described in the application narrative and work plan, and should be justified in detail. All costs should be reasonable and cost-effective. Contracts established resulting from the RFA will be cost reimbursable.
5b) For staff listed in the Personal services (Salary and Fringe) section of the budget, include a breakdown of the total salary needs for staff. Indicate how the positions relate to program implementation. Applicants are instructed to include a justification for each of the requested FTE’s and for the fringe benefits requested.

5c) For each item listed under Non-Personal services, describe how it is necessary for program implementation. Non-Personal services include: Contractual, Travel, Equipment, Space/Property & Utilities, Operating Expenses and Other costs.

5d) For the last three (3) years, does your organizations’ Statement of Activities from your yearly audit show that revenues exceeded expenses or expenses exceeded revenue? If the expenses exceeded revenues, please describe both the cost reduction plan and the deficit reduction plan that will correct this. Please attach the Statement of Activities for past three (3) years from your yearly audit for the last three (3) years. The Statement of Activities must show total support and revenue and total expenditures. The Statement of Activities should be uploaded to the Grants Gateway in the Pre-Submission Uploads section as Attachment 20.

5e) Applicants are required to upload a copy of their agency Time and Effort policy as Attachment 21 in the Pre-Submission uploads section of the Grants Gateway online application.

5f) Describe the specific internal controls your agency uses to comply with the Federal Uniform Guidance (2 CFR 200).

5g) Applicants are required to complete Funding History for HIV Services (Attachment 22). Attachment 22 should be uploaded to the Grants Gateway in the Pre-Submission Uploads section.

5h) Funding requests must adhere to the following guidelines:

- An indirect cost rate of up to 10% of total direct costs can be requested. If your organization has a federally approved rate, an indirect cost rate of up to 20% of total direct costs can be requested. If your agency has a federally approved rate of less than 20%, the maximum indirect rate that can be requested is the federally approved rate.

- Funding may only be used to expand existing activities and create new activities pursuant to this RFA. Funds may not be used to supplant funds for currently existing staff and activities. Agencies currently funded by the NYSDOH AI to provide program services in accordance with the requirements of this RFA must apply for continuation of funding.

- Ineligible budget items will be removed from the budget prior to contracting. Ineligible items are those items determined by NYSDOH/HRI to be inadequately justified in relation to the proposed Work Plan or not fundable under existing federal guidance (Uniform Guidance). The budget amount requested will be reduced to reflect the removal of the ineligible items.
6. Work Plan

For the Grants Gateway Work Plan Project Summary, applicants are instructed to insert the Project Summary as it is listed in Component specific Work Plan for which an application is being submitted. In the Grants Gateway Work Plan Organizational Capacity section, applicants are instructed to list this as “not applicable.” Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Component specific Work Plan for which an application is being submitted. Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.

It is the applicant’s responsibility to ensure that all materials to be included in the application have been properly prepared and submitted. Applications must be submitted via the Grants Gateway by the date and time posted on the cover of this RFA. The value assigned to each section is an indication of the relative weight that will be given when scoring your application.

B. Freedom of Information Law

All applications may be disclosed or used by NYSDOH to the extent permitted by law. NYSDOH may disclose an application to any person for the purpose of assisting in evaluating the application or for any other lawful purpose. All applications will become State agency records, which will be available to the public in accordance with the Freedom of Information Law. Any portion of the application that an applicant believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the application. If NYSDOH agrees with the proprietary claim, the designated portion of the application will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

C. Review & Award Process

Applications meeting the eligibility requirements and guidelines set forth above will be reviewed and evaluated competitively by a panel convened by the NYSDOH AI using an objective rating system reflective of the required items specified for each component.

The NYSDOH AI anticipates that there may be more worthy applications than can be funded with available resources. Please see Section I. B of the RFA for specific review and award information. Applications will be deemed to fall into one of three categories: 1) approved and funded, 2) not funded, due to limited resources, and 3) not approved. Not funded applications may be awarded should additional funds become available.
In the event of a tie score, the applicant with the highest score for Section 3 – Health Equity will receive the award.

Applications with minor issues (missing information that is not essential to timely review and would not impact review scores) MAY be processed, at the discretion of the State, but all issues need to be resolved prior to time of award. An application with unresolved issues at the time award recommendations are made will be determined to be non-responsive and will be disqualified.

NYSDOH AI and HRI reserve the right to revise the award amounts as necessary due to changes in the availability of funding. If changes in funding amounts are necessary for this initiative, funding will be modified and awarded in the same manner as outlined in the award process described above. NYSDOH AI and HRI reserve the right to review and rescind all subcontracts.

Once an award has been made, applicants may request a debriefing of their application (whether their application was funded or not funded). Please note the debriefing will be limited only to the strengths and weaknesses of the subject application and will not include any discussion of other applications. Requests must be received no later than fifteen (15) calendar days from date of award or non-award announcement.

To request a debriefing, please send an email to Margaret Smalls at 2022.AHE.RFA@health.ny.gov here. In the subject line, please write: Debriefing Request (Advancing Health Equity).

In the event unsuccessful applicants wish to protest the award resulting from this RFA, applicants should follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found on the OSC website at http://www.osc.state.ny.us/agencies/guide/MyWebHelp. (Section XI. 17.)

VI. ATTACHMENTS

Please note that certain attachments are accessed under the “Pre-Submission Uploads” section of an online application and are not included in the RFA document. In order to access the online application and other required documents such as the attachments, prospective applicants must be registered and logged into the NYS Grants Gateway in the user role of either a “Grantee” or a “Grantee Contract Signatory”.

Attachment 1: Ryan White Guidance for Part B Direct Service Contractors**
Attachment 2: Electronic Health Records Assessment*
Attachment 3: Statement of Assurances*
Attachment 4: Bureau of HIV Ambulatory Care Services Guiding Principles**
Attachment 5: Component A Work Plan**
Attachment 6: Component B Work Plan**
Attachment 7: Component C Work Plan**
Attachment 8: Health Equity Definitions and Examples**
Attachment 9: General Terms and Conditions – Health Research Incorporated Contracts. **
Attachment 10: MWBE Utilization Plan *
Attachment 11: Vendor Responsibility Attestation *
Attachment 12: Application Cover Page*
Attachment 13: Sites, Days, and Hours of Operations*
Attachment 14: Service Delivery Experience Table*
Attachment 15: Program Implementation Timeline*
Attachment 16: Accessibility, Referral, Navigation, and Services Continuum Assessment*
Attachment 17: Agency Capacity and Staffing Information*
Attachment 18: Organizational Chart
Attachment 19: Grants Gateway Expenditure Budget Instructions
Attachment 20: Statement of Activities for past three (3) years
Attachment 21: Time and Effort Policy
Attachment 22: Funding History for HIV Services*

*These attachments are located / included in the Pre-Submission Upload section of the Grants Gateway online Application.

**These attachments are attached to the RFA and are for applicant information only. These attachments do not need to be completed.
ATTACHMENT 1 - RYAN WHITE GUIDANCE FOR PART B DIRECT SERVICE SUBCONTRACTORS

This guidance sets forth requirements related to AIDS Institute Ryan White Part B contracts as stipulated in the Ryan White HIV/AIDS Treatment Extension Act and as mandated by HRSA policy and New York State policy. The following information provides guidance for contractors in developing budgets and work plans. Ryan White Part B contracts must adhere to these requirements. This guidance includes information on allowable services, client eligibility, time and effort reporting, administration, and payer of last resort requirements. Please note that these policies may not be applicable to Ryan White Part A contracts administered by PHS.

Ryan White Service Categories
The Ryan White law limits the persons eligible for Ryan White services and limits the services that are allowable with Ryan White funds. Activities supported and the use of funds appropriated under the law must be in accordance with legislative intent, federal cost principles, and program-specific policies issued by the federal Health Resources and Services Administration (HRSA). HRSA policy related to Ryan White Parts A and B states that no service will be supported with Ryan White funds unless it falls within the legislatively defined range of services. In addition, the law stipulates that Ryan White is the “payer of last resort” (see payer of last resort section on page 4). In conducting program planning, developing contracts, and overseeing programs, you must comply with legislative intent and HRSA policy regarding allowable services and payer of last resort requirements.

Ryan White funded medical and support services must be provided in settings that are accessible to low-income individuals with HIV disease.

By receiving Part B funds, the contractor agrees to participate, as appropriate, in Ryan White HIV/AIDS Treatment Extension Act initiatives. The contractor agrees that such participation is essential in meeting the needs of clients with HIV as well as achieving the overall goals and objectives of the Ryan White HIV/AIDS Treatment Extension Act.

Ryan White Part B funds as administered by the NYSDOH AIDS Institute may be used to support the following services:

**CORE SERVICES**

**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 provided under this service category may be provided 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
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 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

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, other state or
local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Medical case management may be provided in a variety of medical settings, including community health centers, County Departments of Health, hospitals, or other Article 28 facilities. All medical case management services must be provided in accordance with AIDS Institute medical case management standards.

**SUPPORT SERVICES, defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS.** Support services must be shown to improve clinical outcomes. Support services must facilitate access to care. Allowable support services are:

- **Case management (non-medical)** Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children’s Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, 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-specific advocacy and/or review of utilization of services
  - Continuous client monitoring to assess the efficacy of the care plan
  - Re-evaluation of the care plan at least every 6 months with adaptations as necessary
  - Ongoing assessment of the client’s and other key family members’ needs and personal support systems

In accordance with HRSA HAB policy notice 18-02, this includes transitional case management for incarcerated persons as they prepare to exit the correctional system as part of effective discharge planning, or who are in the correctional system for a brief period, which would not include any type of discharge planning. All non-medical case management services must be provided in accordance with AIDS Institute non-medical case management standards.

- **Emergency Financial Assistance** provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are not permitted.

- **Food Bank/Home Delivered Meals** refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:
  - Personal hygiene products
  - Household cleaning supplies
• **Health Education/Risk Reduction** is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:
  - Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients’ partners and treatment as prevention
  - Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
  - Health literacy
  - Treatment adherence education

• **Housing** provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client’s linkage to permanent housing.

  Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

  Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits.

• **Medical Transportation** is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

• **Psychosocial Support** Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:
  - HIV support groups
  - Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)

• **Other Professional Services** allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:
  - Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
    - Preparation of:
      - Healthcare power of attorney
      - Durable powers of attorney
      - Living wills
• Ryan White funds may also be used to support training of providers delivering allowable services that is intended to improve medical outcomes and consumer education/training that is intended to improve medical outcomes.

Payer of Last Resort
- Ryan White is payer of last resort. The Ryan White HIV/AIDS Treatment Extension Act requires that "...the State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made with respect to 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. Ryan White funding may only be used for services that are not reimbursable by Medicaid, ADAP Plus or other third-party payers.

- The Contractor shall (i) maintain policies and staff training on the requirement that Ryan White be the payer of last resort and how that requirement is met; (ii) screen each client for insurance coverage and eligibility for third party programs, assist clients in applying for such coverage and document this in client files; and (iii) carry out internal review of files and billing system to ensure Ryan White resources are used only when a third-party payer is not available.

- The Contractor shall (i) have billing, collection, co-pay and sliding fee policies that do not act as a barrier to providing services regardless of the client’s ability to pay and (ii) maintain file of individuals refused services with reasons for refusal specified and any complaints from clients with documentation of complaint review and decision reached.

- The Contractor shall ensure that policies and procedures classify veterans receiving VA health benefits as uninsured, thus exempting these veterans from the payer of last resort requirement.

Medicaid Certification & Program Income
- Contractors that provide Medicaid-eligible services pursuant to this agreement shall (i) participate in New York State’s Medicaid program; (ii) maintain documentation of their Medicaid certification; (iii) maintain file of contracts with Medicaid insurance companies; and (iv) document efforts to obtain Medicaid certification or request waiver where certification is not feasible.

- The Contractor shall bill, track and report to HRI all program income (including drug rebates) pursuant to this agreement that are billed and obtained. Report of program income will be documented by charges, collections and adjustment reports or by the application of a revenue allocation formula.

- The Contractor shall (i) establish policies and procedures for handling Ryan White revenue including program income; (ii) prepare a detailed chart of accounts and general ledger that provide for the tracking of Ryan White revenue; and (iii) make the policies and process available for granted review upon request.

Client Charges
The Ryan White HIV/AIDS Program legislation requires grantees and subgrantees to develop and implement policies and procedures that specify charges to clients for Ryan White funded services. These policies and procedures must also establish sliding fee scales and discount schedules for clients with incomes greater than 100% of poverty. The legislation also requires that individuals be charged no more
than a maximum amount (cap) in a calendar year according to specified criteria.

Each subcontractor may adopt the following policy for use in their policies and procedures in order to satisfy this legislative requirement.

All clients receiving Ryan White Part B services must meet the following income eligibility requirements. Financial eligibility is based on 500% of the Federal Poverty Level (FPL). Clients above 500% of FPL are not eligible for services. FPL varies based on household size and is updated semi-annually. Financial eligibility is calculated on the gross income available to the household:

- If an individual’s income is less than or equal to 100% of the Federal Poverty Level (FPL), the individual may not be charged for services.
- For individuals with income from 101% to 200% of the FPL, a nominal fee of $5 will be charged per service visit. Cumulative charges in a calendar year can be no more than 5% of the individual’s annual gross income. Once the 5% cap is reached, the individual may no longer be charged for services.
- For individuals with incomes from 201% to 300% of the FPL, a nominal fee of $7 will be charged per service visit. Cumulative charges in a calendar year can be no more than 7% of the individual’s annual gross income. Once the 7% cap is reached, the individual may no longer be charged for services.
- For individuals with income over 300% of the FPL, a nominal fee of $10 will be charged per service visit. Cumulative charges in a calendar year can be no more than 10% of the individual’s annual gross income. Once the 10% cap is reached, the individual may no longer be charged for services.

The following discounted fee schedule shall be applied to all individuals receiving a Ryan White Part B service as follows:

- For individuals with income from 101% to 200% of the FPL, a discount of $5 will be applied to each charge per service visit.
- For individuals with income from 201% to 300% of the FPL, a discount of $7 will be applied to each charge per service visit.
- For individuals with income over 300% of the FPL, a discount of $10 will be applied to each charge per service visit.

Services must be provided to eligible clients without regard to either the ability of the individual to pay for such services or the current or past health conditions of the individuals to be served.

**Time and Effort Reporting**

Contractors must have systems in place to document time and effort of direct program staff supported by all federal funds. New federal contractors must submit their written policies related to time and effort to HRI for approval. Most often, such systems take the form of a time sheet entry. These time and effort reporting procedures must clearly identify the percentage of time each staff person devotes to contract activities in accordance with the approved budget. The percent of effort devoted to the project may vary from month to month. The employee’s time sheet must indicate the percent of effort the employee devotes to each particular project for a given time period. The effort recorded on the time sheet must reflect the employee’s funding sources, and the percent of effort recorded for Ryan White funds must match the percentage being claimed on the Ryan White voucher for the same time period. In addition, 100 percent of the employee’s time must be documented. In cases where the percentage of effort of contract staff changes during the contract period, contractors must submit a budget modification request to the AIDS Institute.
On audit, contractors will be expected to produce this documentation. Failure to produce this documentation could result in audit disallowances. HRI also has the right to request back-up documentation on any vouchers if they choose to do so. Only indirect staff is not subject to time and effort reporting requirements. Such staff must be included in the indirect costs line, rather than in the salaries section.

Quality

1. The Contractor shall adhere to the most current Standards of Care, including, but not limited to, those issued by the New York State Department of Health AIDS Institute and the HRSA National Monitoring Standards as a condition of receiving Ryan White funds. (http://www.hab.hrsa.gov/manageyourgrant/granteebasics.html)


3. The Contractor shall establish, implement, and update annually an agency-specific quality management plan and shall conduct quality improvement projects addressing the specific needs of Ryan White Part B-funded services utilizing a proven quality improvement framework, such as the Plan-Do-Study-Act (PDSA) model or equivalent.

4. The Contractor shall participate in New York State Department of Health AIDS Institute supported Ryan White Part B Quality Management Program meetings and activities, including, but not limited to, the submission of an annual Ryan White Part B quality management plan and quality improvement project, the reporting of established performance measures and the presentations of quality improvement projects at quality meetings per the timeline established by the AIDS Institute.

5. The Contractor shall provide documentation of quality assurance and improvement activities, including maintenance of client satisfaction surveys and other mechanisms as designated by the AIDS Institute.

6. The Contractor shall participate in Ryan White Part B Quality Management Program-specific quality improvement trainings to ensure that the Contractor staff is aware and capacitated to participate in agency-specific quality improvement projects.

HRSA National Monitoring Standards

The National Monitoring Standards (Standards) are designed to help Ryan White HIV/AIDS Program Part A and B (including AIDS Drug Assistance Program) grantees meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness. Requirements set forth in other sources are consolidated into a single package of materials that provide direction and advice to grantees for monitoring both their own work and the performance of service providers. The Standards consolidate existing HRSA/HAB requirements for program and fiscal management and oversight based on federal law, regulations, policies, and guidance documents.

The Standards were developed by the Division of Service Systems (DSS) within the Health Resources and Services Administration’s HIV/AIDS Bureau (HRSA/HAB) in response to several Office of Inspector General (OIG) and Government Accountability Office (GAO) reports. These reports identified the need for a specific standard regarding the frequency and nature of grantee monitoring of subgrantees and a clear HRSA/HAB Project Officer role in monitoring grantee oversight of subgrantees.

Grantees and Subgrantees are required to comply with the Standards as a condition of receiving Ryan White Part A and Part B funds. The Standards can be accessed by visiting: http://www.hab.hrsa.gov/manageyourgrant/granteebasics.html
**Administration**

The Ryan White legislation imposes a cap on contractor administration. The legislative intent is to fund services and keep administrative costs to a minimum. Contractors shall ensure that expenses on administrative costs do not exceed 10% of the total grant. Administrative expenses may be individually set and may vary; however, the aggregate total of a contractors administrative costs may not exceed the 10% limit. Administrative activities include:

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

The portion of direct facilities expenses such as rent, maintenance, and utilities for areas primarily utilized to provide core medical and support services for eligible RWHAP clients (e.g., clinic, pharmacy, food bank, counseling rooms, areas dedicated to groups) are not required to be included in the 10% administrative cost cap. Note: by legislation, all indirect expenses must be considered administrative expenses subject to the 10% cap.

For contractors funded by Ryan White Part B, the following programmatic costs are not required to be included in the 10% limit on administrative costs; they may be charged to the relevant service category directly associated with such activities specific to the contract:

- RWHAP client re-certification;
- The portion of malpractice insurance related to RWHAP clinical care;
- Electronic Medical Records (EMR) data entry costs related to RWHAP clinical care and support services;
- The portion of the clinic receptionist’s time providing direct RWHAP patient services (e.g., scheduling appointments and other intake activities);
- The portion of medical waste removal and linen services related to the provision of RWHAP services;
- The portion of medical billing staff related to RWHAP services;
- The portion of a supervisor’s time devoted to providing professional oversight and direction regarding RWHAP-funded core medical or support service activities, sufficient to assure the delivery of appropriate and high-quality HIV care, to clinicians, case managers, and other individuals providing services to RWHAP clients (would not include general administrative supervision of these individuals); and
- RWHAP clinical quality management (CQM). However, expenses which are clearly administrative in nature cannot be included as CQM costs.

The following items of expense are considered administrative and should be included in the column for administrative costs when completing the budget forms.

**(A) Salaries**

**Management and oversight:** This includes staff that has agency management responsibility but no direct involvement in the program or the provision of services.

**Finance and Contract administration:** This includes proposal, work plan and budget development, receipt and disbursal of contract funds, and preparation of programmatic and financial reports as required by the AIDS Institute.

A position or percentage of a position may be considered administrative. Examples of titles that are 100% administrative: Controller, Accounting Manager, Director of Operations, Bookkeeper, Accountant, Payroll Specialist, Finance Coordinator, Maintenance Worker, or Security Officer.
Examples of titles that may in part involve administrative duties: Deputy Executive Director; Program Manager, Program Coordinator, or Clinic Manager. With regard to supervision, the percentage of time devoted to supervising programmatic activities and/or providing overall direction to program activities should be considered programmatic.

In the example below, the Chief Operating Officer and Chief Administrative Officer have wholly administrative positions. As such the entire amount requested from the AIDS Institute for these salaries is transferred into the administrative cost line. The Clinic Manager position is 20% administrative so 20% of the requested salary is considered administrative. A calculation on the Salary budget form page will divide all administrative salaries by the total salaries. This percentage in the example below (9.71%) may be applied to items in the miscellaneous category that may be shared by program and administrative staff.

**Administrative Cost Updates:**
AIRS Data entry staff are not required to be included in the 10% limit on Administrative Costs for data entry related to core medical and support services provided to Ryan White HIV/AIDS Program (RWHAP) clients.

Some examples based on the recent updates are:

- A Receptionist’s time providing direct RWHAP patient services is not required to be counted against the 10% administrative cost limit.
- A Supervisor’s time devoted to providing professional oversight and direction regarding RWHAP-funded core medical or support service activities is not required to be included in the 10% administrative cost limit.

Job descriptions provided must describe the position’s involvement with these activities in order to justify the charges.

<table>
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<th>Position Title/Incumbent Name(s)</th>
<th>Hours Worked Per Week</th>
<th>Hours Available per Week, regardless of funding source</th>
<th>% of time spent on this contract</th>
<th>% of salary considered administrative</th>
<th>Amount Requested from AIDS Institute</th>
<th>Notes</th>
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**B) Fringe**
In order to calculate the amount of Administrative fringe benefits on the contract, total fringe costs are multiplied by the administrative rate on the salary page. For example, if total fringe benefits on the budget equals $38,000, the total fringe benefits of $38,000 is multiplied by 9.71% (see sample salary page with rate above) to calculate the total administrative fringe benefits on the contract.

**C) Supplies**
All funds budgeted for office supplies are considered administrative. Supplies such as educational or clinical materials would be considered programmatic. The administrative supply amount should be entered directly on the supply budget form.

**D) Travel**
Travel pertaining to the financial operations or overall management of the organization is
considered administrative. Client travel or travel of program staff to training would be considered programmatic. The administrative travel amount should be entered directly on the travel budget form.

(E) Equipment
Equipment purchased for administrative staff or for the financial operations or overall management of the organization is considered administrative. Equipment purchased for program staff or to support or enhance service delivery would be considered programmatic. The administrative equipment amount should be entered directly on the equipment budget form.

(F) Miscellaneous
Includes any portion of rent, utilities, telecommunications that are not directly related to core medical and support services provided to RWHAP clients. Audit expenses are considered 100% Administrative. Liability insurance can be considered both Administrative and programmatic if a methodology is included by the provider which demonstrates that a portion of the direct service is to RWHAP clients. The percentage of staff time devoted to administration (as calculated on the salary page) should be applied to items of expense shared by program and administrative staff (such as photocopiers, printers, and maintenance agreements). The amount of administrative telecommunications, space and miscellaneous other costs should be entered directly on the miscellaneous budget form.

Cell phone costs for 100% direct program staff will be considered programmatic expenses and should not be charged as administrative costs. If a portion of a staff salary is administrative, then that portion of their cell phone charges must be administrative.

Examples:
• A Case manager has a cell phone whose sole purpose is to use that cell phone for serving Ryan White positive clients would be considered 100% programmatic.
• A Clinic Manager has a cell phone and their administrative effort on the contract is 20%. This means that 20% of the cell phone cost must count towards the 10% administrative cost limit.

(G) Subcontracts/Consultant
Includes contractors who perform non-service delivery functions (bookkeepers, payroll services, accountants, security, maintenance, etc.) The administrative contractual amount should be entered directly on the subcontracts/consultants budget form.

(H) Indirect
100% of funds budgeted in the indirect line are administrative. Any contractor that has never received a Federal negotiated indirect cost rate may charge a de minimis rate of 10% of modified total direct costs. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a contractor chooses to negotiate for a rate, which they may apply to do at any time. The total amount of indirect costs requested should be transferred to the administrative cost line on the indirect costs budget form. All indirect expenses must be considered administrative expenses subject to the 10% cap.

The summary budget form will calculate a rate based on the entries made on each budget form. This rate must be 10% or less for Ryan White contractors. We recognize that some administrative resources are needed by contractors to support direct service programs; however, it is important to note that Ryan White funds are meant to support direct services rather than administration. Upon review of the budget, contract managers will work with you if it is necessary to reduce administrative costs.
Attachment 4
Bureau of HIV Ambulatory Care RFA Guiding Principles

1. Priority Populations - LGBTQ, Young MSM, BIPOC, and disparately impacted communities
   The HIV/AIDS epidemic disproportionately affects BIPOC communities and other at-risk populations (i.e., men who have sex with men, people living with mental illness, substance users, and women of color). Therefore, the AIDS Institute is committed to improving access to prevention and health care services and reducing HIV disparities experienced among these communities. Successful applicants will demonstrate the disparate outcome(s) experienced and how proposed program activities will result in access to a full continuum of high-quality HIV services and a reduction in the number of social determinants of health experienced by the priority population(s) served through the proposed program.

2. Social Determinants of Health and Health Equity
   Successful applicants will incorporate the principles outlined in the Health Equity Competencies for Health Care Providers\textsuperscript{12} and Health Care Organization Considerations in Support of Health Equity\textsuperscript{13} resource tools in the program models proposed. Applicants will also apply a health equity lens\textsuperscript{14} to develop organizational responses that reduce the social determinants of health experienced by health center patients and actively improve the health outcomes of the priority population(s) to be served through the funding. Applicants can access additional health equity resources at the AIDS Institute Health Equity Corner\textsuperscript{15}.

3. Development of Referral Service Agreements
   Clearly defined referral agreements focused on specific services needed by the priority population(s), which are not available at the funded location, will enhance access to patient care. These clinical community partnerships should be tailored and meet the needs of the priority population(s). Best practice suggests a Memorandum or Letter of Agreement between two entities to establish a formal mechanism for patient referral, service provision, and tracking of referral outcomes and delineate the responsibilities of each party.

4. Hepatitis Screening, Diagnosis, and Care in HIV Primary Care Settings
   Persons with HIV infection are disproportionately affected by viral hepatitis; about one-third of HIV-infected persons are co-infected with hepatitis B or hepatitis C, which can cause long-term (chronic) illness and death. Therefore, integrating HCV screening,\textsuperscript{12} https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/health_equity_providers.pdf\textsuperscript{13} https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/organization_considerations.pdf\textsuperscript{14} https://www.hivtrainingny.org/Uploads/Guidance_for_Applying_a_Health_Equity_Lens_to_HIV.pdf\textsuperscript{15} https://www.hivtrainingny.org/Uploads/Guidance_for_Applying_a_Health_Equity_Lens_to_HIV.pdf

Advancing Health Equity through Comprehensive Community-Based HIV Ambulatory Care Services
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5. **Cultural and Linguistic Competency**
   Program models should reflect the intrinsic differences derived from preferred language, culture, race/ethnicity, health literacy, religion, and developmental characteristics. The provision of culturally and linguistically appropriate services (CLAS) is a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity. Program models and services provided ensure accordance with current National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) Standards. \(^{16}\)

6. **Trauma-Informed Care**
   The experience of trauma is widespread, especially among those in the highest need of health services, social services, and prevention services. Adverse life experiences are a risk factor for severe health conditions and likely contribute to an individual's avoidance of and discomfort with medical procedures. Trauma-informed care recognizes the presence of trauma in society, acknowledges the role of trauma, avoids re-traumatization, and incorporates strategies to promote an individual's comfort and engagement with primary care.

7. **Consumer Involvement**
   Consumer participation in program development enhances services and contributes to the quality of care. Consumer advisory groups, focus groups, and quality improvement committees are mechanisms to obtain consumer input. Peers can also be utilized as advocates, providing health education, risk reduction interventions, and support to other patients, specifically newly diagnosed patients. In addition, grant-funded programs are encouraged to facilitate patient involvement in the city, county, and statewide planning groups and statewide consumer-oriented conferences sponsored by the AIDS Institute.

8. **Integration of HIV/STD/HCV Prevention and Treatment**
   The AIDS Institute supports a continuum of care inclusive of HIV/STD/HCV prevention and treatment. Integrate prevention and support services to improve the health and well-being of persons living with STDs and viral hepatitis into HIV primary care. In general, primary care, routine prevention, and testing contribute to early diagnoses, improved health outcomes, and reduced transmission to others.

   Providers are encouraged to use existing infrastructure to sustain activities supporting early identification and diagnosis of HIV infection through routine HIV testing as required by Chapter 308 of the Laws of 2010 HIV Testing in New York State.

9. **HIV Clinical Expertise**
   The AIDS Institute's Office of the Medical Director encourages facilities providing HIV clinical care to employ physicians with significant expertise in HIV medicine. In addition,
when needed, providers are encouraged to develop formal relationships with an HIV clinician to co-manage or consult with complex clinical cases.

10. **Quality of Care Standards**  
All HIV prevention and health care programs must develop and maintain continuous quality improvement programs which meet the AIDS Institute's standards of care. These standards include agency leadership and commitment, staff development and training, participation of staff from all levels and various disciplines, and systematic selection and review of performance criteria, including consumer satisfaction.

All funded health facilities under this RFA will be required to submit annually the Ryan White HIV/AIDS Program Services Report (RSR) and facilitate data collection and analysis of HIV clinical data to assess and improve the quality of care.

11. **Use of Behavioral Science-Based Prevention Strategies**  
Programs may incorporate interventions designed to prevent primary and secondary transmission of HIV based on empirically proven strategies with a foundation in the behavioral sciences. Behavioral science-based approaches have proven effective in disease prevention and behavior change and are effective in HIV prevention. They include specific constructs for understanding how behavior change works and strategies for facilitating and maintaining the reduction and elimination of unwanted high-risk behaviors. If used in the program model, staff should be trained and competent in utilizing behavior change theories in service delivery. Examples of behavior change theories include but are not limited to the Theory of Reasoned Action, Social Cognitive Theory, and Transtheoretical Model of Behavior Change.

12. **Health Literacy Universal Precautions**  
Health literacy universal precautions is an approach that 1) assumes everyone could use help understanding health information, 2) considers it the responsibility of the health care system to make sure patients understand health information, 3) focuses on making health care environments more literacy friendly and ensures training for providers to communicate more effectively. Health literacy impacts all levels of the health care delivery system. Therefore, a universal precautions approach to health literacy is essential to improve health outcomes, reduce disparities and reduce costs. In addition, health literacy universal precautions aim to simplify communication and confirm patient comprehension, minimize the risk of miscommunication, make the health care system easier to navigate, and support patients' efforts to improve their health.

The AIDS Institute recognizes the importance of health literacy universal precautions to improve quality, reduce costs, and reduce health disparities. Funded providers will integrate health literacy universal precautions into their funded program policies, staff training requirements, care models, and quality improvement activities to ensure patient

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*Advancing Health Equity through Comprehensive Community-Based HIV Ambulatory Care Services*  
Page 56 of 92
understanding at all points of contact. Best practice recommendations for health literacy universal precautions include expanding these guiding principles agency-wide.

13. **Harm Reduction Approach Strategies**
   The NYS Department of Health encourages using a harm reduction approach by programs funded to provide HIV/STD/Hepatitis prevention services. Harm reduction is a perspective and a set of practical strategies to reduce the negative consequences of behaviors. In addition, a harm reduction approach recognizes the importance of working with a patient's level of acceptance of services.

14. **Undetectable=Untransmittable (U=U)**
   The NYSDOH supports the clinical evidence that people who take antiretroviral therapy (ART) as prescribed and have achieved and maintained an undetectable viral load for six months or greater have a negligible risk of sexually transmitting the virus. PLWH who are engaged in ongoing clinical care may rely on antiretroviral therapy as a strategy to prevent sexual transmission to an HIV-negative partner, provided there are no active sexually transmitted infections (STIs)

15. **Development of Medical Self-Management**
   Research supports self-management interventions, such as self-monitoring and informed decision making, that lead to improvements in health outcomes and health status and increase patient empowerment. Medical self-management support transforms the patient-provider relationship into a more collaborative partnership and organizes the health care team around the pivotal role of the patient in their care. The process engages patients and providers to identify health goals, choose specific actions, acquire needed information, and monitor progress.

16. **Affiliation with Medicaid Managed Care (MMC), Medicaid Health Homes, and SNPS for NYC Medicaid Beneficiaries**
   Enrollees in managed care with chronic illnesses or co-morbidities have access to specialists and plan disease management staff for care and benefits coordination if needed. Agencies must be committed to maximizing patient participation in health insurance programs. Eligible enrollees for the health benefits marketplace should be encouraged by Article 28 facilities to select an appropriate coverage plan responsive to the enrollee's medical needs. Access to care coverage maximizes available resources and supports continued engagement in care.
PROJECT NAME: Advancing Health Equity through Comprehensive Community-Based HIV Ambulatory Care Services - Component A

RAP

CONTRACTOR SFS PAYEE NAME:

CONTRACT PERIOD: From: 7/1/2023 To: 6/30/2024

PROJECT SUMMARY:

Component A: Retention and Adherence Program (RAP)
The RAP program aims to reduce the HIV health inequity experienced by the priority population(s). Program Models are designed to 1) facilitate rapid access to HIV treatment, including immediate initiation of antiretroviral treatment; 2) identify and engage individuals living with HIV who are not virally suppressed in HIV care and treatment, and 3) address social determinants of health through partnerships with community providers who address the non-medical needs of people living with HIV/AIDS (PLWHA) who are out-of-care, or not regularly engaged in HIV care and treatment.

Component A Priority Populations: People living with HIV who are Black, Indigenous, People of Color, LGBTQ, or other communities experiencing disparate HIV outcomes as demonstrated by New York State Surveillance Data.

Instructions: For the Grants Gateway Work Plan Project Summary, applicants are instructed to insert the Project Summary as it is listed above. In the Grants Gateway Work Plan Organizational Capacity section, applicants are instructed to list this as “not applicable.” Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Attachment 5: Component A Work Plan: Retention and Adherence Program (RAP). Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.
<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>TASKS</th>
<th>PERFORMANCE MEASURES</th>
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<tbody>
<tr>
<td><strong>1: Program Operations and Administration</strong></td>
<td>1.1. Ensure systems that provide administrative leadership, guidance, and support to integrate RAP into the agency’s overall programming achieve the outcomes indicated in the RFA.</td>
<td>1.1.1 Formal meetings with agency leadership to review program progress achieving contract deliverables are routinely conducted and documented, and available for review.</td>
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<td></td>
<td>1.2 Establish support from agency’s administrative leadership to integrate RAP into the agency’s overall programming and ensure success.</td>
<td>1.2.1 Program monitoring and routine communication with program staff indicates adequate resources and program oversight is provided</td>
</tr>
<tr>
<td></td>
<td>1.3 Contractor will create program specific policies and procedures.</td>
<td>1.3.1 Comprehensive program policies and procedures as indicated in the standards and will be created and updated as appropriate. Policies and Procedures will be reviewed during the program monitoring reviews to ensure 100% of required policies have been documented and implemented.</td>
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<td>1.4 Contractor will ensure that the most recent version of AIRS is maintained. Adequate resources will be made available for data entry and management, including the development and maintenance of an AIRS back-up system.</td>
<td>1.4.1 Contractor will submit 100% of all monthly AIRS data extracts and narrative reports (using the prescribed template) adhering to established timeframes.</td>
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<td>1.5 Contractor will document all RAP services in the patient’s medical record and in AI Reporting System. AIRS reports will be reviewed by supervisory staff monthly to ensure accuracy and completeness, prior to submission.</td>
<td>1.5.1 100% of program services will be entered in the patient’s medical record and in AIRS. Adherence will be monitored through quarterly reports sent to the contract manager by the Division Data Unit.</td>
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<td>OBJECTIVE</td>
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<td>2: Improve linkage and retention into HIV clinical care for PLWHA</td>
<td>2.1 Develop systems that support expedited engagement, and retention in HIV clinical care and adherence to current AIDS Institute Clinical Guidance.</td>
<td>2.1.1 Program performance and outcomes will be measured against current ETE target metrics and performance measures as outlined in the Initiative Program Standards.</td>
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<td>2.2 Coordinate and monitor medical treatment, interventions and</td>
<td>2.2.1 Program performance metrics will be measured</td>
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<td>1.6 Contractors will hire appropriate and qualified personnel to perform the functions required under the contract. Changes in program staff (hiring, terminations, etc.) will be documented in monthly reports and discussed with the contract manager.</td>
<td>1.6.1 Contractors will provide evidence that staff meet relevant qualifications, and that coverage is maintained through the submission of monthly reports, ongoing communication with the contract manager, and during program monitoring reviews.</td>
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<td>1.7 Participate in Regional ETE, NY Links, and community meetings to remain abreast of developing strategies and provide agency feedback.</td>
<td>1.7.1 Participation is maintained at community meetings at least quarterly.</td>
</tr>
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<td></td>
<td>1.8 Establish agency and program systems to implement the Initiative Program Standards.</td>
<td>1.8.1 Programs adhere to the current Initiative Program Standards.</td>
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</table>
supportive services to ensure adherence to HIV/AIDS treatment and viral load suppression to improve health outcomes.

against ETE target metrics for linkage to care, receipt of HIV medical care, viral load suppression, RIA and adherence to 100% of the performance measures outline in the Initiative Program Standards.

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
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<tbody>
<tr>
<td>3: Identify and address SDOH related barriers.</td>
<td>3.1 Establish a system to track the outcomes of referrals for SDOH related services that impact retention and adherence.</td>
<td>3.1.1 Contractor will document and track 100% of all referrals and outcomes in AIRS. Contractor will establish mechanisms to track and report SDOH information. Referrals are tracked to completion.</td>
</tr>
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<td></td>
<td>3.2 Develop partnerships with service organizations that address determinants of health and support early access to and engagement in HIV care.</td>
<td>3.2.1 Contractors will show evidence of active linkage agreements with partners to address determinants and other services needed but not available at the funded locations.</td>
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<td>OBJECTIVE</td>
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<td>4: Program Evaluation and Quality Management</td>
<td>4.1 Develop and implement activities that monitor and evaluate program processes, quality of care and outcomes.</td>
<td>4.1.1 Program performance will be measured as per the AI Quality Improvement Program and measures outlined in the Initiative Program Standards.</td>
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<td></td>
<td>4.2 Contractor will participate in NYSDOH Quality of Care program activities.</td>
<td>4.2.1 100% of Clinical Cascade and HRSA RSR submissions are submitted annually, accurately and within specified timeframes.</td>
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<td>4.3 Contractor will develop a mechanism for incorporating consumer feedback into quality improvement.</td>
<td>4.3.1 100% of all programs will have a documented and implemented mechanism for measuring consumer satisfaction. Documentation will be made available during program monitoring reviews.</td>
</tr>
<tr>
<td>5: Flexibility in programming for directing resources effectively</td>
<td>5.1 Flexibility in programming is necessary to ensure that resources are effectively directed to the populations and communities most in need.</td>
<td>5.1.1 N/A</td>
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<td></td>
<td>5.2 Contract activities &amp; deliverables may be modified at any point in this</td>
<td>5.2.1 Aid with non-work plan public health issues if/when</td>
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<td>contract upon direction of the AIDS Institute to address emerging needs or disparities, emerging HIV/STD/HCV epidemiologic patterns, or to accommodate advances in best practice.</td>
<td>5.3 Assist with other priority public health issues if/when they arise (e.g., local STD case increases, outbreaks, emergency situations, etc.). The contract manager must approve non-work plan work.</td>
<td>they arise.</td>
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</table>
PROJECT NAME: Advancing Health Equity through Comprehensive Community-Based HIV Ambulatory Care Services Component B - CYA

CONTRACTOR SFS PAYEE NAME:

CONTRACT PERIOD: From: 7/1/2023 To: 6/30/24

PROJECT SUMMARY:

**Component B: Centers for Young Adults (CYA)**

The CYA program aims to reduce the HIV health inequity experienced by the priority population(s). Program Models are designed to 1) facilitate rapid access to HIV treatment, including immediate initiation of antiretroviral treatment; 2) identify and engage individuals living with HIV who are not virally suppressed in HIV care and treatment; and 3) address social determinants of health through partnerships with community providers who address the non-medical needs of adolescents/young adults living with HIV/AIDS who are newly diagnosed, out-of-care, or not regularly engaged in clinical care and treatment.

Programs will provide comprehensive HIV primary care, sexual and behavioral health, medical case management, and supportive services tailored to the unique needs of adolescents and young adults living with HIV (ages 13-29).

**Component B Priority Populations:** Young adults ages (13-29) living with HIV, who are BIPOC, LGBTQ, or other adolescent young adult communities who are experiencing disparate HIV outcomes as demonstrated by New York State Surveillance Data.

Instructions: For the Grants Gateway Work Plan Project Summary, applicants are instructed to insert the Project Summary as it is listed above. In the Grants Gateway Work Plan Organizational Capacity section, applicants are instructed to list this as “not applicable.” Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Attachment 6: Component B Work Plan. Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.
<table>
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<th>OBJECTIVE</th>
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<tbody>
<tr>
<td>1: Program Operations and Administration</td>
<td>1.1 Ensure systems that provide administrative leadership, guidance, and support to integrate CYA into the agency’s overall programming achieve the outcomes indicated in the RFA.</td>
<td>1.1.1 Formal meetings with agency leadership to review program progress achieving contract deliverables are routinely conducted and documented, and available for review.</td>
</tr>
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<td></td>
<td>1.2 Establish support from agency’s administrative leadership to integrate CYA into the agency’s overall programming and ensure success.</td>
<td>1.2.1 Program monitoring and routine communication with program staff indicates adequate resources and program oversight is provided.</td>
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<td>1.3 Contractor will create program specific policies and procedures.</td>
<td>1.3.1 Comprehensive program policies and procedures as indicated in the standards and will be created and updated as appropriate. Policies and Procedures will be reviewed during the program monitoring reviews to ensure 100% of required policies have been documented and implemented.</td>
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1.4 Contractor will ensure that the most recent version of AIRS is maintained. Adequate resources will be made available for data entry and management, including the development and maintenance of an AIRS back-up system.

1.4.1 Contractor will submit 100% of all monthly AIRS data extracts and narrative reports (using the prescribed template) adhering to established timeframes.

1.5 Contractor will document all CYA services in the patient’s medical record and in AI Reporting System. AIRS reports will be reviewed by supervisory staff monthly to ensure accuracy and completeness, prior to submission.

1.5.1 100% of program services will be entered in the patient’s medical record and in AIRS. Adherence will be monitored through quarterly reports sent to the contract manager by the Division Data Unit.

1.6 Contractors will hire appropriate and qualified personnel to perform the functions required under the contract. Changes in program staff (hiring, terminations, etc.) will be documented in monthly reports and discussed with the contract manager.

1.6.1 Contractors will provide evidence that staff meet relevant qualifications, and that coverage is maintained through the submission of monthly reports, ongoing communication with the contract manager, and during program monitoring reviews.

1.7 Participate in Regional ETE, NY Links, and community meetings to remain abreast of developing strategies and provide agency

1.7.1 Participation is maintained at community meetings at least quarterly.
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<tbody>
<tr>
<td>1: Improve service integration for PLWHA</td>
<td>1.8 Establish agency and program systems to implement the Initiative Program Standards.</td>
<td>1.8.1 Programs adhere to the current Initiative Program Standards.</td>
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<td>2: Improve linkage and retention into HIV clinical care for PLWHA</td>
<td>2.1 Develop systems that support expedited engagement, and retention in HIV clinical care and adherence to current AIDS Institute Clinical Guidance.</td>
<td>2.1.1 Program performance and outcomes will be measured against current ETE target metrics and performance measures as outlined in the Initiative Program Standards.</td>
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<td>2.2 Coordinate and monitor medical treatment, interventions and supportive services to ensure adherence to HIV/AIDS treatment and viral load suppression to improve health outcomes.</td>
<td>2.2.1 Program performance metrics will be measured against ETE target metrics for linkage to care, receipt of HIV medical care, viral load suppression, RIA and adherence to 100% of the performance measures outline in the Initiative Program Standards.</td>
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<td>3: Identify and address SDOH related barriers.</td>
<td>3.1 Establish a system to track the outcomes of referrals for SDOH related services that impact retention and adherence.</td>
<td>3.1.1 Contractor will document and track 100% of all referrals and outcomes in AIRS. Contractor will establish</td>
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<td>4.2.1 100% of Clinical Cascade and HRSA RSR submissions are submitted annually, accurately and within specified timeframes.</td>
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<td>4.3 Contractor will develop a mechanism for incorporating consumer feedback into quality improvement.</td>
<td>4.3.1 100% of all programs will have a documented and implemented mechanism for measuring consumer satisfaction. Documentation will be made available during</td>
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<td>5: Flexibility in programming for directing resources effectively</td>
<td>5.1 Flexibility in programming is necessary to ensure that resources are effectively directed to the populations and communities most in need.</td>
<td>5.1.1 N/A</td>
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<td></td>
<td>5.2 Contract activities &amp; deliverables may be modified at any point in this contract upon direction of the AIDS Institute to address emerging needs or disparities, emerging HIV/STD/HCV epidemiologic patterns, or to accommodate advances in best practice.</td>
<td>5.2.1 Aid with non-work plan public health issues if/when they arise.</td>
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<td>5.3 Assist with other priority public health issues if/when they arise (e.g., local STD case increases, outbreaks, emergency situations, etc.). The contract manager must approve non-work plan work.</td>
<td>5.3.1 Aid with non-work plan public health issues if/when they arise.</td>
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ATTACHMENT 7 – Component C WORK PLAN

SUMMARY

PROJECT NAME: Advancing Health Equity through Comprehensive Community-Based HIV Ambulatory Care Services – Component C FFHC

CONTRACTOR SFS PAYEE NAME:

CONTRACT PERIOD: From: 7/1/2023 To: 6/30/2024

PROJECT SUMMARY:

Component C: Family-Focused Health Care for Women

Family-Focused HIV Health Care Programs (FFHC) provide comprehensive HIV-related services for BIPOC women and birthing individuals who are planning a pregnancy, pregnant, or are caregivers to dependent children (age 18 or younger) and are living with HIV (WLWH). The framework for care and treatment of women and birthing individuals is provided in the context of family. HIV services are tailored to meet the needs of women and birthing individuals with dependent children to improve timely entry, access, and retention in care.

Through an integrated model of service delivery, FFHC clinicians, medical case management staff, and peers support efforts to achieve and maintain viral load suppression, reduce the potential of perinatal HIV transmission and transmission of HIV to sexual partners.

Family Planning/Reproductive Health services must encompass pre- and inter-conception, pregnancy and postpartum care to reduce the potential of perinatal transmission of HIV and the disparate health outcomes experienced by babies who are BIPOC or at increased risk for poor postnatal outcomes.

Component C Priority Populations: BIPOC women living with HIV who are planning a pregnancy, are pregnant, or are living with HIV and serve as the primary caregiver for dependent children.

Instructions: For the Grants Gateway Work Plan Project Summary, applicants are instructed to insert the Project Summary as it is listed above. In the Grants Gateway Work Plan Organizational Capacity section, applicants are instructed to list this as “not applicable.” Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Attachment 7: Component C Work Plan.
Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>TASKS</th>
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<tbody>
<tr>
<td>1: Program Operations and Administration</td>
<td>1.1 Ensure systems that provide administrative leadership, guidance, and support to integrate FFHC into the agency’s overall programming achieve the outcomes indicated in the RFA.</td>
<td>1.1.1 Formal meetings with agency leadership to review program progress achieving contract deliverables are routinely conducted and documented, and available for review.</td>
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<tr>
<td></td>
<td>1.2 Establish support from agency’s administrative leadership to integrate FFHC into the agency’s overall programming and ensure success.</td>
<td>1.2.1 Program monitoring and routine communication with program staff indicates adequate resources and program oversight is provided.</td>
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<td>1.3 Contractor will create program specific policies and procedures.</td>
<td>1.3.1 Comprehensive program policies and procedures as indicated in the standards and will be created and updated as appropriate. Policies and Procedures will be reviewed during the program monitoring reviews to ensure 100% of required policies have been</td>
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<td>Section</td>
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<td>Notes</td>
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<td>1.4</td>
<td>Contractor will ensure that the most recent version of AIRS is maintained. Adequate resources will be made available for data entry and management, including the development and maintenance of an AIRS back-up system.</td>
<td>1.4.1 Contractor will submit 100% of all monthly AIRS data extracts and narrative reports (using the prescribed template) adhering to established timeframes.</td>
</tr>
<tr>
<td>1.5</td>
<td>Contractor will document all FFHC services in the patient’s medical record and in AI Reporting System. AIRS reports will be reviewed by supervisory staff monthly to ensure accuracy and completeness, prior to submission.</td>
<td>1.5.1 100% of program services will be entered in the patient’s medical record and in AIRS. Adherence will be monitored through quarterly reports sent to the contract manager by the Division Data Unit.</td>
</tr>
<tr>
<td>1.6</td>
<td>Contractors will hire appropriate and qualified personnel to perform the functions required under the contract. Changes in program staff (hiring, terminations, etc.) will be documented in monthly reports and discussed with the contract manager</td>
<td>1.6.1 Contractors will provide evidence that staff meet relevant qualifications, and that coverage is maintained through the submission of monthly reports, ongoing communication with the contract manager, and during program monitoring reviews.</td>
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<td>1.7</td>
<td>Participate in Regional ETE, NY</td>
<td>1.7.1 Participation is</td>
</tr>
<tr>
<td>OBJECTIVE</td>
<td>TASKS</td>
<td>PERFORMANCE MEASURES</td>
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<tr>
<td>2: Improve linkage and retention into HIV clinical care for PLWHA</td>
<td>2.1 Develop systems that support expedited engagement, and retention in HIV clinical care and adherence to current AIDS Institute Clinical Guidance.</td>
<td>2.1.1 Program performance and outcomes will be measured against current ETE target metrics and performance measures as outlined in the Initiative Program Standards.</td>
</tr>
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<td>2.2 Coordinate and monitor medical treatment, interventions and supportive services to ensure adherence to HIV/AIDS treatment and viral load suppression to improve health outcomes.</td>
<td>2.2.1 Program performance metrics will be measured against ETE target metrics for linkage to care, receipt of HIV medical care, viral load suppression, RIA and adherence to 100% of the performance measures outline in the Initiative Program Standards.</td>
</tr>
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<td></td>
<td>1.8 Establish agency and program systems to implement the Initiative Program Standards</td>
<td>1.8.1 Programs adhere to the current Initiative Program Standards</td>
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<td></td>
<td>Links, and community meetings to remain abreast of developing strategies and provide agency feedback.</td>
<td>maintained at community meetings at least quarterly.</td>
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<td>OBJECTIVE</td>
<td>TASKS</td>
<td>PERFORMANCE MEASURES</td>
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<td>3: Identify and address SDOH related barriers.</td>
<td>3.1 Establish a system to track the outcomes of referrals for SDOH related services that impact retention and adherence.</td>
<td>3.1.1 Contractor will document and track 100% of all referrals and outcomes in AIRS. Contractor will establish mechanisms to track and report SDOH information. Referrals are tracked to completion.</td>
</tr>
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<td>3.2 Develop partnerships with service organizations that address determinants of health and support early access to and engagement in HIV care.</td>
<td>3.2.1 Contractors will show evidence of active linkage agreements with partners to address determinants and other services needed but not available at the funded locations.</td>
</tr>
<tr>
<td>4: Program Evaluation and Quality Management</td>
<td>4.1 Develop and implement activities that monitor and evaluate program processes, quality of care and outcomes.</td>
<td>4.1.1 Program performance will be measured as per the AI Quality Improvement Program and measures outlined in the Initiative Program Standards.</td>
</tr>
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<td></td>
<td>4.2 Contractor will participate in NYSDOH Quality of Care program activities.</td>
<td>4.2.1 100% of Clinical Cascade and HRSA RSR submissions are submitted annually, accurately</td>
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<tr>
<th>OBJECTIVE</th>
<th>TASKS</th>
<th>PERFORMANCE MEASURES</th>
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<tr>
<td>5: Flexibility in programming for directing resources effectively</td>
<td>5.1 Flexibility in programming is necessary to ensure that resources are effectively directed to the populations and communities most in need.</td>
<td>5.1.1 N/A</td>
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<td>5.2 Contract activities &amp; deliverables may be modified at any point in this contract upon direction of the AIDS Institute to address emerging needs or disparities, emerging HIV/STD/HCV epidemiologic patterns, or to accommodate advances in best practice.</td>
<td>5.2.1 Aid with non-work plan public health issues if/when they arise.</td>
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<td>5.3 Assist with other priority public health issues if/when they arise (e.g., local STD case increases, outbreaks,</td>
<td>5.3.1 Aid with non-work plan public health issues if/when they arise.</td>
</tr>
</tbody>
</table>

4.3 Contractor will develop a mechanism for incorporating consumer feedback into quality improvement.

4.3.1 100% of all programs will have a documented and implemented mechanism for measuring consumer satisfaction. Documentation will be made available during program monitoring reviews.
|               | emergency situations, etc.). The contract manager must approve non-work plan work. |               |               |
Attachment 8
Health Equity Definitions and Examples

SOCIAL DETERMINANTS OF HEALTH (SDOH): Social determinants of health (SDOH) are the overarching factors in society that impact health. SDOH include:

• Secure employment, safe, bias-free working conditions and equitable living wages;
• Healthy environment, including clean water and air;
• Safe neighborhoods and housing;
• Food security and access to healthy food;
• Access to comprehensive, quality health care services;
• Access to transportation;
• Quality education; and
• Access to a social support network.

Inequities in access to SDOH are a result of structural racism, sexism, homophobia, transphobia, poverty, stigma, and other forms of oppression that are perpetuated by current social structures and institutions.

STRUCTURAL RACISM: The combination of public policies, institutional practices, social and economic forces that systematically privilege White people and disadvantage Black, Indigenous and other people of color. This term underscores that current racial inequities within society are not the result of personal prejudice held by individuals. Adapted from Aspen Institute and Bailey, Feldman, Bassett.

HEALTH DISPARITIES: The statistical difference in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States. USDHHS.

HEALTH INEQUITIES: Disparities in health that result from social or policy conditions that are unfair or unjust.

HEALTH EQUITY: Health equity is achieved when no one is limited in achieving good health because of their social position or any other social determinant of health. The goal of health equity is to eliminate health inequities that are avoidable and unjust through proactive and inclusive processes.

Examples of how social and structural determinants can impact our health include: (note: this is not an exhaustive list)

• Stigma and discrimination are pervasive within healthcare and social support service delivery systems and exacerbate health inequities. Explicit and implicit biases persist among health and social service providers related to HIV status, race/ethnicity, sexual orientation, gender identity and expression, age, mental health, socioeconomic status, immigration status, substance use, criminal justice involvement, and the exchange of sex for money, drugs, housing, or other resources; these result in stigma and discrimination in healthcare and are demonstrated barriers to uptake and sustained engagement in HIV prevention and care services.

• Other overlapping social and structural determinants of health further exacerbate health inequities including housing status, food insecurity, poverty, unemployment, neighborhood conditions, mental health issues, domestic violence, sexism, homophobia, transphobia, ableism, agism, racism, and other complex and integrated systems of oppression. These social and structural determinants of health are barriers to achieving positive health outcomes.

• Culturally and linguistically appropriate services are one way to improve the quality of services provided to all individuals, which will ultimately help reduce disparities and inequities and achieve health equity. The provision of services that are responsive to the individuals first or preferred language, health beliefs, practices and needs of diverse populations, individuals and clients can help close the gaps in health outcomes. What is CLAS? - Think Cultural Health
Attachment 9
General Terms and Conditions - Health Research Incorporated Contracts

1. Term - This Agreement shall be effective and allowable costs may be incurred by the Contractor from the Contract Start Date through the Contract End Date, (hereinafter, the “Term”) unless terminated sooner as hereinafter provided or extended by mutual agreement of the parties.

2. Allowable Costs/Contract Amount –
   a) In consideration of the Contractor’s performance under this Agreement, HRI shall reimburse the Contractor for allowable costs incurred in performing the Scope of Work, which is attached hereto as Exhibit A, in accordance with the terms and subject to the limits of this Agreement.

   b) It is expressly understood and agreed that the aggregate of all allowable costs under the Agreement shall in no event exceed the Total Contract Amount, except upon formal amendment of this Agreement as provided herein below.

   c) The allowable cost of performing the work under this Agreement shall be the costs approved in the Budget attached hereto as Exhibit B and actually incurred by the Contractor, either directly incident or properly allocable, to the Agreement, in the performance of the Scope of Work. For work performed under a Scope of Work that results from a federally funded grant or contract, Contractor’s costs must be in accordance with cost principles of the Department of Health and Human Services Grants Policy Statement (HHS GPS). To be allowable, a cost must be reasonable, necessary, and cost-effective (as reasonably determined by HRI). In calculating costs, the accounting practices of Contractor must be based on generally accepted accounting principles and practices appropriate to the circumstances and consistent with other comparable activities of Contractor. Costs resulting from inconsistent practices in excess of the amount that would have resulted from using practices consistent with this Section 2(c) are unallowable. Contractor shall supply documentation of such policies and procedures to HRI when requested.

   d) Irrespective of whether the “Audit Requirements” specified in paragraph 3(a) are applicable to this Agreement, all accounts and records of cost relating to this Agreement shall be subject to audit by HRI or its duly authorized representative(s) and/or the Project Sponsor during the Term and for three years after the final voucher is submitted for payment. This provision includes the right for HRI to request copies of source documentation in support of any costs claimed. If an audit is started before the expiration of the 3-year period, the records must be retained until all findings involving the records have been resolved and final action taken. Any reimbursement made by HRI under this Agreement shall be subject to retroactive correction and adjustment upon such audits. The Contractor agrees to repay HRI promptly any amount(s) determined on audit to have been incorrectly paid. HRI retains the right, to the extent not prohibited by law or its agreements with the applicable Project Sponsor(s) to recoup any amounts required to be repaid by the Contractor to HRI by offsetting those amounts against amounts due to the Contractor from HRI pursuant to this or other agreements. The Contractor shall maintain appropriate and complete accounts, records, documents, and other evidence showing the support for all costs incurred under this Agreement.

3. Administrative, Financial and Audit Regulations –
   a) This Agreement shall be audited, administered, and allowable costs shall be determined in accordance with the terms of this Agreement and the requirements and principles applicable to the Contractor as noted below, including, but not limited to, the Office of Management and Budget (OMB) Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (referred to herein as the “Uniform Guidance”) as codified in Title 2 of the Code of Federal Regulations. The federal regulations specified below apply to the Contractor (excepting the "Audit Requirements," which apply to federally-funded projects only), regardless of the source of the funding specified (federal/non-federal) on the face page of this Agreement. For non-federally funded projects any right granted by the regulation to the federal sponsor shall be deemed granted to the Project Sponsor. It is understood that a Project Sponsor may impose restrictions/requirements beyond those noted below in which case such restrictions/requirements will be noted in Attachment B Program Specific Clauses.
b) If this Agreement is federally funded, the Contractor will provide copies of audit reports required under any of the above audit requirements to HRI within 30 days after completion of the audit.

4. Payments -
   a) No payments will be made by HRI until such time as HRI is in receipt of the following items:
      • Insurance Certificates pursuant to Article 9;
      • A copy of the Contractor's latest audited financial statements (including management letter if requested);
      • A copy of the Contractor's most recent 990 or Corporate Tax Return;
      • A copy of the Contractor's approved federal indirect cost rate(s) and fringe benefit rate (the "federal rates"); or documentation (which is acceptable to HRI) which shows the Contractor's methodology for allocating these costs to this Agreement. If, at any time during the Term the federal rates are lower than those approved for this Agreement, the rates applicable to this Agreement will be reduced to the federal rates;
      • A copy of the Contractor's time and effort reporting system procedures (which are compliant with the Uniform Guidance) if salaries and wages are approved in the Budget.
      • A copy of equipment policy if equipment is in the approved budget.
      • Further documentation as requested by HRI to establish the Contractor's fiscal and programmatic capability to perform under this Agreement.

      Unless and until the above items are submitted to and accepted by HRI, the Contractor will incur otherwise allowable costs at its own risk and without agreement that such costs will be reimbursed by HRI pursuant to the terms of this Agreement. No payments, which would otherwise be due under this Agreement, will be due by HRI until such time, if ever, as the above items are submitted to and accepted by HRI.

   b) The Contractor shall submit voucher claims and reports of expenditures at the Required Voucher Frequency noted on the face page of this Agreement, in such form and manner, as HRI shall require. HRI will reimburse Contractor upon receipt of expense vouchers pursuant to the Budget in Exhibit B, so long as Contractor has adhered to all the terms of this Agreement and provided the reimbursement is not disallowed or disallowable under the terms of this Agreement. All information required on the voucher must be provided or HRI may pay or disallow the costs at its discretion. HRI reserves the right to request additional back up documentation on any voucher submitted. Further, all vouchers must be received within thirty (30) days of the end of each period defined as the Required Voucher Frequency (i.e. each month, each quarter). Contractor shall submit a final voucher designated by the Contractor as the “Completion Voucher” no later than sixty (60) days from termination of the Agreement. Vouchers received after the 60 day period may be paid or disallowed at the discretion of HRI.

   c) The Contractor agrees that if it shall receive or accrue any refunds, rebates, credits or other amounts (including any interest thereon) that relate to costs for which the Contractor has been reimbursed by HRI under this Agreement it shall notify HRI of that fact and shall pay or, where appropriate, credit HRI those amounts.

   d) The Contractor represents, warrants and certifies that reimbursement claimed by the Contractor under this Agreement shall not duplicate reimbursement received from other sources, including, but not limited to client fees, private insurance, public donations, grants, legislative funding from units of government, or any other source. The terms of this paragraph shall be deemed continuing representations upon which HRI has relied in entering into and which are the essences of its agreements herein.
5. **Termination** - Either party may terminate this Agreement with or without cause at any time by giving thirty (30) days written notice to the other party. HRI may terminate this Agreement immediately upon written notice to the Contractor in the event of a material breach of this Agreement by the Contractor. It is understood and agreed, however, that in the event that Contractor is in default upon any of its obligations hereunder at the time of any termination, such right of termination shall be in addition to any other rights or remedies which HRI may have against Contractor by reason of such default. Upon termination of the Agreement by either party for any reason, Contractor shall immediately turn over to HRI any works in progress, materials, and deliverables (whether completed or not) related to the services performed up to the date of termination.

6. **Representations and Warranties** – Contractor represents and warrants that:
   a) it has the full right and authority to enter into and perform under this Agreement;
   b) it will perform the services set forth in Exhibit A in a workmanlike manner consistent with applicable industry practices;
   c) the services, work products, and deliverables provided by Contractor will conform to the specifications in Exhibit A;
   d) there is no pending or threatened claim or litigation that would have a material adverse impact on its ability to perform as required by this Agreement.

7. **Indemnity** - To the fullest extent permitted by law, Contractor shall indemnify, hold harmless and defend HRI, its agents, employees, officers, board members, the New York State Department of Health, and the People of the State of New York against all claims, damages, losses or expenses including but not limited to attorneys’ fees arising out of or resulting from the performance of the agreement, provided any such claim, damage, loss or expense arises out of, or in connection with, any act or omission by Contractor, or anyone directly or indirectly employed or contracted by Contractor, in the performance of services under this Agreement, and such acts or omissions (i) constitute negligence, willful misconduct, or fraud; (ii) are attributable to bodily injury, sickness, disease or death, or to injury to or destruction of tangible property, including loss of use resulting there from; (iii) cause the breach of any confidentiality obligations set forth herein; (iv) relate to any claim for compensation and payment by any employee or agent of Contractor; (v) result in intellectual property infringement or misappropriation by Contractor, its employees, agents, or subcontractors; or (vi) are violations of regulatory or statutory provisions of the New York State Labor Law, OSHA or other governing rule or applicable law. The obligation of the Contractor to indemnify any party under this paragraph shall not be limited in any manner by any limitation of the amount of insurance coverage or benefits including workers’ compensation or other employee benefit acts provided by the Contractor. In all subcontracts entered into by the Contractor related to performance under this Agreement, the Contractor will include a provision requiring the subcontractor to provide the same indemnity and hold harmless to the indemnified parties specified in this paragraph.

8. **Amendments/Budget Changes** –
   a) This Agreement may be changed, amended, modified or extended only by mutual consent of the parties provided that such consent shall be in writing and executed by the parties hereto prior to the time such change shall take effect, with the exception of changes and amendments that are made mandatory by the Project Sponsor under the sponsoring grant/contract, which will take effect in accordance with the Project Sponsor’s requirements and schedule.
   
   b) In no event shall there be expenses charged to a restricted budget category without prior written consent of HRI.
   
   c) The Budget Flexibility Percentage indicates the percent change allowable in each category of the Budget, with the exception of a restricted budget category. As with any desired change to this Agreement, budget category deviations exceeding the Budget Flexibility Percentage in any category of the Budget are not permitted unless approved in writing by HRI. In no way shall the Budget Flexibility Percentage be construed to allow the Contractor to exceed the Total Contract Amount less the restricted budget line, nor shall it be construed to permit charging of any unallowable expense to any budget category. An otherwise allowable charge is disallowed if the charge amount plus any Budget Flexibility Percentage exceeds the amount of the budget category for that cost.

9. **Insurance** –
   a) The Contractor shall maintain or cause to be maintained, throughout the Term, insurance or self-insurance equivalents of the types and in the amounts specified in section b) below. Certificates of Insurance shall evidence all such insurance. It is expressly understood that the coverage’s and limits referred to herein shall not in any way limit the liability of the Contractor. The Contractor shall include a provision in all subcontracts requiring the subcontractor to maintain the same types and amounts of insurance specified in b) below.
b) The Contractor shall purchase and maintain at a minimum the following types of insurance coverage and limits of liability:

1) Commercial General Liability (CGL) with limits of insurance of not less than $1,000,000 each Occurrence and $2,000,000 Annual Aggregate. If the CGL coverage contains a General Aggregate Limit, such General Aggregate shall apply separately to each project. HRI and the People of the State of New York shall be included as Additional Insureds on the Contractor’s CGL, using ISO Additional Insured Endorsement CG 20 10 11 85 or an endorsement providing equivalent coverage to the Additional Insureds. The CGL insurance for the Additional Insureds shall be as broad as the coverage provided for the Named Insured Contractor. It shall apply as primary and non-contributing insurance before any insurance maintained by the Additional Insureds.

2) Business Automobile Liability (AL) with limits of insurance of not less than $1,000,000 each accident. AL coverage must include coverage for liability arising out of all owned, leased, hired and non-owned automobiles.

3) Workers Compensation (WC) & Employers Liability (EL) with limits of insurance of not less than $100,000 each accident for bodily injury by accident and $100,000 each employee for injury by disease.

4) If specified by HRI, Professional Liability Insurance with limits of liability of $1,000,000 each occurrence and $3,000,000 aggregate.

c) Provide that such policy may not be canceled or modified until at least 30 days after receipt by HRI of written notice thereof; and

d) Be reasonably satisfactory to HRI in all other respects.

10. Publications and Conferences –

a) All written materials, publications, journal articles, audio-visuals that are either presentations of, or products of the Scope of Work which are authorized for publication or public dissemination, subject to the confidentiality restrictions herein, will acknowledge HRI, the New York State Department of Health (DOH) and the Project Sponsor and will specifically reference the Sponsor Reference Number as the contract/grant funding the work with a disclaimer, as appropriate, such as: "The content of this publication (journal article, etc.) is solely the responsibility of the authors and does not necessarily represent the official views of HRI or the Project Sponsor. This requirement shall be in addition to any publication requirements or provisions specified in Attachment B – Program Specific Clauses.

b) Conference Disclaimer: Where a conference is funded by a grant, cooperative agreement, sub-grant and/or a contract the recipient must include the following statement on conference materials, including promotional materials, agenda, and Internet sites, "Funding for this conference was made possible (in part) by the <insert Project Sponsor name>. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of HRI, NYS Department of Health or the Project Sponsor, nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government."

Use of Logos: In order to avoid confusion as to the conference source or a false appearance of Government, HRI or DOH endorsement, the Project Sponsor, HRI and/or DOH’s logos may not be used on conference materials without the advance, express written consent of the Project Sponsor, HRI and/or DOH.

11. Title -

a) Unless noted otherwise in an attachment to this Agreement, title to all equipment purchased by the Contractor with funds from this Agreement will remain with Contractor. Notwithstanding the foregoing, at any point during the Term or within 180 days after the expiration of the Term, HRI may require, upon written notice to the Contractor, that the Contractor transfer title to some or all of such equipment to HRI. The Contractor agrees to expeditiously take all required actions to effect such transfer of title to HRI when so requested. In addition to any requirements or limitations imposed upon the Contractor pursuant to paragraph 3 hereof, during the Term and for the 180 day period after expiration of the Term, the Contractor shall not transfer, convey, sublet, hire, lien, grant a security
interest in, encumber or dispose of any such equipment. The provisions of this paragraph shall survive the termination of this Agreement.

b) Contractor acknowledges and agrees that all work products, deliverables, designs, writings, inventions, discoveries, and related materials (collectively, "Works") made, produced or delivered by Contractor in the performance of its obligations hereunder will be owned exclusively by HRI. All copyrightable Works are "works made for hire", which are owned by HRI. Contractor will assign, and hereby assigns and transfers to HRI, all intellectual property rights in and to Works, including without limitation, copyrights, patent rights, trademark rights, and trade secret rights. The Contractor shall take all steps necessary to effect the transfer of the rights granted in this paragraph to HRI. As set forth in paragraph 18(d) herein, Standard Patent Rights Clauses under the Bayh-Dole Act (37 C.F.R. 401) are hereby incorporated by reference and shall supersede any terms in this Agreement that may conflict therewith. The provisions of this paragraph shall survive the termination of this Agreement.

12. Confidentiality - Information relating to individuals who may receive services pursuant to this Agreement shall be maintained and used only for the purposes intended under the Agreement and in conformity with applicable provisions of laws and regulations or specified in Attachment B, Program Specific Clauses. Contractor acknowledges and agrees that, during the course of performing services under this Agreement, it may receive information of a confidential nature, whether marked or unmarked, ("Confidential Information"). Contractor agrees to protect such Confidential Information with the same degree of care it uses to protect its own confidential information of a similar nature and importance, but with no less than reasonable care. Contractor will not use Confidential Information for any purpose other than to facilitate the provision of services under this Agreement, and Contractor will not disclose Confidential Information in an unauthorized manner to any third party without HRI's advance written consent.

13. Equal Opportunity and Non-Discrimination - Contractor acknowledges and agrees, whether or not required by Article 15 of the New York State Executive Law (also known as the Human Rights Law) or any other State or Federal statutory or constitutional non-discrimination provisions, that Contractor will not discriminate against any employee or applicant for employment because of race, color, creed, religion, sex, sexual orientation, gender identity, national origin, age, disability, pregnancy-related condition, military or veteran status, genetic predisposition or carrier status, marital or familial status, domestic violence victim status, individual's relationship or association with a member of a protected category or any other basis protected by applicable state and federal law. Furthermore, Contractor agrees that neither it nor its authorized subcontractors, if any, shall, by reason of race, color, creed, religion, sex, sexual orientation, gender identity, national origin, age, disability, pregnancy-related condition, military or veteran status, genetic predisposition or carrier status, marital or familial status, domestic violence victim status, individual's relationship or association with a member of a protected category or any other basis protected by applicable state and federal law: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this Agreement. Contractor is subject to fines of $50.00 per person per day for any violation of this provision, or of Section 220-e or Section 239 of the New York State Labor Law, as well as possible termination of this Agreement and forfeiture of all moneys due hereunder for a second or subsequent violation.

14. Use of Names - Unless otherwise specifically provided for in Attachment B, Program Specific Clauses, and excepting the acknowledgment of sponsorship of this work as required in paragraph 10 hereof (Publications), the Contractor will not use the names of Health Research, Inc. the New York State Department of Health, the State of New York or any employees or officials of these entities without the express written approval of HRI.

15. Site Visits and Reporting Requirements -
   a) Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance of the services under this Agreement (collectively, "Records"). The Records must be kept for three years after the final voucher is paid.

   b) HRI and the Project Sponsor or their designee(s) shall have the right to conduct site visits where services are performed and observe the services being performed by the Contractor and any subcontractor and inspect Records. The Contractor shall render all assistance and cooperation to HRI and the Project Sponsor in connection with such visits. The surveyors shall have the authority, to the extent designated by HRI, for determining contract compliance as well as the quality of services being provided.

   c) The Contractor agrees to provide the HRI Project Director, or his or her designee complete reports, including but not limited to, narrative and statistical reports relating to the project's activities and progress at the Reporting
16. Miscellaneous –

a) Contractor and any subcontractors are independent contractors, not partners, joint venturers, or agents of HRI, the New York State Department of Health or the Project Sponsor; nor are the Contractor's or subcontractor's employees considered employees of HRI, the New York State Department of Health or the Project Sponsor for any reason. Contractor shall pay employee compensation, fringe benefits, disability benefits, workers compensation and/or withholding and other applicable taxes (collectively the "Employer Obligations") when due. The contractor shall include in all subcontracts a provisions requiring the subcontractor to pay its Employer Obligations when due. Contractor is fully responsible for the performance of any independent contractors or subcontractors.

b) This Agreement may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet, subjected to any security interest or encumbrance of any type, or disposed of without the previous consent, in writing, of HRI.

c) This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns.

d) Contractor shall have no interest, financial or otherwise, direct or indirect, or engage in any business, transaction, or professional activity, that may create a conflict, or the appearance of a conflict, with the proper discharge of Contractor’s duties under this Agreement or the conflict of interest policy of any agency providing federal funding under this Agreement. In the event any actual or potential conflict arises, Contractor agrees to notify HRI in writing within ten (10) days to allow HRI to evaluate any potential or actual conflict. Contractor certifies that it has implemented and is in compliance with a financial conflict of interest policy that complies with 42 CFR Part 50 Subpart F, as may be amended from time to time. Contractor acknowledges that it cannot engage in any work or receive funding from HRI until they have disclosed all financial conflicts of interest and identified an acceptable management strategy to HRI. At HRI’s request, Contractor will provide information about how it identified, managed, reduced or eliminated conflicts of interest. Failure to disclose such conflicts or to provide information to HRI may be cause for termination as specified in the Terms & Conditions of this Agreement. HRI shall provide Contractor with a copy of notifications sent to the funding agency under this Agreement.

e) Regardless of the place of physical execution or performance, this Agreement shall be construed according to the laws of the State of New York and shall be deemed to have been executed in the State of New York. Any action to enforce, arising out of or relating in any way to any of the provisions of this Agreement may only be brought and prosecuted in such court or courts located in the State of New York as provided by law; and the parties’ consent to the jurisdiction of said court or courts located in the State of New York and to venue in and for the County of Albany to the exclusion of all other court(s) and to service of process by certified or registered mail, postage prepaid, return receipt requested, or by any other manner provided by law. The provisions of this paragraph shall survive the termination of this Agreement.

f) All official notices to any party relating to material terms hereunder shall be in writing, signed by the party giving it, and shall be sufficiently given or served only if sent by registered mail, return receipt requested, addressed to the parties at their addresses indicated on the face page of this Agreement.

g) If any provision of this Agreement or any provision of any document, attachment or Exhibit attached hereto or incorporated herein by reference shall be held invalid, such invalidity shall not affect the other provisions of this Agreement but this Agreement shall be reformed and construed as if such invalid provision had never been contained herein and such provision reformed so that it would be valid, operative and enforceable to the maximum extent permitted.

h) The failure of HRI to assert a right hereunder or to insist upon compliance with any term or condition of this Agreement shall not constitute a waiver of that right by HRI or excuse a similar subsequent failure to perform any such term or condition by Contractor.

i) It is understood that the functions to be performed by the Contractor pursuant to this Agreement are non-sectarian in nature. The Contractor agrees that the functions shall be performed in a manner that does not discriminate on
the basis of religious belief and that neither promotes nor discourages adherence to particular religious beliefs or to religion in general.

j) In the performance of the work authorized pursuant to this Agreement, Contractor agrees to comply with all applicable project sponsor, federal, state and municipal laws, rules, ordinances, regulations, guidelines, and requirements governing or affecting the performance under this Agreement in addition to those specifically included in the Agreement and its incorporated Exhibits and Attachments.

k) This Agreement may be executed in two or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument. Delivery of an executed signature page to the Agreement by facsimile transmission or PDF shall be as effective as delivery of a manually signed counterpart.

l) The following pertains only to Contractors located in New York City or doing business in New York City: Contractor agrees it is compliant with NYC Local Law 96 (2018) Stop Sexual Harassment in NYC Act.

m) Contractor agrees it is compliant with New York State's training requirements for preventing sexual harassment and provides such training on an annual basis, pursuant to Section 201-g of the Labor Law.

17. Federal Regulations/Requirements Applicable to All HRI Agreements -
   The following are federal regulations, which apply to all Agreements; regardless of the source of the funding (federal/non-federal) specified on the face page of this Agreement. Accordingly, regardless of the funding source, the Contractor agrees to abide by the following:
   a) Human Subjects, Derived Materials or Data - If human subjects are used in the conduct of the work supported by this Agreement, the Contractor agrees to comply with the applicable federal laws, regulations, and policy statements issued by DHHS in effect at the time the work is conducted, including by not limited to Section 474(a) of the HHS Act, implemented by 45 CFR Part 46 as amended or updated. The Contractor further agrees to complete an OMB No. 0990-0263 form on an annual basis.
   b) Laboratory Animals - If vertebrate animals are used in the conduct of the work supported by this Agreement, the Contractor shall comply with the Laboratory Animal Welfare Act of 1966, as amended (7 USC 2131 et. seq.) and the regulations promulgated thereunder by the Secretary of Agriculture pertaining to the care, handling and treatment of vertebrate animals held or used in research supported by Federal funds. The Contractor will comply with the HHS Policy on Humane Care and Use of Laboratory Animals by Awardee Institutions and the U.S. Government Principles for the Utilization and Care of Vertebrate Animals Used in Testing, Research and Training.
   c) Research Involving Recombinant DNA Molecules - The Contractor and its respective principle investigators or research administrators must comply with the most recent Public Health Service Guidelines for Research Involving Recombinant DNA Molecules published at Federal Register 46266 or such later revision of those guidelines as may be published in the Federal Register as well as current NIH Guidelines for Research Involving Recombinant DNA Molecules.
   d) Contractor is required to register with SAM.gov and maintain active status as stated in 2 CFR Subtitle A, Chapter 1, and Part 25. Contractor must maintain the accuracy/currency of the information in SAM at all times during which the Contractor has an active agreement with HRI. Additionally, the Contractor is required to review and update the information at least annually after the initial registration, and more frequently if required by changes in information.
   e) Equal Employment Opportunity – for all agreements

   This contractor and subcontractor shall abide by the requirements of 41 CFR 60-1.4(a) which is hereby incorporated herein.

   This contractor and subcontractor shall abide by the requirements of 41 CFR 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability, and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.
This contractor and subcontractor shall abide by the requirements of 41 CFR 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans, and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans.

f) National Labor Relations Act (Executive Order 13496)

Contractors that are not exempt from the National Labor Relations Act and have contracts, subcontracts or purchase orders subject to EO 13496 must satisfy the requirements of that Executive Order and its implementing regulations at 29 CFR Part 471 to be in compliance with the law.

18. Federal Regulations/Requirements Applicable to Federally Funded Agreements through HRI -
The following clauses are applicable only for Agreements that are specified as federally funded on the Agreement face page:

a) If the Project Sponsor is an agency of the Department of Health and Human Services: The Contractor must be in compliance with the following Department of Health and Human Services and Public Health Service regulations implementing the statutes referenced below and assures that, where applicable, it has a valid assurance (HHS-690) concerning the following on file with the Office of Civil Rights, Office of the Secretary, HHS.

1) Title VI of the Civil Rights Act of 1964 as implemented in 45 CFR Part 80.
2) Section 504 of the Rehabilitation Act of 1973, as amended, as implemented by 45 CFR Part 84.
4) Title IX of the Education Amendments of 1972, in particular section 901 as implemented at 45 CFR Part 86 (elimination of sex discrimination).
5) Sections 522 and 526 of the HHS Act as amended, implemented at 45 CFR Part 84 (non-discrimination for drug/alcohol abusers in admission or treatment).
6) Section 543 of the HHS Act as amended as implemented at 42 CFR Part 2 (confidentiality of records of substance abuse patients).
7) Trafficking in Persons – subject to the requirement of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104).
8) HHS regulatory requirements on Responsibility of Applicants for Promoting Objectivity in Research and financial conflicts of interest set forth in 42 C.F.R Parts 50 and 94.
9) Contractor agrees to comply with other requirements of the Project Sponsor, if applicable, set forth in the HHS Grants Policy Statement.

b) Notice as Required Under Public Law 103-333: If the Project Sponsor is an agency of the Department of Health and Human Services, the Contractor is hereby notified of the following statement made by the Congress at Section 507(a) of Public Law 103-333 (The DHHS Appropriations Act, 1995, hereinafter the "Act"): It is the sense of the Congress that, to the greatest extent practicable, all equipment and products purchased with funds made available in this Act should be American-made.

c) Contractor agrees that if the Project Sponsor is other than an agency of the DHHS, items 1, 2, 3 and 4 in subsection a) above shall be complied with as implemented by the Project Sponsor.

d) Contractor agrees that the Standard Patent Rights Clauses under the Bayh-Dole Act (37 C.F.R 401) are hereby incorporated by reference and shall supersede any terms in this Agreement that may conflict therewith.

e) Criminal Penalties for Acts Involving Federal Health Care Programs - Recipients and sub-recipients of Federal funds are subject to the strictures of 42 U.S.C. 1320A-7B(b)) and should be cognizant of the risk of criminal and administrative liability under this statute, including for making false statements and representations and illegal remunerations.

f) Equipment and Products - To the greatest extent practicable, all equipment and products purchased with federal funds should be American-made.

g) Acknowledgment of Federal Support – When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part by federal money, all awardees receiving Federal funds, including and not limited to State and local governments and recipients of
Federal research grants, shall clearly state (1) the percentage of the total costs of the program or project which will be financed with Federal money, (2) the dollar amount of Federal funds for the project or program, and (3) percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

h) 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 recognizant 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) and 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.

i) Clean Air Act and the Federal Water Pollution Control Act Compliance - If this contract is in excess of $150,000, Contractor agrees to comply and to require that all subcontractors have complied, where applicable, with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. § 7401-7671q.) and the Federal Water Pollution Control Act as amended (33 U.S.C. §1251-1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

j) Americans With Disabilities Act - This agreement is subject to the provisions of Subtitle A of Title II of the Americans with Disabilities Act of 1990, 42. U.S.C. 12132 ("ADA") and regulations promulgated pursuant thereto, see 28 CFR Part 35. The Contractor shall not discriminate against an individual with a disability, as defined in the ADA, in providing services, programs or activities pursuant to this Agreement.

k) Whistleblower Policy: Congress has enacted whistleblower protection statute 41 U.S.C. 4712, which applies to all employees working for contractors, grantees, subcontractors, and subgrantees on federal grants and contracts. This program requires all grantees, subgrantees and subcontractors to: inform their employees working on any federally funded award they are subject to the whistleblower rights and remedies of the program; inform their employee in writing of employee whistleblower protections under 41 U.S.C. 4712 in the predominant native language of the workforce; and Contractors and grantees will include such requirements in any agreement made with a subcontractor or subgrantee. The statute (41 U.S.C. 4712) states that an “employee of a contractor, subcontractor, grantee [or subgrantee] may not be discharged, demoted, or otherwise discriminated against as a reprisal for “whistleblowing”. In addition, whistleblower protections cannot be waived by any agreement, policy, form, or condition of employment.

Whistleblowing is defined as making a disclosure “that the employee reasonably believes is evidence of any of the following: 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 or grant (including the competition for, or negotiation of, a contract or grant). To qualify under the statute, the employee’s disclosure must be made to: a Member of Congress or a representative of a Congressional committee; or an Inspector General; or the Government Accountability Office; or a Federal employee responsible for contract or grant oversight or management at the relevant agency; or an authorized official of the Department of Justice or other law enforcement agency; or a court or grand jury; a management official or other employee of the contractor, subcontractor, grantee or subgrantee who has the responsibility to investigate, discover or address misconduct.

19. Required Federal Certifications –

Acceptance of this Agreement by Contractor constitutes certification by the Contractor of all of the following:

a) The Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal department or agency.
b) The Contractor is not delinquent on any Federal debt.


d) The Contractor shall comply with the requirements of the Pro-Children Act of 1994 and shall not allow smoking within any portion of any indoor facility used for the provision of health, day care, early childhood development, education or library services to children under the age of eighteen (18) if the services are funded by a federal program, as this Agreement is, or if the services are provided in indoor facilities that are constructed, operated or maintained with such federal funds.

e) The Contractor has established administrative policies regarding Scientific Misconduct as required by the Final Rule 42 CFR Part 93, Subpart A as published at the 54 Federal Register 32446, August 8, 1989.


g) If the Project Sponsor is either an agency of the Public Health Service or the National Science Foundation, the Contractor is in compliance with the rules governing Objectivity in Research as published in 60 Federal Register July 11, 1995.

h) Compliance with EO13513, Federal Leadership on Reducing Text Messaging while Driving, October 1, 2009. Recipients and sub recipients of CDC grant funds are prohibited both from texting while driving a Government owned vehicle and/or using Government furnished electronic equipment while driving any vehicle. Grant recipients and sub recipients are responsible for ensuring their employees are aware of this prohibition and adhere to this prohibition.

i) EO 13166, August 11, 2000, requires recipients receiving Federal financial assistance to 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 OCR website at http://www.hhs.gov/sites/default/files/ocr/civilrights/resources/specialtopics/lep/lepguidance.pdf.


The Contractor shall require that the language of all of the above certifications will be included in the award documents for all subawards under this Agreement (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. The Contractor agrees to notify HRI immediately if there is a change in its status relating to any of the above certifications.
Attachment 19
Grants Gateway Expenditure Budget Instructions

This guidance document is intended to help applicants with understanding the types and level of detail required in Grants Gateway for each individual budget line. For Grantee questions and instructions about entering an application in the Grants Gateway, please go to https://grantsreform.ny.gov/Grantees for more training and guidance resources.

Please be aware of the following:
- NYSDOH AI Program Managers may require additional information or clarification necessary for approval of requested amounts on funded applications; and
- The allowability of costs are subject to the OMB Uniform Guidance.

Grants Gateway Categories of Expense

There are two major Budget Categories, Personal Services and Non-Personal Services. Each of these categories include individual sub-categories for more specific budget items that can be requested in a budget. Each line requires different information.

1. Personal Services
   a. Salary (including peers who receive W2s)
   b. Fringe

2. Non-Personal Services
   a. Contractual (subcontractors, peers who receive 1099s, etc.)
   b. Travel
   c. Equipment
   d. Space/Property & Utilities
   e. Operating Expenses (supplies, audit expenses, postage, etc.)
   f. Other (indirect costs only)

Guidance on allowable expenditures can be found in the “Basic Considerations for Allowability of Costs” document. This document can be found here: http://www.ecfr.gov/cgi-bin/text-idx?SID=1728c16d0aca3b9aabbd3c25d38d5483&mc=true&node=pt2.1.200&rgn=div5.

Title 2 → Subtitle A → Chapter II → Part 200 — UNIFORM ADMINISTRATIVE REQUIREMENTS, COST PRINCIPLES, AND AUDIT REQUIREMENTS FOR FEDERAL AWARDS, Subpart E - Basic Considerations, §200.402 - §200.475

PERSONAL SERVICES – SALARY

For each salary position funded on the proposed contract, provide the following:

Details:
- **Position/Title**: Enter the title and the incumbent’s name. If the position is yet to be filled, enter “TBH” (to be hired.)
- **Role/Responsibility**: Enter the position description, including the duties supported by the contract.

Financial:
- **Annualized Salary Per Position**: Enter the full salary for 12 months regardless of funding source.
• **STD Work Week (hrs):** Enter the standard work week for this position regardless of funding. If it is a full-time position, this is often either 35, 37.5 or 40 hours per week. If it is a part-time position, enter the expected number of hours per week the person will work.

• **% Funded:** Enter the percent of effort to be funded on this proposed contract.

• **# of Months Funded:** Enter number of months this position will be funded during the proposed contract period. Use months only; do not use pay periods.

• **Total Grant Funds:** Enter the total amount for this position requested during the proposed contract period. Grants Gateway will not automatically calculate this. Please check your calculation for accuracy.

**Items to Note:**

- The Total Match Funds and Total Other Funds lines are not used. You will not be able to enter information on those lines.
- While Grants Gateway does not calculate the Line Total, it does calculate the cumulative Category Total.

**PERSONAL SERVICES - FRINGE**

**Details:**

- **Fringe – Type/Description:** Enter a description (examples, fringe rate, union fringe rate, nonunion fringe rate, part-time fringe rate, full-time fringe rate) and the percentage.

- **Justification:** Specify whether fringe is based on federally approved rate, audited financials or actual costs.

**Financial:**

- **Total Grant Funds:** Enter the total amount of fringe requested for this proposed contract period.

**CONTRACTUAL**

**Details:**

- **Contractual – Type/Description:** Enter the name of the agency, consultant or TBA (if not yet selected). Use a separate Contractual line for each subcontractor or consultant. Include an estimated cost for these services.

- **Justification:** Briefly describe the services to be provided.

**Financial:**

- **Total Grant Funds:** Enter the total amount requested for the subcontractor.

**TRAVEL**

**Details:**

- **Travel – Type/Description:** Describe the type of travel cost and/or related expenses.

- **Justification:** Briefly describe how the travel relates to the proposed contract.

**Financial:**

- **Total Grant Funds:** Enter the total amount requested for the Travel item.

**EQUIPMENT**

**Details:**
• **Equipment – Type/Description:** Describe the equipment and who it is for.

• **Justification:** Briefly describe how this equipment relates to the proposed contract and why it is necessary.

**Financial:**

• **Total Grant Funds:** Enter the total amount requested for this Equipment item.

**Items to Note:**

• Equipment is defined as any item costing $1,000 or more.
• Rental equipment (if applicable) can be included in this section.

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**SPACE/PROPERTY RENT or Own**

**Details:**

• **Space/Property: Rent or Own – Type/Description:** Describe the property, whether it is the agency’s main site or satellite and provide the address. Use a separate Space line for each different location.

• **Justification:** Explain why this proposed contract is paying for the space costs at this location.

**Financial:**

• **Total Grant Funds:** Enter the total amount requested for this Space/Property item.

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**UTILITY**

**Details:**

• **Utility – Type/Description:** Describe the utility expense.

• **Justification:** Indicate the property address for which this expense will be incurred.

**Financial:**

• **Total Grant Funds:** Enter the total amount requested for this Utility item.

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**OPERATING EXPENSES**

This section is used to itemize costs associated with the operation of the program, including but not limited to insurance/bonding, photocopying, advertising, and supplies.

**Details:**

• **Operating Expenses – Type/Description:** Describe what is being purchased.

1. **Supplies –** Briefly describe items being purchased.

2. **Equipment –** Include all items with a total cost under $1,000, including computer software. Use a separate line for each group of items.

3. **Telecommunications –** Include costs for all telephone lines funded by this proposed contract, fax and modem lines, telecommunications installation costs, hotlines, long distance, cell phones, and
internet expenses.

4. Miscellaneous – Includes postage, printing, insurance, equipment maintenance, stipends, media advertising, recruitment, or other appropriate costs.
   - For incentives, briefly detail the types of incentives to be purchased and what they will be used for.

   - **Justification:** Describe how this item relates to the contract and why it is necessary.

**Financial:**
- **Total Grant Funds:** Enter the total amount requested for this Operating Expense item.

**OTHER**

**Details:**
- **Other Expenses – Type/Description:** This section will only be used to document Indirect Costs. Enter the words "Indirect Cost rate" and the rate being requested.

- **Justification:** Enter whether or not this rate is based on a federally approved rate agreement.

**Financial:**
- **Total Grant Funds:** Enter the total amount requested for this Expense item.

**Items to Note:**
- Up to 10% is allowed for all applicants.
- Up to 20% is allowed if applicant has a federally approved rate that can justify the request.
- No cost that is billed directly to this contract can be part of the indirect rate.