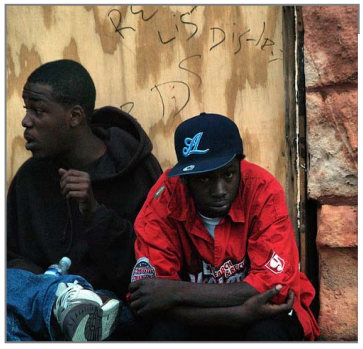
Funding Opportunity

Government of the District of Columbia Department of Health
HIV/AIDS, Hepatitis, STD, and TB Administration

H A H S T A



Retention for Results: Towards Durable Viral Suppression in the District of Columbia

CARE Act
Part A and Part B

Request for Applications

RFA # RW_A&B03.29.13

Application Due Date: May 23, 2013
No Late Applications will be Accepted

Government of the District of Columbia
Adrian M. Fenty, Mayor

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

DEPARTMENT OF HEALTH (DOH)
HIV/AIDS, Hepatitis, STD & TB Administration (HAHSTA)
Notice of Funding Availability (NOFA)
RFA #RW A&B_032913

FY 2013 Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A & B

The Government of the District of Columbia, Department of Health, HIV/AIDS, Hepatitis, STD & TB Administration (HAHSTA) is soliciting applications from qualified applicants to provide a variety of clinical and medical support services to indigent, uninsured and under-insured persons who are living with HIV/AIDS in the District of Columbia and the Eligible Metropolitan Area (EMA).

Approximately $**17,000,000** (for a twelve-month period) in FY 2013 Ryan White Part A & B grants funds are expected to be available for services in the following areas:

Clinical Services	$**12,750,000**
Medical Support Services	**$4,250,000**

Services under the FY 2013 Ryan White Part A & B grant programs include outpatient primary medical health care, specialized case management, basic life needs and a variety of support services. All activities funded will support people with HIV to enroll and be retained in a regular system of medical care, to maximize the achievement of durable viral suppression.

All awards are contingent upon an award to the District of Columbia Department of Health by the U.S. Health Resources & Services Administration (HRSA) under the Ryan White Part A & B programs.

The Request for Application (RFA) release date is Friday, March 29, 2013. The RFA will be available for pick up at The District of Columbia, Department of Health, HAHSTA located at 899 North Capitol Street NE, 4th floor and on the Office of Partnerships and Grant Services, DC Grants Clearinghouse website www.opgs.dc.gov on **Friday, March 29, 2013**. The Pre-Application Conference will be held on **Tuesday, April 9, 2013 from 10:00 am – 12:00 pm at 899 North Capitol St. NE, 4th floor, Washington, DC.**

The submission deadline for the HAHSTA RFA# RWA&B_032913 is 4:45 pm Thursday, May 23, 2013.at the HAHSTA offices, 899 North Capitol St. NE, 4th floor, Washington, DC 20002. Proposals that are not delivered and received by this deadline will not be considered for funding.

Please contact **T'Wana Holmes at (202) 671-4900** for additional information.

District of Columbia Department of Health
Terms for Requests for Applications & Funding

The following terms and conditions are applicable to this and all Requests for Applications issued by the District of Columbia Department of Health (DOH):

- Funding for an award is contingent on continued funding from the DOH grantor or funding source.
- The RFA does not commit DOH to make an award.
- DOH reserves the right to accept or deny any or all applications if the DOH determines it is in the best interest of DOH to do so. DOH shall notify the applicant if it rejects that applicant's proposal.
- DOH may suspend or terminate an outstanding RFA pursuant to its own grant making rule(s) or any applicable federal regulation or requirement.
- DOH reserves the right to issue addenda and/or amendments subsequent to the issuance of the RFA, or to rescind the RFA.
- DOH shall not be liable for any costs incurred in the preparation of applications in response to the RFA. Applicant agrees that all costs incurred in developing the application are the applicant's sole responsibility. No funds already awarded the applicant under other instruments or agreements shall be used by the applicant to fund the preparation of the application.
- DOH may conduct pre-award on-site visits to verify information submitted in the application and to determine if the applicant's facilities are appropriate for the services intended.
- DOH may enter into negotiations with an applicant and adopt a firm funding amount or other revision of the applicant's proposal that may result from negotiations.
- DOH shall provide the citations to the statute and implementing regulations that authorize the grant or sub-grant; all applicable federal and District regulations, such as OMB Circulars A-102, A-133, 2 CFR 180, 2 CFR 225, 2 CFR 220, and 2 CFR 215; payment provisions identifying how the grantee will be paid for performing under the award; reporting requirements, including programmatic, financial and any special reports required by the granting Agency; and compliance conditions that must be met by the grantee.
- If there are any conflicts between the terms and conditions of the RFA and any applicable federal or local law or regulation, or any ambiguity related thereto, then the provisions of the

applicable law or regulation shall control and it shall be the responsibility of the applicant to ensure compliance.

Additional information about RFA terms may be obtained at the following site: www.opgs.dc.tov (click on Information) or click here: City-Wide Grants Manual
If your agency would like to obtain a copy of the **DOH RFA Dispute Resolution Policy,** please contact the Office of Grants Management and Resource Development at doh.grants@dc.gov or call (202) 442-9237. Your request for this document will not be shared with DOH program staff or reviewers. Copies will be made available at all pre-application conferences.

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I. Overview

Ryan White HIV/AIDS Treatment Extension Act of 2009 (CARE Act)

The legislation previously known as the Ryan White CARE Act was amended in 2006, extended in 2009, and renamed the Ryan White HIV/AIDS Treatment Extension Act of 2009. The legislation can be obtained at: http://hab.hrsa.gov/abouthab/legislation.html.

The purpose of the CARE Act is to create and maintain a system of services that achieves improved health status outcomes for people with HIV/AIDS. The Washington Metropolitan Regional HIV Health Services Planning Council has adopted a comprehensive service delivery plan for the Washington Eligible Metropolitan Area (EMA) and has established funding priorities for services to be supported by CARE Act Part A funds in each of the four jurisdictions of the EMA. Consistent with the requirements of the CARE Act, HAHSTA has established funding priorities for CARE Act Part B funds for the District of Columbia.

This Request for Application (RFA) will result in sub-grants for services that will be funded by Part A or Part B.

The primary objectives of the CARE Act are:

> *To expand and improve the range of ambulatory and outpatient health and support services, including comprehensive treatment, case management, community-based and transitional services that are available to individuals and families with HIV infection, in order to complete the continuum of care and provide services in the least restrictive setting*
>
> *To make these services known and accessible to low income individuals and families and under served populations*
>
> *To establish and/or strengthen a coordinated, community-wide approach to planning and delivering HIV-related services*

Purpose of this Request for Applications (RFA)

The purpose of this RFA is to create a system of services that has highest probability of serving individuals with HIV as they achieve durable viral suppression. It is perhaps best described as having two distinct, but complementary, sets of purposes.

The client-centered purposes of this RFA are to:

- Ensure each client is prepared for receiving HIV-related care services.

- Increase the extent to which clients are retained in a system of HIV-related care services.
- Improve the ability of clients to consume necessary and effective services by increasing the coordination of services.
- Assist clients to achieve durable viral suppression.

The system-centered purposes of this RFA are to:

- Increase access to HIV-related care.
- Reduce disparities in HIV-related outcomes, including
  - Speed of entry into care upon HIV diagnosis
  - HIV viral load at time of detection of HIV infection, and at time of enrollment into care
- Assist entities supported by CARE Act funding for participation in an expanded, reformed system of health care
- Demonstrate compliance with CARE Act legislative requirements and expectations, and especially with ensuring that HIV support services are associated with achieving HIV-related health outcomes. [See 2604(d)(1) and (2)]

Service Delivery and Continuum of Care

No single set of services can effectively address the needs of the wide range of races, ethnicities, social identities, risk behaviors, clinical statuses and service expectations of clients throughout the Washington DC, EMA. The best hope for a service delivery system lies in establishing and maintaining a continuum that ensures access, retention and coordination of all required care and support services.

The District of Columbia is working towards eliminating the fragmented system of care clients are currently accessing. Over the course of the next funding cycle HAHSTA will be working with key stakeholders and providers in the CARE Act care system to refine delivery of services in ways that will maximize the health benefit to clients.

As the overall coordination of services is improved, HAHSTA will focus further on evaluating the impact of services on the health status of clients. In addition, outcome measures for the service system as a whole will be clarified or defined as a means of assessing the impact of an increased coordination of services.

An effective continuum is characterized by a full complement of client-focused, culturally competent and multi-directional interventions. The service delivery system model will include coordination, collaboration, comprehensiveness, co-location, cultural competency and chronic care. Client access, enrollment and retention in outpatient/ambulatory medical care are central to the healthcare delivery system in the Washington DC, EMA. It is a system that is flexible, with multiple points of entry, and yet must ensure that the many services delivered to clients contribute to improving health outcomes. It is a system that embraces the reality that clients consume services in very different proportions, sequences and frequencies—that one size does not fit all. It is designed to improve integration, collaboration and focused outreach among an extensive provider network system, and incorporates early intervention, prevention, counseling and testing, and care services.

The continuum is designed for flexibility so as to model the many, varied ways in which clients experience the service needs. It is the expectation that this will increase the likelihood that all eligible people with HIV, including the newly diagnosed, historically underserved and disproportionately impacted populations and hard–to-serve individuals will effectively be served. To ensure that all infected and affected persons of the EMA are able to access services, a special emphasis has been placed on newly enrolling and then retaining in care those clients who are aware of their HIV status but not in care, and recapturing those clients out of care for six months or more.

The integration of care and prevention services is a key component of the continuum of care, and one that is especially challenging in an EMA of overlapping jurisdictions. Planning for care and prevention services will expand over time, and must field the complex questions unique to our multi-jurisdictional EMA including: variable access to services, differential challenges to retention, multiple funding sources with different requirements and expectations, and the difficulties of coordinating among four prevention planning groups and a single care planning group.

The Washington DC EMA has created and supports a comprehensive HIV/AIDS primary health care system in every part of the EMA. The core medical services are outpatient/ambulatory medical care, AIDS drug assistance program (ADAP), AIDS pharmaceutical assistance (local), oral health care, early intervention services, health insurance premium and cost sharing, home health care, home and community-based health services, hospice services, mental health services, medical nutrition therapy, medical case management and substance abuse services. Supportive services are critical in the continuum. In addition to helping maintain clients in primary care, improving quality of life, and providing stabilizing factors to help clients maximize adherence to care, sometimes supportive services can be the final connection that prevents a client from being lost entirely from the system of services. Applicants applying for services other than the core should demonstrate how the services will expand, enhance, support and facilitate connection to primary care. The applicant can accomplish this through memorandums of understanding with providers to assure a continuum of care for access and retention in care.

The Washington DC EMA has a diverse multicultural client population and with the use of Part A Minority AIDS Initiative (MAI) funding more expansive and culturally specific programs have been implemented to support a cluster of services. The cluster of services is designed to provide an intensive set of care and support services for very high need clients.

The Washington DC EMA benefits from an active Early Intervention Services network, financed through CARE Act Part C Funds. An important portal into the HIV continuum of care, early intervention services include intensive outreach for medical services, which is designed to ensure that hard-to-serve individuals are identified and empowered to consume HIV health and support services.

NOTE: It is a requirement that CARE Act funded services are provided to individuals with a HIV-positive test result. It is permissible to use CARE Act funds to support a confirmatory HIV test result, and preferable that confirmatory tests are provided in the context of a first medical appointment for HIV care. It is not permissible to use CARE At funds to support testing for HIV.

II. Entities Eligible to Apply

The following entities are eligible to apply for grant funds under this RFA: not-for-profit health and support services providers, including universities; government-operated health facilities, which are located within and provide service in the designated service area; and for-profit health and support service providers if evidence is provided that they are the only organization able to provide the service.

Applicants under this RFA will propose whole programs, or “tiers,” of services. Successful applicants for will propose a plan to ensure that all service categories within a given tier will be provided either directly by the applicant, or indirectly by a documented partnership between the applicant and a partner in care.

Tiers One, Two, and Four are for services to eligible residents of the District of Columbia. Tier Three: MAI Cluster includes services for eligible residents of the District of Columbia, as well as for services to eligible residents of the Washington DC Eligible Metropolitan Area. Tier Five is for services to eligible residents of the Washington, DC Eligible Metropolitan Area (EMA).

III. Tiers and System-Wide Considerations

For the purposes of this RFA, all service categories to be supported are organized into Tiers. The Tiers are intended to ensure that the full-range of client needs are addressed, and that the services provided support the improvement of the client’s health status. Review of health status will guide the modification of individual service

plans, and could prompt a modification in the strategies designed to deliver one or more service.

The Tiers are described individually in the section below, and generally offer guidance as to the organizations that may apply under each Tier. This section discusses issues of concerns for applicants for all Tiers.

Ambulatory Outpatient Medical Care

Applicants for all Tiers must describe how they ensure the ambulatory outpatient medical care provided – directly by successful applicants in some Tiers, indirectly by successful applicants in other Tiers -- is consistent with the most current Public Health Service (PHS) standards of care and treatment guidelines and all other applicable professional standards. This requirements applies to applicants under all Tiers, and applies to all providers of ambulatory outpatient medical are included as a partner in care without regard for funding source.

For more information about the most recent PHS guidelines visit

http://aidsinfo.nih.gov/guidelines/

Partners in Care

HAHSTA anticipates that an effective response to this RFA will require applicants to create, maintain and expand ongoing partnerships with other service providers and other service systems. HAHSTA intends that these partnerships will result in effective co-management of client services, improvement of health outcomes of clients and more clear documentation of the benefit of a range of services to clients.

HAHSTA encourages Tier One applicants to enter into partnerships that will improve their ability to serve effectively high-need populations that may benefit from targeted, intensive support services. In addition, some of the service categories for which Tier One successful applicants are responsible may be most effectively accomplished by identifying a partner for those services.

In addition, HAHSTA encourages Tier Two successful applicants to initiate, maintain or expand partnerships with providers of primary or specialty medical care that are not sub-grantees of CARE Act Part A, Part A MAI or Part B funds. These potential partners may have other funding sources – in particular, Medicaid or private insurance – to support primary care, but those funding sources may not provide the full range of supportive services available under the CARE Act to serve eligible residents. Partnerships resulting from this RFA are intended to improve the extent to which a single standard of care and support services are provided to people with HIV without regard to the payor source for primary care.

Please note that the clients served through all partnerships will be those who otherwise meet the eligibility criteria for CARE Act Part A, Part A MAI and Part B services, and the services provided will be those that can be supported without violation of the payor of last resort and other relevant provisions of the CARE Act.

A core, required element of these partnerships is a written, signed partnership agreement. Key issues include

1. The relative roles and responsibilities of the partners.

   Particular care should be given to the relative roles and responsibilities for service categories that may be shared. For example, a Tier One applicant may apply to provide one sub-set of medical case management services directly, and to provide another sub-set of medical case management services indirectly through a partnership agreement.

2. A description of the client cohort that will be served through the partnership agreement. (See “Client Cohort and Co-Management” below.)

3. A clear description of the costs to be incurred by the partner and supported by the successful applicant, including the source of funds.

   a. The cost drivers of the service(s) to be supported should be specified, and may include the number of clients served as well as the units of service provided.

   b. Administrative costs should be shared. The CARE Act legislation imposes a cap of ten percent (one-tenth) of program costs that may be spent on the administrative activities of the successful applicant. The partnership agreement should describe which portion of allowable CARE Act-funded administrative costs will be used by the successful applicant, and which portion will be used by the partner.

   c. Please note that the source of funds may include Part A, Part A MAI or Part B funds, but may also include program income generated by the Part A, Part A MAI or Part B program of the successful applicant.

   d. It is permissible to use program income funds to support the uncompensated administrative costs of the successful applicant or the partner.

4. The plan for periodic and ongoing evaluation of the effectiveness of the partnership, identification of challenges, and proposed solutions, such as requests for technical assistance and other strategies to improve the partnership. The evaluations will be quarterly at minimum, and will include a written summary of key issues and indicators.

Other key considerations include:

1. Successful applicants with multiple partners in care are strongly encouraged to implement partnership agreements that are consistent with one another; partners in care are strongly encouraged to develop and propose consistent partnership agreements with successful applicants.

2. For at least some service categories, a simple fee-for-service may be the most effective and efficient means to implement a partnership agreement. For example, it may be ideal to pay for the delivery of meals to eligible clients on a fixed cost-per-meal basis.

3. All partnership agreements are subject to review and approval by HAHSTA, and all partnership agreements are public information.

4. Successful applicants remain responsible for all fiscal and programmatic matters for including ensuring compliance with local and federal regulations. This includes regular reports on

    a. Key indicators for clients served, including retention in care and health outcome indicators.

    b. Number and demographics of clients served.

    c. Number of service units provided.

    d. Costs incurred, billed and reimbursed.

5. Consistent with the practices and regulations of the District of Columbia, successful applicants will be reimbursed for costs incurred and paid. This will require that successful applicants pay agreed-upon costs to partners in care prior to submitting a claim for payment to the District of Columbia.

6. HAHSTA will consider requests for advances, subject to federal and local regulations and requirements.

Applicants will describe their plan to provide services, and may choose to include a documentation of current and proposed partnerships in Appendix B of their application.

For the purposes of this RFA, applicants are advised that any specification of a partner organization should be documented by either a current memorandum of agreement or a letter of intent from the partner organization, included in Appendix B of their application.

Applicants are advised that any proposal that depends upon partnership agreements for implementation will be evaluated in part on the status of the partnership agreement(s) at the time of application submission.

Following the description of the Tiers is a listing of service categories, goals and priorities.

Client Cohort and Co-Management

Tiers improve the likelihood that a range of client needs will be addressed, and that coordination of services will be a central activity of each successful applicant.

Partnership agreements will seek to ensure that the duplication of services to any individual client is minimized. Generally, a client will be seen by a single ambulatory outpatient medical provider, and generally a single organization (funded by any of Tiers One, Two or Three) is best-suited for coordination of services.

Partnership agreements between Tier One and Tier Two organizations will include a means to identify and expand the roster of clients whose care is co-managed by partners. Partnership agreements should describe the procedure for referral of clients to a roster of a partner, as well as establish clear expectations with respect to services to be delivered.

Partnership agreements may include a distribution of case management responsibilities between partners. HAHSTA expects that any such distribution

1. Would be limited to two partner organizations, and that no client would be designated as served by more than two medical case managers.

2. The components of medical case management for which each partner is responsible would be clearly specified.

3. The successful applicant will convene a case conference – at least quarterly – to include all partners providing medical case management.

HAHSTA expects that all successful applicants will work diligently towards providing effective sets of services without duplication of services. In very limited circumstances, some duplication of services may be in the best interests of client service, and are

1. Services designed to ensure linkage to care following an HIV diagnosis. Early linkage and treatment are clearly important to the well-being of clients served, and multiple, simultaneous efforts may be necessary and appropriate.

2. During the first six months of client enrollment in ambulatory outpatient medical care, some flexibility should be offered to clients to ensure a “good fit” with their medical and other providers of services.

3. Services designed to return clients to care following an interruption may require multiple and simultaneous efforts.

Data and Reporting and Evaluation

Successful applicants must comply with all District of Columbia, Department of Health, HAHSTA evaluation efforts, including monthly data reporting, suitable internal quality management activities and HRSA data requirements, including unduplicated client-level data.

HAHSTA will require the regular submission of data through CAREWare or a data file conforming to a specified format. Technical specifications for the data file will be provided, so that awardees and partners in care may take advantage of systems already in use to capture this information. Training and technical assistance on the use and submission of data, depending on the data submission process utilized, will be provided.

For coordination of care and services purposes, each awardee will be ability to exchange the data listed below with each partner agency. All data exchanges will be secure, consistent with client disclosure authorization and all local and federal requirements, including the Health Information Portability and Accountability Act (HIPAA).

Data Required for each Patient Served

Identifiers
Basic Demographics
Federally Required Demographics
Expanded Housing Information
Medical History

Data Required for Each Enrollment

Referral (Into Program) Details
Discharge and Disposition Information
Dates and Level of Service

Medical Information

Primary Care Visits and Date
CD4 and Date
VL and Date
Diagnoses
Medications

Care Coordination Medical Information

ARV Adherence
Other Medical Considerations (e.g., Drug Relapse)
Medical Decision Re: Intervention Intensity (Package of Services)

Treatment Plan Required Data

Plan Element (e.g., Referral, Return Appointment)
Details (Date, Provider, Etc.)
Program Resources Used
Outcome(s)

Data With Regard To Treatment Interruptions and Other Reasons for Outreach and Disposition

Indication
Outreach Activities with Detail
Outcome/Disposition

Social Services and Public Benefits Data

Assessment Date
Housing Status Detail
Identified Needs (Must Correlate With Elements of the Treatment Plan)

Health Education, Skills Building, and Coaching

Date
Service/Content

Community Health Workers

HAHSTA encourages applicants to consider including Community Health Workers as part of their plan to provide services. For the purposes of this RFA, Community Health Workers are individuals who provide paraprofessional or peer-based services, and are supervised by successful applicants. Community Health Workers may be proposed by applicants for any Tier, and may be proposed to provide services in any service category. HAHSTA expects Community Health Workers will be supported in the service categories Early Intervention Services, Medical Case Management, Psychosocial Support Services.

Service categories designed to be provided by licensed health professionals – examples include Ambulatory Outpatient Medical Care, Mental Health, Substance Abuse – may be complemented by Community Health Workers whose work will assist clients to enroll in care, support them as they are maintained in care and re-enroll those lost to care.

HAHSTA anticipates that Community Health Workers may be particularly effective in serving one or more of the Focus Populations, and may also be a useful resource for reducing barriers associated with language and cultural competence.

In proposing the use of Community Health Workers, applicants should describe the criteria and means to ensure that Community Health Workers are prepared to provide services, including the certification required as a condition of employment.

The successful applicant in Tier Five: EMA-Wide Services will be a proposal that provides direct services through Community Health Workers, under the supervision of the successful applicant.

It is not permissible to use CARE Act Part A or Part B funds to support the costs of a jobs training program. Training and supervision costs are permissible to improve the skills and abilities of staff, and include any staff costs of the Community Health Workers as they are trained.

Applicants are advised to ensure that the cost of training of Community Health Workers is managed in ways that maximize the delivery of services; supervision requirements may be proportional to the number of hours of direct service provided by a Community

Health Worker. No more than five percent of a given service category budget should be allocated to support the costs of training Community Health Workers.

See above for a description of "Partners in Care." HAHSTA encourage applicants to identify a partner who may provide an initial training program for newly-hired Community Health Workers.

IV. Tier Descriptions

Tier One: Primary Care and Care Coordination.

Applicants proposing in Tier One will include all applicants that propose ambulatory outpatient medical care. Applicants under Tier One are not eligible to apply under Tier Two. Key characteristics of this cluster are

- Two services categories -- Ambulatory Outpatient Medical Care and Medical Case Management -- provided directly by the applicant.
- Successful applicants will demonstrate experience with managing HIV disease in a clinical setting for a minimum of one hundred and fifty patients. The minimum case load may include clients with HIV disease without regard to the funding source used to support the primary care needs of the clients.
    - Applicants with a client case load smaller than one hundred and fifty will be considered provided that the application supports a program that is transitional or time-limited by design, and serves one or more very high-need or highly-vulnerable client populations.
    - Although it is permissible for Tier One applicants to propose a program that is time-limited, it will remain the responsibility of successful applicants to ensure and provide documentation that the clients served are retained in care for the first twelve months following enrollment. The documentation required may include demonstration of ongoing primary care services at another site or through another organization.
- Successful applicants will be responsible for ensuring assessment, access and referral for all other services supported under this RFA.
- With the exception of Ambulatory Outpatient Medical Care and Medical Case Management, services may be provided by demonstrated, documented relationships with non-profit organizations as partners in care.
    - The description of partners in care will include a clear description of the plan to ensure the distribution of funds requested under this RFA to support services provided indirectly by partners in care.

    - Applicants funded under Tier One may propose to provide Medical Case Management in close collaboration with one or more partners in care that are funded under Tier Two to provide Medical Case Management. This collaboration must be described in the application, and should emphasize the strategies to ensure clear roles and responsibilities, minimize duplication of services and maximize culturally competent services.

- Successful applicants will be responsible for managing confidential, secure exchange of information among the partners in care.

- Successful applicants will be responsible for reporting all services provided under this Tier, including those services provided indirectly by partners in care.

- Successful applicants will be responsible for ensuring that they -- and all partners in care -- bill and collect from Medicaid and other third-party payor sources.

    - Any service supported by Medicaid or other third-payor source, when provided to a beneficiary of Medicaid or other third-party payor source, must be billed and collected.

    - If the billed service was provided by a staff person whose position is supported by CARE Act funds, it is required that the revenue from the Medicaid or other third-party payor source be considered "program income," and used to benefit the HIV program.

      Please note that program income may be used in ways not permissible for CARE Act funds. Examples include supporting administrative costs greater than the amount permitted under CARE Act requirements, or providing eligible CARE Act clients with medications unrelated to HIV disease.

Expected Awards.

HAHSTA expects to award between ten and fifteen Tier One sub-grants for services to residents of the District of Columbia.

Tier Two: Medical Case Management and Care Coordination

Applicants proposing in Tier Two will include all applicants that propose medical case management but do not propose under Tier One. Key characteristics of this Tier are

- Medical Case Management is provided directly by the applicant.

- Successful applicants will be responsible for ensuring assessment, access and referral for all other services supported under this RFA. This responsibility may

be accomplished by demonstrated, documented relationships with non-profit organizations as partners in care.

  - The description of partners in care will include a clear description of the plan to ensure the distribution of funds requested under this RFA to support services provided indirectly by partners in care.

- Successful applicants will be responsible for managing confidential, secure exchange of information among the partners in care.

- Successful applicants will be responsible for reporting all services provided under this Tier, including those services provided indirectly by partners in care.

- Successful applicants will be responsible for ensuring that they -- and all partners in care -- bill and collect from Medicaid and other third-party payor sources.

  - Any service supported by Medicaid or other third-payor source, when provided to a beneficiary of Medicaid or other third-party payor source, must be billed and collected.

  - If the billed service was provided by a staff person whose position is supported by CARE Act funds, it is required that the revenue from the Medicaid or other third-party payor source be considered "program income," and used to benefit the HIV program.

    Please note that program income may be used in ways not permissible for CARE Act funds. Examples include supporting administrative costs greater than the amount permitted under CARE Act requirements, or providing eligible CARE Act clients with medications unrelated to HIV disease.

Expected Awards.

HAHSTA expects to award between six and ten Tier Two sub-grants for services to residents of the District of Columbia.

Tier Three: MAI Cluster

Tier Three applicants are required to propose to provide medical case management services directly. Unlike Tier Two, Tier Three applicants may also propose to provide ambulatory outpatient medical care directly or indirectly.

Each proposal must include a plan for the provision of the eight service categories that comprise the MAI cluster. The eight service categories are: medical case management, outpatient ambulatory medical care, linguistic services, mental health services, outreach services, substance abuse services, medical transportation and psychosocial services.

The plan for these funds is to support services designed to provide an intensive set of care and support services for high need clients. All proposals must detail how each client served will be re-assessed at a minimum of every six months for appropriateness with this intensive approach of service delivery.

Applicants must provide medical case management directly, and all other MAI services on site or through a partner in care. The application must include all services but some may be supported by other funding sources, including but not limited to other parts of the CARE Act.

Successful applicants must demonstrate the ability to implement a cluster that demonstrates how each service component of the cluster adds value to one another and improve the health outcomes of the population targeted.

The applicant must characterize the proposed target population by describing the need for services, and should emphasize those characteristics that underscore the need for this set of services.

The tier and the services within it may be provided by the applicant, or on behalf of the applicant through a documented partnership agreement, as described in the section "Partners in Care."

Successful applicants will be responsible for ensuring that they -- and all partners in care -- bill and collect from Medicaid and other third-party payor sources.

- Any service supported by Medicaid or other third-payor source, when provided to a beneficiary of Medicaid or other third-party payor source, must be billed and collected.

- If the billed service was provided by a staff person whose position is supported by CARE Act funds, it is required that the revenue from the Medicaid or other third-party payor source be considered "program income," and used to benefit the HIV program.

  Please note that program income may be used in ways not permissible for CARE Act funds. Examples include supporting administrative costs greater than the amount permitted under CARE Act requirements, or providing eligible CARE Act clients with medications unrelated to HIV disease.

Funding to support these services are from CARE Act Part A Minority AIDS Initiative (MAI) program. As such, these funds will support services to people of color with HIV, which are defined as African Americans, Latinos, Native Americans, Asian Americans, Native Hawaiians and Pacific Islanders.

For a detailed description of all the service categories comprising the MAI cluster of services and their key activities see the Compendium of Services.

All awards for the cluster of services will award a minimum of 75% to core medical services.

Service clusters will be reviewed in conjunction with Service Summary Table (Attachment D) and Linkages Table (Attachment E).

Applicants must demonstrate how the provision of service delivery will have an impact on the following health outcomes, including but not limited to:

- Improvement with regard to HIV disease, as measured by viral load and CD4 levels
- Improved or sustained enrollment and maintenance in ongoing HIV primary care

CARE Act funds are always the payer of last resort. CARE Act funds cannot be used to pay for services reimbursable by private insurance, Medicaid or Medicare.

Expected Awards.

HAHSTA expects to award between two and four Tier Three sub-grants for services to residents of the District of Columbia for a combined total of $1,176,015.

HAHSTA expects to award one Tier Three sub-grants for services to residents of the Eligible Metropolitan Area with limited English proficiency for a total of $394,548.

The Washington, DC Eligible Metropolitan Area (EMA) is a geographic area that includes Washington, District of Columbia (Wards 1 – 8), Suburban Maryland (Prince George's, Montgomery, Frederick, Charles and Calvert Counties), Suburban Virginia (Alexandria City, Fairfax City, Falls Church City, Fredericksburg City, Manassas Park City, Manassas City, Arlington, Clarke, Culpeper, Fairfax, Fauquier, King George, Loudoun, Prince William Spotsylvania, Stafford and Warren Counties) and West Virginia (Jefferson and Berkley Counties).

The successful applicant may be located in any part of the EMA, and will provide services to eligible clients with limited English proficiency.

Tier Four: Single Point of Payment

Applicants proposing in Tier Five will serve as a source of payment for specific service activities upon request of providers funded under Tier One, Tier Two or Tier Three, and will provide these services under a partnership agreement with these providers. HAHSTA expects that the role of the Tier Four provider will be primarily accepting referrals from their partners in care, addressing the specific eligibility and needs of the clients referred, and liaising with the Tier One, Two or Three provider to report delivery of the service. HAHSTA expects that the Tier One, 2 or 3 provider will be responsible

for reporting on the health outcome status of the clients served by the Tier Four provider.

Expected Awards.

HAHSTA expects to award one Tier Four sub-grant for services to residents of the District of Columbia.

Tier Five: Early Intervention, Psychosocial Support and Transportation (EMA-Wide)

HAHSTA will make an award to one provider in Tier Five to provide a coordinated set of Early Intervention, Psychosocial and Medical Transportation services, as well as to support consumer activities in the HAHSTA Quality Management Program.

Inserted service description from EIS (EMA-Wide) below

Tier Five will support services for eligible residents of the Washington, DC Eligible Metropolitan Area (EMA), a geographic area that includes Washington, District of Columbia (Wards 1 – 8), Suburban Maryland (Prince George's, Montgomery, Frederick, Charles and Calvert Counties), Suburban Virginia (Alexandria City, Fairfax City, Falls Church City, Fredericksburg City, Manassas Park City, Manassas City, Arlington, Clarke, Culpeper, Fairfax, Fauquier, King George, Loudoun, Prince William Spotsylvania, Stafford and Warren Counties) and West Virginia (Jefferson and Berkley Counties). The successful applicant may be located in any part of the EMA, and the expectation of each service category is that the services provided will be offered in multiple locations throughout the EMA.

Please see the Compendium of Services for the definitions of each of the service categories supported in this Tier. The description below provides additional focus and requirements for this particular RFA.

Services provided in this Tier will be provided by Community Health Workers, supported by appropriate training and supervision.

Early Intervention Services

Early Intervention Services will emphasize ensuring the movement of clients along the prevention to care continuum – specifically ensuring retention in care and improved health outcomes. These services will be targeted to vulnerable populations at very high risk of HIV infection; with demonstrated high rates of HIV prevalence; lost to care (poor engagement in care and did not return after initial medical appointment); and recently diagnosed ("no show" for first medical appointment).

Early Intervention Services will be offered through a para-professional and peer-based model of services using Community Health Workers to provide the direct services. For the purposes of this Tier, Community Health Workers are individuals who have received services under Part A of the CARE Act within the previous twelve months, or the adult caregiver of a child who has received services under Part A of the CARE Act in the previous twelve months.

Applicants should demonstrate their ability to provide EIS services across the entire Eligible Metropolitan Area, and include in Appendix B of their application documentation of their partnerships to provide these services.

Attachment R is a suggested draft memorandum of understanding between the provider of EIS services are sites offering HIV testing or treatment.

Note: For the purposes of this Tier, funding is available for those services offered to individuals whose HIV infection has been detected, and who are in need of assistance to enter into and remain in ambulatory outpatient medical care.

Psychosocial Support Services

The successful applicant will be responsible for providing psychosocial services in multiple locations, including at least twenty percent of groups in each of the District of Columbia, Northern Virginia and Suburban Maryland.

This service must be integrated with the EIS services offered in this tier, and complement the goals and of objectives of linking and supporting people with HIV in care.

The successful applicant will describe the intended target population for each psychosocial support group, and provide one or more psychosocial support groups in one or more locations that target each of the groups below:

- African-born
- Individuals aged fifty or older
- Individuals newly diagnosed with HIV.
- Latina

Medical Transportation Services

A modest award of Medical Transportation Services will be provided to assist clients in services offered in this Tier.

Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Key activities include: (1) providing transportation services to medical/clinical appointments for non-Medicaid eligible clients with HIV/AIDS; (2) utilizing leased vans with drivers, a taxi voucher system, fare cards for metro rail, metro bus passes, disability commuter tickets, reimbursement's to family/friends for mileage and parking or a combination of approaches; (3) providing appropriate modes of transportation for HIV disabled persons needing assistance or wheelchair accommodations; and (4) improve transportation services for clients with dependent children.

In addition to services, applicants under Tier Five will propose in their Program Description to support the consumer activities in Quality Management Activities. This will include facilitation of Positive All-Parts Collective for Quality (Q-PAC), and Consumer Advisory Committee (CAC) of the Planning Council in their development and provision of training for front-desk staff.

Key activities include

1. Provide logistical support for Q-PAC "Making Patient Self-Management Work" consumer trainings.

2. Reimburse Q-PAC members for committee meetings, including transportation, meals, and childcare costs.

3. Reimburse Q-PAC members for attendance to DC EMA Collaborative in-person meetings, including transportation, meals, and childcare costs.

4. Reimburse Q-PAC members attendance to professional development programs, including transportation, meals, and childcare costs.

5. Develop and support CAC front-desk training efforts.

Expected Awards.

HAHSTA expects to award one Tier Five sub-grant for residents of the Eligible Metropolitan Area.

V. Service Categories

Compendium

See the Compendium of Services: CARE Act Part A and Part B for a narrative description of service categories. These service category definitions, goals and priorities apply to the service categories of each Tier.

Tiers and Service Categories

See Table 1: Service Categories and Tiers for a listing of all service categories required for inclusion in each Tier. In each Tier, service categories are organized as required to be

- Provided directly by the applicant
- Provided directly by the applicant or indirectly through a partner in care

Table 1: Service Categories and Tiers	Tier One: Primary Care	Tier Two: Medical Case Management	Tier Three: MAI Cluster (DC and EMA-Wide)	Tier Four: Single Point of Payment	Tier Five: EMA-Wide
Ambulatory Outpatient Medical Care	**Direct**	**Indirect**	**Direct**		
AIDS Drug Assistance Program (ADAP)	Direct **OR** Indirect	Direct **OR** Indirect			
AIDS Pharmaceutical Assistance (Local)	Direct **OR** Indirect	Direct **OR** Indirect			
Oral Care	Direct **OR** Indirect	Direct **OR** Indirect			
Early Intervention Services	Direct **OR** Indirect	Direct **OR** Indirect			**Direct**
Health Insurance Premium and Cost Sharing Assistance	Direct **OR** Indirect	Direct **OR** Indirect			
Home & Community Based Care	Direct **OR** Indirect	Direct **OR** Indirect			
Mental Health Services	Direct **OR** Indirect	Direct **OR** Indirect	Direct **OR** Indirect		
Medical Nutrition Therapy	Direct **OR** Indirect	Direct **OR** Indirect			
Medical Case Management	**Direct** Indirect (Optional)	**Direct** Indirect (Optional)	**Direct** Indirect (Optional)		
Substance Abuse Services - Outpatient	Direct **OR** Indirect	Direct **OR** Indirect	Direct **OR** Indirect		
Case Management (Non Medical)					
Child Care	**Indirect**	**Indirect**		**Direct**	
Emergency Financial Assistance	**Indirect**	**Indirect**		**Direct**	
Food Bank, Home Delivered Meals	Direct **OR** Indirect	Direct **OR** Indirect			
Legal Services	Direct **OR** Indirect	Direct **OR** Indirect			
Linguistic Services	Direct **OR** Indirect	Direct **OR** Indirect	Direct **OR** Indirect		
Medical Transportation Services	Direct **OR** Indirect	Direct **OR** Indirect	Direct **OR** Indirect		**Direct**
Outreach Services	Direct **OR** Indirect	Direct **OR** Indirect	Direct **OR** Indirect		
Psychosocial Support Services	Direct **OR** Indirect	Direct **OR** Indirect	Direct **OR** Indirect		**Direct**
Treatment Adherence Services	Direct **OR** Indirect	Direct **OR** Indirect			

Applicants must complete a Service Categories Scopes of Work (Attachment G), identifying the service category, total number of clients to be served, service units to be delivered and service category request amount. For Medicaid covered services, applicants must provide evidence of Medicaid certification or application for certification.

Service categories will be reviewed in conjunction with Client Summary (Attachment D) and Linkages Summary (Attachment E).

CARE Act funds are always the payer of last resort. CARE Act funds can not be used to pay for services reimbursable by private insurance, Medicaid or Medicare.

HIV Testing and CARE Act Funds

CARE Act funded services are provided to individuals with an HIV-positive test result. It is permissible to use CARE Act funds to support a confirmatory HIV test result, and preferable that confirmatory tests are provided in the context of a first medical appointment for HIV care. It is not permissible to use CARE Act funds to support testing for HIV.

VI. Target Populations

In keeping with the objectives of the CARE Act and the recommendations of the Metropolitan Washington Regional HIV Health Services Planning Council, HAHSTA has determined that the target populations for this RFA are indigent, uninsured, and under-insured persons who are HIV-infected and affected. Documentation of HIV infection – including a preliminary diagnosis of HIV infection – are required of clients served.

Focus Populations

Applicants are invited to demonstrate their understanding of, and history of service, one or more of the focus populations listed below. Submission of one or more “Focus Population Description” are optional, and will not be scored.

Rather, the Focus Population Descriptions will be rated, and used by HAHSTA to ensure the full complement of high-quality fundable proposals are funded in ways that address the specific needs of each focus population.

Awards resulting from applications with Focus Population Descriptions may include requirements associated with service delivery to members of one or more Focus Populations, along with reporting requirements.

HAHSTA anticipates that Tier One awards will include a minimum of one award that effectively demonstrates understanding, expertise and capacity to address each Focus Population, and HAHSTA hopes to make multiple Tier One awards to offer members of

each Focus Population a choice of HIV-expert service provider. A single Tier One award may include multiple Focus Populations.

HAHSTA invites Tier Two applicants to demonstrate their expertise in one or more Focus Populations. The Focus Populations for this RFA are

Families

A "family" is a unit that shares a living space, and includes at least one adult and at least one minor child or disabled adult for whom the adult has at least half-time custodial responsibility. At least one of these individuals is a person with HIV.

Clients served with CARE Act Part A or Part B funds are people with an HIV diagnosis, and services for this Focus Population should contribute to the clinical improvement of the client with HIV, and applicants should describe the direct or indirect benefit of services requested.

Key activities may include: a treatment adherence program that supports age-appropriate disclosure and discussion of HIV disease, or addresses family dynamics that may intrude upon adherence to medication regimens; psychosocial assessment and support for children of one or more HIV-positive parents that ease the responsibility burden of the adult.

Homeless

A "homeless" person is an individual with HIV who has a current or recent (within six month) episode of homelessness lasting at least three days. For the purposes of this definition, "homelessness" may include living in a homeless shelter or a location not intended for human habitation.

Key activities may include: treatment adherence services within a homeless shelter or other acute facility to promote adherence to treatment; directly observed therapy (as indicated); day program; intensive (short-term) medical case management services.

Older Clients

"Older" clients include individuals with HIV who are at present at least fifty years old. This group may include people with long-term HIV disease, or individuals who have recently learned they are HIV-positive.

Peri-Incarcerated

The "peri-incarcerated" are individuals with HIV who have a recent history (within sixty days) or multiple incidents of incarceration, and emphasizes services to

individuals recently released from custody or at very high risk of recidivism. This includes individuals who are living in “halfway houses” or are on parole.

With narrow exceptions, it is not permissible to support services with CARE Act Part A or Part B funds to individuals while in custody. It is permissible to support models of medical case management that provide services to inmates in preparation for release, including developing service plans, establishing appointments for primary care, implementing early steps of a housing stability plan and applying for Medicaid or ADAP.

Services to the peri-incarcerated may be designed to be short-term interventions intended to stabilize clients as they enter into a more “mainstream” set of services. Under all circumstances, it will remain the responsibility of successful applicants to ensure and provide documentation that the clients served are retained in care for the first twelve months following enrollment. The documentation required may include demonstration of ongoing primary care services at another site or through another organization.

Applicants are advised to demonstrate their ability to establish or maintain documented relationships with custodial officials.

Pregnant Women

For the purposes of this RFA, “pregnant women” are those with HIV who are not enrolled in an ongoing system of HIV-expert ambulatory outpatient medical care, or are at very high risk of dropping out of HIV-expert ambulatory outpatient medical care.

Applicants are advised to describe:

- Expertise, experience and documented relationships necessary for identifying pregnant women with HIV who are not well served by HIV-expert ambulatory outpatient medical care
- The ability to address the health care needs of the pregnant clients – including peri-natal care – and to ensure the client is prepared for birth.
- Their plan for ensuring each client has a successful transition – following pregnancy – to an appropriate and indicated level of HIV core medical and support services.

Transgender Individuals

“Transgender” refers to any individual with HIV whose gender expression may result in one or more barriers to HIV-expert ambulatory outpatient medical care

or may discourage the client from seeking care. Applicants are advised to demonstrate their expertise in supporting transgender clients as they seek and receive HIV core medical and support services.

Young People Transitioning

This RFA provides a focus on young people with HIV who are making a transition from adolescent to adult care.

Focus Population Descriptions

For each Focus Population Description, applicants may submit a narrative not to exceed four pages. Please see "Application Format" in the section "Application Preparation and Submission" for the specifications, including page and font size.

Applicants should rely upon the narrative description of the Tier as the foundation of the services to members of each Focus Population. The Focus Population Description should emphasize the specific issues and barriers common to members of the Focus Population, and the specific plan to maximize the likelihood that members of the Focus Population will be appropriately supported and retained in care.

The narrative for each Focus Population should include the following elements:

1. Data Elements

    a. The number of clients with HIV currently served by the applicant

    b. The number of Focus Population clients with HIV currently served by the applicant.

    c. The number of Focus Population clients with HIV expected to be served within the first twelve months of the program proposed.

2. Barriers and Challenges. Describe the specific difficulties encountered by members of the Focus Population with respect to receiving HIV-expert care.

3. Strategies and Solutions. Describe the specific approaches proposed to address the barriers and challenges encountered by members of the Focus Populations

    a. Demonstrate expertise in providing culturally competent HIV-expert core medical and support services to members of the Focus Population.

    b. Demonstrate the ability to support members of the Focus Population by addressing specific barriers experienced as they seek and receive HIV core medical and support services

c. Partners. Describe the partners in care that will be responsible for direct service provision to members of the Focus Population. Be specific about the organization(s) and describe their expertise.

4. Services. Describe the specific mix of service categories expected to be provided to members of the Focus Population.

VII. Available Funding

Funds awarded in this RFA are contingent upon availability of funds to the Grantee, the District of Columbia HIV/AIDS, Hepatitis, STD, TB Administration (HAHSTA) by the U.S. Health Resources & Services Administration (HRSA) under the CARE Act Part A, Part A Minority AIDS Initiative (MAI) and Part B program for the Washington, DC EMA. The funding is authorized by the CARE Act to provide services for indigent, uninsured, and under-insured persons who are HIV-infected.

Funds will be awarded among multiple tiers. Tabled immediately below is the amount of funding expected to be awarded under this RFA by service category and tier.

Table 2: Funding Amounts by Service Categories and Tiers	Tier One: Primary Care and Care Coordination	Tier Two: Medical Case Management and Care Coordination	Tier Three: MAI Cluster	Tier Four: Single Point of Payment	Tier Five: EMA-Wide	TOTAL
Ambulatory Outpatient Medical Care EMA-Wide	4,500,000	-	513,898	-	-	**5,013,898**
Oral Care	764,766	-	-	-	-	**764,766**
Early Intervention Services - EMA-Wide	350,920	350,920	-	-	325,000	**1,026,839**
Health Insurance Premium and Cost Sharing Assistance	-	-	-	500,000	-	**500,000**
Home & Community Based Care	261,534	-	-	-	-	**261,534**
Mental Health Services	807,077	142,425	181,760	-	-	**1,131,262**
Medical Nutrition Therapy	381,142	-	-	-	-	**381,142**
Medical Case Management	3,353,119	1,092,698	556,114	-	-	**5,001,930**
Substance Abuse Services - Outpatient	677,651	-	85,544	-	-	**763,195**
Core Medical Services Subtotal	**11,096,208**	**1,586,042**	**1,337,316**	**500,000**	**325,000**	**14,844,566**
Child Care	-	-	-	27,727	-	**27,727**
Emergency Financial Assistance	-	-	-	548,032	-	**548,032**
Food Bank, Home Delivered Meals -- Food Banks	363,732	121,244	-	-	-	**484,976**
Food Bank, Home Delivered Meals -- Home Delivered Meals	363,732	121,244	-	-	-	**484,976**
Legal Services	102,202	18,036-	-		-	**120,238**
Linguistic Services	44,578-	7,867	43,100		-	**95,545**
Medical Transportation Services	56,976	10,055	4,310	-	15,000	**86,340**
Outreach Services	-	-	98,980	-	-	**98,980**
Psychosocial Support Services	-	94,943	86,857	-	85,000	**266,800**
Treatment Adherence Services	372,191	849,352	-	-	-	**1,221,543**
Support Services Subtotal	**1,303,410**	**1,222,740**	**233,247**	**748,442**	**100,000**	**3,435,156**
PROGRAM TOTAL	**12,399,618**	**2,808,782**	**1,570,563**	**1,248,442**	**425,000**	**18,279,722**
Consumer Support for Quality Management	-	-	-	-	60,000	**60,000**

The final award of Part A and Part B funds by the federal Health Resources and Services Administration to HAHSTA may adjust the amount of funding available for service category and by tier.

Sub-grants for successful applicants of Tiers One, Two and Four may be funded by a combination of Part A and Part B funds. Tier Three will be funded by Part A MAI funds, and Tier Five by Part A funds.

Period of Funding

Grants supported by funds awarded under this RFA are expected to begin on October 1, 2013 through February 28, 2014 (Part A and Part A MAI) or March 31, 2014 (Part B). Pending performance reviews, compliance with reporting requirements, adherence to National Monitoring Standard expectations, participation in quality management activities and reporting as directed by HAHSTA and availability of funds, awards may be extended for two option years after February 28, 2014 or March 31, 2014.

VIII. Eligible Applicants

The following organizations/entities are eligible to apply for grant funds under this RFA:

- Not-for-profit health and support service providers, including universities.
- Government-operated health facilities, which are located within and provide service in the jurisdictions of the Washington, DC EMA, as identified.
- For-profit health and support service providers may be funded if evidence is provided that they are the only organization able to provide the service.

Applicants that provide Medicaid covered services must be Medicaid certified and authorized to bill in the jurisdiction where the client resides. Evidence can be presented in the form of a Medicaid approval letter or an actual Medicaid number for the agency and/or provider. If an organization is not Medicaid certified, evidence of an application to the appropriate jurisdiction for Medicaid certification must be submitted as a part of the application in response to this RFA. This documentation must be included in the Assurance package. Organizations proposing to provide Medicaid billable services must have Medicaid certification and be authorized to bill for services to receive funds awarded under this RFA. For a listing of eligible Medicaid reimbursable services for each jurisdiction in the EMA please see

- For Washington, DC: http://doh.dc.gov/doh/cwp/view,a,3,q,573226,dohNav_GID,1807,dohNav,|33345|.asp

- For Maryland: http://www.dhmh.state.md.us/mma/mmahome.html
- For Virginia: http://www.dmas.virginia.gov/

IX. Program Requirements

Location of Services

All service providers and sites must be located in the Washington, DC EMA. This requirement applies to all successful applicants, and all partners in care.

Awards for services to residents of the District of Columbia must be located in the District of Columbia. These awards include all Tiers One, Two and Four, and a majority of awards in Tier Three.

Awards for a portion of Tier Three and for all of Tier Five may be for services to residents of the EMA, and may be located in any portion of the EMA.

Preference will be given to proposals for services located in the same geographic area as the clients proposed to be served. Organizations may propose to provide services in a part of the EMA in which they have no service delivery site, but should take care to demonstrate that their particular proposed program offers clear and significant benefits and services that might otherwise not be available to clients who live in the area proposed to be served.

Monitoring, Evaluation and Quality Improvement

Successful applicants shall have a plan for Evaluation, Monitoring and Quality Improvement that includes a continuous quality improvement system and an implementation work plan to monitor and evaluate the delivery of all services, to ensure that identified deficiencies are addressed.

Successful applicants shall develop and implement policies and procedures to evaluate the accuracy of data collection and reporting.

Successful applicants shall adhere to all current and newly revised standards and protocols as they become effective. As of the release of this RFA, various standards have been approved and others are in the process of being revised. Specific information regarding the service category standards is listed in each corresponding service category.

National Monitoring Standards

All successful applicants are required to meet all responsibilities outlined in the National Monitoring Standard expectations for fiscal, programmatic and universal monitoring of

Part A, Part A MAI or Part B programs. Any sub- grantee found to be non-compliant with the standards at any time, will be held responsible and required by the District of Columbia to restore any damages and/or costs associated with grantee non-compliance. Please see website

http://hab.hrsa.gov/manageyourgrant/granteebasics.html

Monitoring

1. Successful applicants will be monitored and evaluated in each jurisdiction by HAHSTA according to the scope of work, approved budgets and related service delivery standards.

2. Successful applicants will be responsible for assuring that all clients receiving services provided through funds detailed in this RFA should sign the appropriate written consent forms.

3. Successful applicants will have all written policies and procedures applicable to the project; monthly, quarterly, annual program and fiscal reports reviewed by HAHSTA. HAHSTA will conduct site inspections; and hold periodic conferences with the successful applicant to assess performance in meeting the requirements of the grant.

Evaluation

The performance of successful applicants shall be assessed to determine the quality of the services delivered. The successful applicants' fiscal performance shall be assessed to determine compliance with accounting standards, OMB circulars and expenditure requirements.

Quality Management

HRSA's expectation of Ryan White Program grantees with respect to improving the quality of care and establishing quality management programs may be found online at:

http://hab.hrsa.gov/deliverhivaidscare/qualitycare.html.

HRSA guidance in selecting the appropriate service- and client-level performance measures is also available online at:

http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

or

https://careacttarget.org

Successful applicants are also required to meet local Quality Management standards and participate in local Quality Management activities as directed by HAHSTA.

Data Collection and Reporting

Successful applicants must be able to track and report unduplicated client-level demographic, clinical/medical, and core and support services data. CAREWare is a HRSA-supported software program, is free and comes with technical assistance. Beginning in 2013, all successful applicants will be required to use CAREWare, or a system that is compatible with CAREWare, to report client-level data.

Information about CAREWare, included download instructions, can be obtained at:

http://hab.hrsa.gov/manageyourgrant/careware.html.

All providers will be required to submit timely and accurate CAREWare or CAREWare compatible data files to meet reporting requirements, including the Ryan White Services Report (RSR). All providers will be required to collaborate with and share clinical and service information for the purpose of coordinating care. Failure to comply with data requirements can result in the termination of an agency's grant with the District of Columbia government.

Cultural Competence

Applicants are advised that all service providers should deliver services in a manner that is culturally and linguistically competent, which includes addressing limited English proficiency (LEP) and health literacy needs of clients. HRSA defines cultural and linguistic competence as "a set of congruent behavior, attitudes, and policies that come together in a system or agency among professionals and enable that system, agency, or those professionals to work efficiently in cross-cultural and linguistically diverse situations."

Healthcare providers funded by HRSA grants need to be alert to the importance of cross-cultural and language appropriate communications and general health literacy issues. HRSA supports and promotes a unified health communication perspective that addresses cultural competency, limited English proficiency, and health literacy in an integrated approach in order to develop that skills and abilities needed by HRSA-funded providers and staff to deliver the best quality health care effectively to the diverse populations they serve.

For additional information on HHS guidelines on cultural competency, see the Office of Minority Health National Standards on Culturally and Linguistically Appropriate Services (CLAS) at:

http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

Reporting Requirements

Successful applicants will be required to submit monthly, quarterly, annual and final reports to HAHSTA, to house and manage a client-level data system, and to participate in all site visits, evaluation and quality assurance activities as required by HAHSTA. All reports contain required information in the format determined by HAHSTA. Reports may include the following:

- Service Utilization by Service Category
- Performance Measures / Quality Improvement
- Client Demographics
- Ryan White Services Report (RSR)
- Programmatic Narrative Information
- Financial Expenditure and Supporting Documentation
- Program Income
- Unusual Incident Report, Include Report Of Client Death

The use of CAREWare, HRSA's client-level software package, will fulfill the client-level data collection requirement.

Training

HAHSTA will organize quarterly training for Medical Case Management staff. These training are designed to facilitate communication among frontline entities and the evolving medical case management system in the District of Columbia. They provide an opportunity for sharing best practices and identifying areas of particular concern.

Successful applicants of Tiers One, Two and Three must ensure representation in quarterly trainings. It is the responsibility of the representative to share the materials, topics and tools among key staff in their organization and partners in care.

X. Administrative Requirements

1. Nondiscrimination in the Delivery of Services

In accordance with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), as amended, no person shall, on the grounds of race, color, religion, nationality, sex, or political opinion, be denied the benefits of, or be subjected to discrimination under, any service category receiving CARE Act funds.

2. Client Eligibility Criteria

In accordance with the CARE Act, the following criteria must be used by service providers to determine client eligibility for CARE Act Part A, Part A MAI or Part B services:

a. Be a resident of the jurisdiction which is funding the services to be provided;

b. Be HIV positive;

c. Have an annual gross income no greater than 500% of the Federal Poverty Level

3. Sliding Fee Scale and Cap on Charges

Successful applicants will use a sliding fee scale for clients accessing services through CARE Act Part A, Part A MAI or Part B funds as directed by HAHSTA. The scale will be based on the most current Federal Poverty Guidelines. Sub-grantees will develop and post the sliding fee scale so that it is visible to clients and the general public. The requirements regarding imposition of charges for services are as follows:

a. Clients with an income less than or equal to 100% of the most current Federal Poverty Guidelines will not pay a fee for the provision of service.

b. Clients with an income greater than 100% of the most current Federal Poverty Guidelines will be asked to pay a fee for the provision of services and will be charged according to a sliding fee scale.

c. Clients with an income greater than 100%, but not exceeding 200% of the most current Federal Poverty Guidelines will not, for any calendar year, pay charges in an amount exceeding 5% of their annual gross income;

d. Clients with an income greater than 200%, but not exceeding 300% of the most current Federal Poverty Guidelines will not, for any calendar year, pay charges in an amount exceeding 7% of their annual gross income; and

e. Clients with an income greater than 300% of the most current Federal Poverty Guidelines will not, for any calendar year, pay charges in an amount exceeding 10% of their annual gross income.

f. The sliding fee scale will be implemented through a nominal fee, and will be charged for each primary care visit with a licensed medical professional with the ability to prescribe medications.

g. The CARE Act does not require collection of the fee charged to clients.

CARE Act services will not be denied to any eligible HIV-positive client seeking services.

All Sliding Fee Scale Policies are subject to review and approval by HAHSTA.

3. Grievances

a. Successful applicants shall develop and implement an agency grievance procedure that is sensitive to the needs of the target population. Successful applicants must include a copy of their internal client grievance procedures prior to signing for the sub-grant award.

b. Successful applicants shall inform clients of their rights and responsibilities, agency and EMA-wide grievance procedures, and services offered by the agency and other available community and CARE Act funded resources.

4. Records

a. Successful applicants shall keep accurate documentation of all activities of the project. When delivering services to clients, the successful applicants must maintain records reflecting initial and periodic assessments (if appropriate), initial and periodic service plans; and the ongoing progress of each client.

b. Successful applicants are responsible for assuring screening of potential clients for all third party payer sources including, but not limited to Medicaid, Medicare, ADAP private, and the District Alliance insurance, and maintaining documentation of the same.

c. Successful applicants shall maintain compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure confidentiality and security.

5. Staff Requirements

For the purposes of this grant, “staff” is defined as any individual employee, individual consultant or individual contracted worker that receives compensation through these CARE Act Part A, Part A MAI or Part B funds.

a. Successful applicants shall maintain documentation that staff possess adequate training and competence to perform the duties which they have been assigned.

b. Successful applicants shall maintain a complete written job description covering all positions funded through the grant, which must be included in the project files and be available for inspection on request. When hiring staff for this grant project, successful applicants shall obtain written documentation of relevant work experience and personal references.

c. Successful applicants that use individual contracted workers and or individual consultants must have signed and dated written contractual agreements maintained in a contract file.

d. Successful applicants shall maintain an individual personnel file for each project staff member. Personnel files must be available to HAHSTA upon request;

e. Successful applicants shall provide orientation sessions for each staff member with respect to administrative procedures, program goals, policies and practices to be adhered to under the grant agreement.

f. Successful applicants shall demonstrate sufficient supervision of staff attached to projects and maintain evidence of continuing education opportunities to keep staff informed of new developments regarding the provision of HIV/AIDS health care and support services.

6. Memoranda of Understanding (MOU) and Subcontracts

a. MOU and subcontracts must clearly state objectives, goals, mutual obligations and quantifiable outcomes that are consistent with the CARE Act and terms and conditions required by the applicable jurisdiction.

b. All MOU and subcontracts must be signed and dated by both parties within six months of the application and include an effective term that reflects a period that includes October 1, 2013 through February 28, 2014.

c. All MOU and subcontracts require prior review and approval by HAHSTA

7. Facility Requirements

a. Regulations

Successful applicants' facilities used during the performance of the grant agreement shall meet all applicable federal, state, and local regulations for their intended use throughout the term of the grant agreement.

b. Emergency Back-up Site

Successful applicants shall submit the address of the identified emergency site facility for use as a result of a catastrophic event of the primary facility.

c. Handicapped Access

All facilities offered for the provision of services must be accessible to persons with mobility limitations, consistent with the Rehabilitation of the Handicapped Act of 1990, Public Law Section 95-602 (Section 504) and the Americans with Disabilities Act, as appropriate.

8. Use of Funds

Successful applicants shall only use grant funds to support HIV core medical and support services. Funds detailed in this RFA cannot be used to provide cash and or direct financial assistance to individuals with HIV disease or to fund education and training for clients.

9. Insurance

Successful applicants shall show proof of all insurance coverage required by law. All applicants that receive a Notice of Intent to Award or Letter of Intent to Award under this RFA must meet the insurance requirements in “Terms & Conditions” section within the time frame designated.

10. Audits

Successful applicants at any time before final payment and in accordance to federal, state and local laws thereafter will be required to keep all financial records as the District of Columbia may have expenditure statements and source documentation audited.

XI. Pre-Application Submission Requirements

1. Pre-application Conference

One Pre-Application Conference will be held for services to residents of the District of Columbia and services EMA-Wide on Tuesday, April 9, 2013 from 10:00 AM to 1:00 PM 899 North Capitol Street NE, Washington DC 20002 on the fourth floor. Printed copies of the RFA will not be provided. Please bring a copy of the RFA for your use during the conference.

The pre-application conferences will provide an overview of the programmatic and submission requirements of the RFA.

2. Internet

Applicants who received this RFA via the Internet shall e-mail the appropriate administrative agency with the information listed below. For e-mail contact information see the Application Submission section appearing later in the RFA. Please be sure to put “RFA Contact Information” in the subject box.

Name of Organization
Key Contact
Mailing Address
Telephone and Fax Number
E-mail Address

This information shall be used to notify applicants re: updates or addenda to this RFA.

3. Letter of Intent to Apply

A letter of intent to apply (LOI) is not required, but is highly recommended. The applicant should deliver the letter of intent to HAHSTA using the format provided in Attachment I, no later than 4:45 p.m. on April 9, 2013.

4. Contact Information

In order to ensure consistent access to information about this RFA, HAHSTA asks that all questions or requests for clarification be sent via e-mail to the contact noted below. The last day to submit questions for a response is Thursday, May 9, 2013.

HAHSTA will notify all potential applicants in writing of any updates, addenda and responses to frequently asked questions by May 14, 2013.

Note: This information can only be received if you have provided HAHSTA with your contact information at either the pre-application conference or via e-mail to the HAHSTA contact.

HAHSTA Contact: T'Wana L. Holmes; twana.holmes@dc.gov or by phone at (202) 671- 4900.

XII. Application Preparation and Submission

1. Application Format

- Font size: 12-point Times New Roman
- Spacing: Double-spaced
- Paper size: 8.5 by 11 inches
- Page margin size: 1 inch
- Numbering: Sequentially from page 1 (Attachment C: Applicant Profile) to the end of the application, including all charts, figures, tables, and Attachments.
- Printing: Only on one side of page
- Binding: Only by metal (binder) clips or by rubber bands; do not bind in any other way

2. Application Elements

Each application is required to contain the following information and shall be divided by index tabs that clearly mark each section. Applications must conform to

the page requirements by section detailed below. Note that the Attachment D: Client Summary and the Attachment E: Linkages Summary~~)~~ are critical components of the application and will be taken into account during the scoring of all related areas.

All applications are submitted as a package. An application package includes the following elements

a. Application Checklist Form (See Attachment A. Not counted in page total.)

b. Applicant Profile (See Attachment C. Not counted in page total.)

c. Client Summary (See Attachment D. Not counted in page total.)

d. Linkages Summary (See Attachment E. Not counted in page total.)

e. Table of Contents (1 page)

f. Abstract (1 page)

g. Organization Knowledge and Capacity (10 pages)

h. Project Description will describe the program to be supported within the Tier. each service category within the respective Tier. Applications may include up to fifty pages to describe the plan to provide core medical services and may include an additional twenty-five pages to describe the plan to provide support services categories, a total of 75 pages).

i. Prevention to Care Continuum (5 pages)

j. Monitoring, Evaluation and Quality Improvement (5 pages)

k. Budget and Budget Narrative **for each service category within the respective Tier.** (Not counted in page total)

l. Appendix A: Focus Population Description(s) (Optional, 4 pages per Focus Population).

m. Appendix B: Partners in Care (Not counted in page total)

n. Attachments (Not counted in page total)

The number of pages designated for each section is the maximum number of pages permitted per section. **Applicants should feel free to submit fewer pages than the maximum stated.** However, the maximum number of pages for each section **cannot exceed that stated above**. The review panel shall not review applications that do not conform to these requirements.

3. Description of Application Elements

Applicants should include all information needed to describe adequately the services they propose to provide. It is important that applications reflect continuity among the goals and objectives, program design and activities, and that the budget reflects the level of effort required for the proposed services.

a. Applicant Profile

Each application shall have an Applicant Profile (Attachment A) affixed to the outside of each application envelope, which identifies the applicant, type of organization, project service category and the amount of grant funds requested. Project service categories or funds not included on this profile may not be considered for review.

b. Application Checklist

The checklist is a tool designed to assist applicants with ensuring that they have responded to all sections of the Request for Application.

c. Table of Contents

Lists major sections of the application with quick reference page indexing. Failure to include an accurate Table of Contents may result in the application not being reviewed fully or completely.

d. Abstract

This section of the application should provide a summary overview of the applicant's total grant application including a description of how the proposed service(s) will impact primary medical care services, enhance quality of life and sustain clients living with HIV in primary medical care.

e. Organizational Capacity and Experience

The **primary purpose** of this section is to fully describe your organization's past and current experience in the achievement of improved health outcomes for clients. This can be described as the success your organization has had in contributing to the movement of clients along the continuum from prevention to care: early diagnosis, linkage to care and other services, offering of antiretroviral treatment, adherence to medication and medical care, retention in medical care, re-engagement in care and improved health outcomes. It should describe any unique niche, knowledge and relationship to the community to be served and your capacity for growth or success in the service categories for which you are applying.

Applicants for Tiers One, Two and Three should describe in detail, based on aggregate data between July 1, 2011 and June 30, 2012, their success and experience with

- □ Increasing the rate of retention in care
- □ Decreasing the rate of those lost to care
- □ Achieving durable viral load suppression and CD4 count increases consistent with USPHS guidelines
- □ Compliance with USPHS anti-retroviral treatment guidelines at http://hab.hrsa.gov/publications.htm

The application must describe innovative strategies and program elements that have contributed to retention in care and improvement in health outcomes for clients; the extent to which the proposed service will facilitate the movement of clients along the prevention to care continuum described above and the extent to which the specific collaborations and specific linkages to other organizations have facilitated movement of clients along the prevention to care continuum described above.

It should also include critical systems or systems improvements that will support quality and efficiency in performance. Data and evidence of current capacity or past performance are critical to strong applications. This section will be reviewed in conjunction with Client Summary (Attachment D) and Linkages Summary (Attachment E), so direct references to these tables may be included. Specific elements to include are listed below.

The **secondary purpose** of this section is to describe your organizations capacity and experience in adhering to the payer of last resort provision, the ability to leverage resources and establish collaborative relationships to provide comprehensive services for clients.

The remaining subsections are required of any applicant proposing to provide a service for which Medicaid, Medicare, Alliance or private insurance is available. HAHSTA is interested in maximizing the available resources for each organization and for the District as a whole through full utilization of all payer systems, and is committed to working with providers throughout the grant period to achieve these goals.

Applicants should clearly describe how these grant funds will be used to fill critical gaps to ensure comprehensive services.

1. Demonstrate compliance with the payer of last resort provisions of the CARE Act. Describe the experience and capacity for screening for eligibility for all third-party payer systems, including Medicaid, Medicare, Alliance and private insurance.

a. Describe the process for initial screening for clients new to the applicant agency.

b. Describe the system for regular review of eligibility screening and outcomes for the proposed grant period.

c. Describe all reviews and any findings conducted by or about your organization in the last twelve months that assessed success in screening clients for eligibility in third party payer systems. If your organization has not conducted an internal review of third party payer systems in the last twelve months, describe your plan and timeline to conduct it.

2. Provide the number of clients enrolled in services.

   a. Of those enrolled, provide the number screened for eligibility for one or more third-party payer.

   b. Of those eligible for one or more third-party payer source, provide the number for whom enrollment was confirmed

   c. Provide the number of clients who are not eligible for third-party payer source, and describe the circumstances of these clients in general terms.

3. Demonstrate compliance with requirements associated with program income. Generally, program income includes all payments generated by services supported by CARE Act funds. Examples of program income include Medicaid and other reimbursement from third party payer systems, and all fees and co-payments made by clients.

   a. Describe the accounting and business systems in place to identify, track and report program income.

   b. Describe the programmatic practices in place to ensure that program income is used for the goals of the program – in this case, to support the direct, indirect and administrative costs of achieving the goals of services supported under this RFA. Describe the activities the applicant supports with program income.

   c. Describe any particular challenges to complying with the CARE Act expectations regarding program income, including those challenges associated with guidance and expectations of program income from other funding sources.

f. Agency Experience

- Description of the history of the agency, specifically, the history in providing services to People Living with HIV/AIDS (PLWHA) in the DC EMA. If the applicant has not provided services to PLWHA in the past, describe why it is proposing to serve this population.

- Description of the applicant's organizational structure, such as board of directors, key staff positions, officers, advisory councils/committees. Include a current organizational chart.

- Level of organization's competence in the provision of the services for which funding is requested including relevant experience and expertise of key management and front-line staff.

- Description of how the National HIV/AIDS Strategy (NHAS) has been integrated into the applicant's programs and activities. Provide specific organizational changes, enhancements, and collaborations the agency has implemented to address components of the NHAS

  http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf

g. Program Description

The purpose of this section is to provide a thorough description of the proposed projects and how they will improve health outcomes. Programs that effectively reach and serve clients with high need, those with a sound technical basis, those that address known challenges and gaps in services, those that strive to build stronger results through collaboration, innovation, and those that will contribute to the overall quality, scope and impact of the service area response will rate most highly. This section will be reviewed in conjunction with Client Summary (Attachment D) and Linkages Summary (Attachment E), so direct references to these tables may be included.

1. Describe the population to be served

Applications must describe the geographic area where the target population is found, the need for services, the demographic characteristics of the population to be served and the barriers to care experience by the population to be served, as well as ways in which you will address those barriers.

2. Describe the proposed services and how they will improve health outcomes

- Applications must describe with specific detail how services will be provided in accordance with the service category definitions and key activities.

- Applications must describe the services which will facilitate movement of clients along the continuum from prevention to care: early diagnosis, linkage to care and other services, offering of antiretroviral treatment, adherence to medication and medical care, retention in medical care, re-engagement in care and improved health outcomes.

- Applications should pay special attention to addressing the issues highlighted in the 'goals and priorities' and 'key activities' sections of the service category. These goals, priorities and activities highlight areas of known technical complexities, service gaps, or frequent challenges. Approaches to addressing these issues are critical.

- Applications must develop goals and objectives for the proposed project that are clearly defined, measurable, time-specific and responsive to service area specific goals and priorities.

- Describe how the proposed activities will impact the following health outcomes:
  - Retention and stability in care over time
  - Durable viral load suppression
  - Increased CD4 counts
  - Fewer hospitalizations
  - Fewer opportunistic Infections
  - Improved quality of life

- Applications must describe how the agency will determine client eligibility and enroll and maintain clients in care.

- Applications must describe how the agency will make services accessible by detailing your hours of operation and flexible schedules that provide for evening and weekend hours of operation, and cultural capability and linguistic capacity.

h. Care and Service Coordination

The purpose of this section is to highlight how the applicant creates and maintains a system of care for the clients to be served; specifically how the system will facilitate the movement of clients from early diagnosis to linkage to care and other services; enable their access to antiretroviral treatment; support their adherence to medication and medical care; support their retention in medical care and re-engagement in care if needed, and ultimately, contribute to the achievement of improved health outcomes for the clients. Almost no organization can fulfill all of a client's needs themselves. This section should highlight what the most common needs of your clients are, which ones are met directly, and which are routinely served by partner organizations and show how the services you directly provide feeds into the continuum. Applicants are encouraged to develop clear and routine collaborative relationships with other organizations and fully

described the extent to which routine exchange of information and joint clinical management of these clients is achieved. This section will be reviewed in conjunction with Client Summary (Attachment D) and Linkages Summary (Attachment E), so direct references to these tables may be included.

- Describe how your proposed services facilitate the movement of clients along this prevention to care continuum where you fit into the continuum and ultimately contribute to improved health outcomes for clients

- Describe the program linkage, retention and reengagement plan for clients including coordination, referral and follow-up mechanisms, and how the provision of services will support these elements.

- Describe your plan for monitoring and addressing loss-to-care.

    - Provide the number and proportion of clients lost to care, and a narrative summary of key issues and demographics.

    - Discuss recent (within twelve months) efforts to return client lost to care, as well as the number and proportion of those returned.

- Describe how the organization will provide or collaborate to provide a comprehensive package of care services, internally or through formal partnerships. Provide documentation of coordination and collaboration with other partners/providers.

- Extent to which private insurance, Medicare, Medicaid, or DC Alliance (available to residents of the District of Columbia only) or other support services are effectively used in the organization or that there are plans to improve their use. Extent to which the organization has implemented the policies and procedures in place ensure these payer systems are fully utilized, including soundness and adequacy of client program eligibility determination, and that CARE Act funds are clearly ‘gap-fillers’ and the payer of last resort.

- The applicant has detailed how the program will actively interchange and exchange patient treatment information among partners in care of core and support services and designated primary medical care providers and ensure the information is received and acted upon.

i. Monitoring and Evaluation

Describe the organizational systems in place to monitor and evaluate service delivery. Descriptions should include:

- Person(s) responsible for monitoring and evaluation of services—describe whether there is a dedicated staff (part time, full time, team) responsible for client level data, surveillance, and RSR reporting and what the training and qualifications of these staff are.

- How your organization will collect and report quality client-level data. Does your program have an electronic medical record (EMR) or other data systems? Plans to improve or expand existing systems that will result in accurate reporting during the grant period. In addition, the organization must explain how it will work with the CARE Act and HAHSTA mandated reporting systems.

- Description of security and confidentiality policies and procedures; particularly mechanisms for secure and timely data transfer between partners in care. Describe how data are used within your organization to impact program management and planning.

- Describe your organization's ability to monitor how the proposed activities will have an impact the following health outcomes:
    - Retention and stability in care over time
    - Durable viral load suppression
    - Increased CD4 counts
    - Fewer hospitalizations
    - Fewer opportunistic Infections
    - Improved quality of life

j. Quality Management

- Described the organization's Quality Management program and consumer advisory activities.

- Data Quality: Procedures for ensuring quality of client-level data, including data completeness and quality assurance activities.

- Quality Improvement: describe of the organization's service-area specific Quality Improvement Plan for administrative, programmatic, fiscal and data collection activities, and how the data will be used to improve delivery and quality of services, including those suggested by HRSA.

- Recent (within twelve months) QI project.

- The organization's provisions for periodic and ongoing continuous and specific staff and consumer education and training.

- Extent to which lessons learned from underperformance are translated to program improvements.

k. Budget and Budget Narrative

Applicants must provide a detailed line-item budget and budget narrative that includes the type and number of staff you will need to successfully provide your proposed services. All Applicants applying for services must use the HAHSTA approved budget form. The form is located and can be downloaded at the following website http://doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/budget_format_attachment_mandatory.xls.There cannot be any changes made to the format or content areas of the Excel workbook. Applicants must input budget projections each project description submitted.

HAHSTA reserves the right to not approve or fund all proposed activities. Give as much detail as possible to support each requested budget item. List each cost separately when possible. Provide a brief description for each staff position including job title, general duties and activities related to this grant, including the rate of pay and whether it is hourly or salary and the level of effort (FTE) including how much time will be spent on proposed activities (give this in a percentage, e.g., 50% of time spent on evaluation).

Federal legislation imposes a maximum of ten percent (10%) for all administrative or indirect costs activities for CARE Act Part A, Part A MAI and Part B sub-grants.

NOTE: Organizations with a Negotiated Indirect Cost Rate Agreement (NICRA) with HRSA or HHS may propose a rate for administrative and indirect costs, provided that the proposed rate does not exceed ten percent of the proposed total budget.

Organizations that do not have a current and approved HRSA NICRA must submit specific budgets for staff and other costs that comprise the administrative and indirect costs associated with the grant.

l. Attachments

The Attachments do not count in the page total. The allowable formats for the appendix items are found in the Attachments section of the RFA.

1. Application Checklist Form (Attachment A)
2. Applicant Profile (Attachment C)
3. Client Summary (Attachment D)
4. Linkages Summary (Attachment E)
5. Other Sources of Funding Table (Attachment F);
6. Service Categories Scopes of Work (Attachment G)
7. Capacity to Provide Culturally Competent Services (Attachment M);
8. Medicaid Eligibility Chart (Attachment N)

9. Organizational Chart;
10. Copies of all Memoranda of Understanding (MOU) and/or Subcontracts related to providing services funded by this grant;

Application Submission

Application materials must be submitted to the appropriate administrative agency **by 4:45 p.m. on Thursday, May 23, 2013.** Applications delivered after the deadline will not be reviewed or considered for funding. Applicants are required to submit an original hard copy, printed copies of the application and a copy on compact disk (CD) or jump drive. The original hard copy, each copy, and the CD or jump drive (where applicable) must be submitted in separate envelopes. Each of the envelopes must have a copy of the RFA Checklist (Attachment A), Applicant Profile (Attachment C) and Application Receipt (Attachment J) attached.

Applicants proposing to apply for more than one tier of services must submit one application package with one project description for each tier and one budget for each service category proposed within each tier.

An electronic copy of the application must be submitted via CD or thumb inclusive of all application elements and attachments, compiled in separate files labeled with the titles below and organizational initials:

a. Applicant Profile (MS word file)
b. Client Summary (MS word file)
c. Linkages Summary (MS word file)
d. Table of Contents (MS word file)
e. Abstract (MS word file)
f. Organization Knowledge and Experience (MS word file)
g. Project Description (MS word file)
h. Monitoring, Evaluation and Quality Improvement Plan(MS word file)
i. Budget and Budget Narrative (MS Excel file) for each service category within the tier proposed;
j. Attachments (A separate MS word file for each appendix item)
    - Other Sources of Funding Table (MS word file) (Attachment F);
    - Service Categories Scopes of Work (MS word file) (Attachment G) must be included for each proposed service category;
    - Medicaid Eligibility Chart (MS word file) (Attachment N);
    - Organizational Chart (MS word file); and

- Copies of all Memoranda of Understanding (MOU) and/or Subcontracts related to providing services funded by this grant (Acrobat PDF file).

The required formats for all program files included on the CD or jump drive are: MS Word, MS Excel and Adobe Acrobat. Files must have clear identifiable titles for all application elements. For example: ABC Clinic Applicant Profile and ABC Clinic Oral H. Program Description). Each component of the application must be saved in a separate document file on the CD or thumb drive. See Attachment A: Application Checklist for a listing of the files, file types and naming conventions.

Applications that are mailed or delivered by messenger or courier services must be sent in sufficient time to be received by the deadline at the appropriate locations. Applications arriving via messenger or courier services after **4:45 p.m. on Thursday, May 23, 2013** will not be accepted.

Submit one original hard copy and one CD or jump drive of your application package, and in addition, provide three complete application packages for each service category within the tier proposed.

For the purpose of making copies for submission, consider each application for a given Tier as a distinct application. For example, applicants proposing services under Tier One and Tier Three must submit

- One original, three printed copies and one copy on a jump drive of the Tier One application

- One original, three printed copies and one copy on a jump drive of the Tier Three application.

Staff of the HIV/AIDS, Hepatitis, STD, TB Administration Care, Housing and Support Service Bureau must accept and provide a written receipt for the DC and EMA-Wide application(s) and assurance package(s) for them to be considered received.

4. Assurance Submission Requirements

This section describes the requirements for submission of assurances, certifications and other documents required. Please note that these requirements vary among the jurisdictions.

Assurances and certifications are of two types: those required to submit applications and those required to sign grant agreements. Failure to submit the required assurance package will make the application ineligible for funding consideration [required to submit assurances] or in-eligible to sign/execute grant agreements [required to sign grant agreements assurances].

A list of current HAHSTA sub-grantees with valid assurance packages on file with HAHSTA will be available for review at the pre-application conference. Current sub-grantees who do not attend the pre-application conference may contact their grant monitor after the conference to review the list of their valid assurance packages on file. Organizations with confirmed valid assurance package on file will not be required to submit additional information. Organizations without a confirmed valid assurance package on file will be required to submit the pre-application assurances listed below.

Assurances Required to Submit Applications (Pre-Application Assurances)

1. Signed Federal Assurances
2. A Current Business license, registration, or certificate to transact business in the relevant jurisdiction:
3. 501 (C) (3) Certification. For non-profit organizations
4. Current Certificate of Clean Hands (formerly "Certificate of Good Standing")
5. List of Board of Directors
6. All Applicable Medicaid Certifications

   It is recommended that the HAHSTA Assurance Packet is submitted to Financial Management and Administrative Services Division by May 9, 2013 to allow for review and evaluation. **Proposals from organizations that do not have complete and current "Assurances Required to Submit Applications" will not be considered for funding.** Applicants who submit assurances prior to the May 9, 2013 deadline should CONFIRM that the HAHSTA Assurance Packet has been listed as complete. The Financial Management and Administrative Services Division can be reached at 202-671-4900.

For contact and submission information see the "Application Submission" section.

XIII. Grant Terms and Conditions: District of Columbia

All grants awarded under this program, shall be subject to the following terms and conditions:

1. Audits

At any time or times before final payment and three (3) years thereafter, the Grantee (District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, TB Administration) may have the organization's expenditure statements audited.

The organization shall retain independent auditors to audit all projects which are funded by a CARE Act grant award on an annual basis, or at such time as the Federal, State or the County shall determine, in accordance with OMB Circular No. A-133.

2. Insurance

During the term of the grant, all organizations will be required to obtain and keep in force commercial general liability insurance, to include off premises activities when applicable, covering bodily injury, death, and property damage in the minimum amounts of two hundred thousand dollars ($200,000.00) per person and five hundred thousand dollars ($500,000.00) per occurrence. All Certificates of Insurance must list the specific applicable dollar amounts as described herein. Organizations may be required to carry additional insurance depending on the service categories provided under the terms of their award, as follows:

a. The organization shall carry employer's professional liability coverage of at least two hundred thousand dollars ($200,000.00) per person and five hundred thousand dollars ($500,000.00) per occurrence.

b. The organization shall require and maintain professional liability coverage on all contracted workers/consultants of at least two hundred thousand dollars ($200,000.00) per person and five hundred thousand dollars ($500,000.00) per occurrence.

c. In instances where organization-owned vehicles are utilized in transporting clients served or employees and/or consultants funded by this project, the organization shall carry comprehensive automobile liability insurance covering all automobiles used in connection with the grant. The policy shall provide for bodily injury, death, and property damage liability in the minimum amounts of Two hundred thousand dollars ($200,000.00) per person and Five hundred thousand dollars ($500.000.00) per occurrence.

d. The organization shall carry workers' compensation insurance covering all of its employees employed upon the premises and in connection with its other operations pertaining to the grant agreement, and shall comply at all times with the provisions of the workers' compensation laws of the District of Columbia.

e. Organization must include original Certificates of Insurance for all insurance requirements as detailed by this section in grant proposals submitted for consideration. All Certificates of Insurance shall set forth District of Columbia as a Certificate Holder and as Additional Insured. All insurance shall be written with responsible companies licensed by the District of Columbia. The policies of insurance shall provide for at least thirty (30) days written notice to the Grantee's Grants Management Division, prior to their termination or material alteration. All certificates must have an original written or stamped signature. Copies are not acceptable.

3. Compliance with Tax Obligations

Prior to execution of a grant agreement as a result of this announcement, a recipient must be in compliance with tax requirements as established in the District of Columbia

or eligible jurisdiction and with Federal tax laws and regulations. Nonprofit organizations must register annually to meet tax exemption requirements.

4. Drug-Free Workplace

The organization agreement shall contain a provision requiring the organization to abide by the certifications contained in this announcement (Attachment O).

5. Vendor Assurances

The organization shall submit and comply with all document requirements as determined by the District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, TB Administration. The following documents will be included for completion with the organization agreement:

a. Vendor Oath and Certification;

b. Certification of Assurance of Compliance Regarding Fair Labor Standards Act;

c. Bidder/Offer or Affidavit and Statement of Ownership; and

d. Corporate Acknowledgment - Whenever the DOH is contracting with a corporate entity or partnership, an acknowledgment must be executed in order to assure the DOH that the person signing the document on behalf of the entity has the authority to bind the entity to the terms and conditions of the agreement. This Corporate Acknowledgment must be notarized.

6. District of Columbia Regulatory Requirements

a. Organizations seeking funding for Food Bank and Home Delivered Food (Meals or Groceries) services must include a copy of the current Food Permit issued by the Food Protection Division of District of Columbia or such appropriate designated division of the government with proposal.

b. Organizations seeking funding for Child Care services are required to comply with the regulations set forth by the Day Care Licensing Division of District of Columbia. Organizations seeking funding in any service categories that include work with children are required to complete Criminal Background Investigations annually (conducted through local law enforcement agency) on all paid or volunteer service providers.

c. Organizations employing or contracting with Health Care Professionals licensed under Health Occupations Code must include copies of the appropriate jurisdictional licenses with grant proposals.

7. Confidentiality

The applicant must demonstrate that they will protect the identity of those HIV infected persons receiving services. All records and other identifying information will be maintained in a secure place. The purpose of confidentiality is to protect persons by minimizing disclosure of information about them. Any breach of this policy is liable for civil penalty damage.

All Covered Entities and Business Associates (as defined by the HIPAA Privacy Standards) must comply with HIPAA.

8. Quality Improvement

The organization will agree to participate in Quality Improvement activities and record review processes established by the Grantee, the District of Columbia Department of Health.

9. Compliance with the Americans with Disabilities Act

Consistent with the American with Disabilities Act of 1990, all facilities shall be accessible to persons with mobility limitations.

10. Client Satisfaction and Grievance Procedure

The organization will agree to maintain and disseminate information regarding the client grievance process and will provide a mechanism for assessing client satisfaction with services annually.

11. Term

The term of the FY 2013 grant year shall be October 1, 2013 through February 28, 2014 (Part A) or March 31, 2014 (Part B).

12. Availability of Funds

The funds listed in this RFA are projections. The actual amount allocated to a given service category are not known at this time. The funds for each service category will depend upon the receipt of funds from HRSA, to the Part A Eligible Metropolitan Area, the allocation plan approved by the Planning Council and the Part B program.

13. Budget

A complete set of budget forms must be submitted for each service category for which you are requesting funding. Budget forms and instructions are included in Attachment H.

14. Information Systems

During the term of the grant, organizations are required to obtain and maintain all hardware, software and training necessary to collect and report all data via CAREWare or data collection tools provided by or approved by HAHSTA.

XIV. General Requirements -- Applicable To All Services

Items 1-6 below describe requirements that all applicants must meet regardless of which services they propose to provide. Applicants should reference how they will accomplish these requirements in the Program Description of each service application.

1. Referral Sources

The applicant is responsible for accepting referrals from hospitals, HIV counseling and testing centers, physicians, community organizations, HIV/AIDS service providers, and discharge planners in the correctional system, as well as from individuals seeking services for themselves or on behalf of others.

2. Coordination among Agencies

The applicant is responsible for developing linkage agreements with shelters, congregate living facilities, community residential facilities (CRFs), day treatment facilities including, primary care sites, skilled nursing facilities, personal care services, and other potential referral sources for HIV+ persons seeking care.

3. Staff Cultural Competency

The applicant is responsible for employing culturally competent staff that reflects the racial, ethnic, sexual orientation, gender and linguistic background of the client population(s) the applicant expects to serve.

4. Consistency with the Medical Care Plan

The applicant will provide services consistent with the client's requirements as described in the medical plan of care. HIV-expert Ambulatory Outpatient Medical and Medical Case Management providers should be considered the authoritative source for explaining the necessity of particular services.

5. CARE Act as Payer of Last Resort

CARE Act funds are always the payer of last resort. CARE Act funds can not be used to pay for services reimbursable by private insurance, Medicaid, Medicare, or any other federal, state or local services/programs which can reasonably be expected to be available to Suburban Virginia residents with HIV/AIDS.

6. Preparation of Project Scope, Budget and Budget Narrative Justification

Applicants are reminded to prepare and attach a Service Category Scope of Work (Attachment G) and Budget and Budget Narrative (Attachment H).

XV. Review and Selection of Applications

Review Process and Funding Decisions

All applications that are received on time will undergo a review to determine whether all required components have been addressed and included. Proposals that are determined by the District of Columbia, Department of Health, HAHSTA staff to be incomplete will not be further considered. Proposals that are determined to be complete will be evaluated using an objective internal (District of Columbia, Department of Health, HAHSTA staff) and external (panel reviewers) process.

The review panel forwards its recommendations and comments to the District of Columbia, Department of Health, HAHSTA. Past grant performance are considered for applicants that have previously received funding from the HAHSTA. Final funding decisions are made by the Director, Department of Health.

Applicants should review the criteria for guidance on what will be considered a successful application.

Technical Review Panel

The technical review panel will be composed of District of Columbia, Department of Health, HAHSTA staff members who will examine each application for technical accuracy, consistency with local and federal guidelines, cost effectiveness and program eligibility.

External Review Panel

The external review panel will be composed of neutral, qualified, professional individuals who have been selected for their unique experiences in human services,

public health, data analysis, health program planning and evaluation, social services planning and implementation. The review panel will review, score and rank each applicant's application. When the review panels have completed the reviews, the panel will make recommendations for awards based on the scoring process.

In addition to the comprehensive objective review, the following factors may affect the funding decision:

- Prevalence Areas: the successful applicants and awards may be adjusted based on the burden of infections in the target area as measured by HIV/AIDS reporting.
- Prevalence populations: the successful applicants and awards may be adjusted based on the burden of infections among racial and ethnic groups as measured by HIV/AIDS reporting.
- Focus Populations: the successful applicants and awards may be adjusted to ensure each Focus Population is included in one or more Tier One application.
- Overall scope and impact of the services to be delivered, to balance depth of services with breadth of services and numbers of clients served.

Award amounts are dependent upon available funds. The District of Columbia, Department of Health, HAHSTA reserves the right to recommend qualified funding proposals out of rank in order to ensure adequate geographic distribution.

If an insufficient number of qualified proposals are submitted for any particular Tier, the District of Columbia, Department of Health, HAHSTA reserves the right to adjust the distribution of funds among Tiers.

Applicants' submissions will be objectively reviewed against the following specific scoring criteria listed below.

Scoring Criteria

Points have been assigned to these component areas. The total possible points for these component areas are as follows:

Component/Criteria	Total Possible Points
Criteriion A. Technical Proposal	290
Criteriion B. Financial Proposal	No points awarded
Criteriion C. HAHSTA Past Performance	No points awarded

Criterion A Technical Proposal (Total 290 Points)

Organizations will be scored on agency experience, project description, care and service coordination, monitoring and evaluation, and quality management. This section will be reviewed in conjunction with Client Summary (Attachment D) and Linkages Summary (Attachment E).

Criterion A.1 Agency Experience (Total 20 Points)

- Description of the history of the agency. Specifically, the applicant's history in providing services to People Living with HIV/AIDS (PLWHA) in the DC EMA. If the applicant has not provided services to PLWHA in the past, describe why it is proposing to serve this population.

- Description of the applicant's organizational structure, such as board of directors, key staff positions, officers, advisory councils/committees. Include a current organizational chart.

- Level of organization's competence in the provision of the services for which funding is requested including relevant experience and expertise of key management and front-line staff.

- Description of how the National HIV/AIDS Strategy (NHAS) has been integrated into the applicant's programs and activities. Provide specific organizational changes, enhancements, and collaborations the agency has implemented to address components of the NHAS - http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf

Criterion A.2 Project Description (Total 70 Points)

This section will be evaluated on the extent to which the proposed projects, and the ways in which they will improve health outcomes, are feasible, incorporate best practices, and will positively impact the designated population. Programs that effectively reach and serve clients with high need, those with a sound technical basis, those that address known challenges and gaps in services, those that strive to build stronger results through innovation, and those that contribute to the overall quality, scope and impact of the area response will rate most highly. The applicant has described the target population, the need for services, the demographic characteristics of the population to be served and the barriers to care experienced by the population to be served and how the applicant will address those barriers.

- Description of the geographic area where the target population is found, the need for services, the demographic characteristics of the population to be served and the barriers to care experience by the population to be served, as well as ways in which you will address those barriers.

- Extent to which the plan to provide services matches the service category definitions and key activities.

- Extent to which applicant effectively addressed how their services will facilitate the movement of clients along the prevention to care continuum: early diagnosis, linkage to care and other services, offering of antiretroviral treatment, adherence to medication and medical care, retention in medical care, re-engagement in care and improved health outcomes.

- The extent to which the proposed project are clearly defined, measurable and time-specific, and respond effectively to service area specific goals and priorities and highlight technical complexities, service gaps, and frequent challenges.

- Description of proposed services how the activities will contribute to positive medical outcomes, including:

  1) Retention and stability in care over time
  2) Durable viral load suppression
  3) Increased CD4 counts
  4) Reduced hospitalizations
  5) Reduced opportunistic infections
  6) Improved quality of life.

- Applications must describe how the agency will determine client eligibility and enroll and maintain clients in care.

- The applicant has described how the organization will make services accessible by detailing its hours of operation, flexible schedules that provide for evening and weekend hours of operation, and cultural capability and linguistic capacity.

Criterion A.3 Care and Service Coordination (Total 80 Points)

Organizational success in retention in care, loss to follow-up rate; success in achieving viral load suppression and CD4 count increases consistent with USPHS guidelines; organizations adherence to USPHS anti-retroviral treatment guidelines These should be described in detail with the support of aggregate clinical data for the timeframe of January 1, 2012 to December 31, 2012. Data and evidence are critical to strong applications.

- Extent to which the specific collaborations and specific linkages to other organizations have facilitated movement of clients along the prevention to care continuum described above.

- The applicant has detailed the program linkage, retention and reengagement plan for clients including coordination, referral and follow-up mechanisms, and how the provision of services will support these elements.

- Description of the plan for monitoring and addressing loss-to-care.

  - Number and proportion of clients lost to care, and a narrative summary of key issues and demographics.

  - Discussed recent (within twelve months) efforts to return client lost to care, as well as the number and proportion of those returned.

- Description of how the organization will provide or collaborate to provide a comprehensive package of care services that are provided internally or through formal partnerships, and are paid for by funds requested in this RFA and/or other funding streams; and demonstrates the ability to create and maintain partnerships required for provision of the services.

- Documented coordination and collaboration with other partners/providers.

- Extent to which private insurance, Medicare, Medicaid, or DC Alliance (available to residents of the District of Columbia only) or other support services are effectively used in the organization or that there are plans to improve their use. Extent to which the organization has implemented the policies and procedures in place ensure these payer systems are fully utilized, including soundness and adequacy of client program eligibility determination, and that CARE Act funds are clearly 'gap-fillers' and the payer of last resort.

- The applicant has detailed how the program will actively interchange and exchange patient treatment information among partners in care of core and support services and designated primary medical care providers and ensure the information is received and acted upon.

Criterion A.4 Monitoring and Evaluation (Total 70 Points)

- Extent to which organizational systems are in place to monitor and evaluate service delivery; are complete and translate to useful data for reporting and for routine program management and planning; and dedicated well-trained staff members are in place to maintain these activities.

- Data System: Description of how client-level data will be collected and reported. Established electronic medical record (EMR) or alternative data system in place. Soundness and feasibility of plans to improve or expand existing systems that will result in accurate reporting during the grant period. In addition, the organization must

explain how it will work with the CARE Act and HAHSTA mandated reporting systems.

- Data Collection, Reporting, and Use: Applicant's ability to collect, report, and utilize required HRSA and HAHSTA client-level data. Description of how data are used within your organization to impact program management and planning.

- Data Security: Description of security and confidentiality policies and procedures; particularly mechanisms for secure and timely data transfer between partners in care.

- Assessment and Use of Outcome measures: The applicant is able to assess how activities and how data will be used to support enrollment and maintenance in care; coordinate ambulatory outpatient medical care and other services; and contribute or improve positive medical outcomes, including: 1) Retention and stability in care over time; 2) Viral load suppression; 3) Increased CD4 count; 4) Fewer hospitalizations; 5) Fewer opportunistic Infections; and 6) Improved quality of life. If the applicant is unable to assess these factors currently, the extent to which it presents a feasible improvement plan or effectively justifies why these measures are not applicable to the services proposed.

Criterion A.5 Quality Management (Total 50 Points)

- Extent to which applicant has described their Quality Management program and consumer advisory activities

- Data Quality: Procedures for ensuring quality of client-level data, including data completeness and quality assurance activities.

- Quality Improvement: The applicant's description of the organization's service-area specific Quality Improvement Plan for administrative, programmatic, fiscal and data collection activities demonstrates commitment to quality processes and measures, and how the data will be used to improve delivery and quality of services, including those suggested by HRSA.

- Relevance of recent (within twelve months) QI project.

- Capacity Building: The applicant details the organization's provisions for periodic and ongoing continuous and specific staff and consumer education and training.

- Extent to which lessons learned from underperformance are translated to program improvements.

Criterion B Budget and Budget Narrative (No Points Awarded)

The budget and budget narrative will be reviewed during the selection process, but are not included in the scoring of the proposal. Comments on the budget will be invited from the review panel and the technical review panel, and will help guide the negotiation of the budget with those applications that are recommended for funding.

In preparing budgets, applicants are advised to:

- Maximize the cost efficiency of the services provided
- Provide a clear description of the contribution of each item proposed in the budget towards achieving the goals of the program
- Support – to the extent permitted by the funding source – necessary and appropriate indirect and administrative costs
- Describe how other payer systems and non-CARE Act resources are used to maintain and complement all programs.
- Appropriateness of methodology for assigning costs for deliverable services; Strength of fiscal management and accounting systems; and strength of the organization's financial stability through the description of sources of funding (see Attachment F) and demonstrated capability to implement and maintain service delivery and administrative operations under a cost-reimbursement grant.
- Soundness of proposed budget and applicant's financial capacity and stability to manage a program of the size and scope contemplated

Criterion C HAHSTA Past Performance (No Points Awarded)

- Grant and program level of performance on activities funded by any HAHSTA program (October 1, 2011 – December 31, 2012) will be considered but not scored during internal review process. The performance review shall be an objective review based on the documented results of reviews conducted by both fiscal/administrative and program staff of HASHTA.

XVI. Post-Submission Processes

Application Review & Selection Process

Review Process

Applications shall be reviewed by an external review panel made up of technical and subject matter experts for the expressed purpose of providing an independent, objective review of applications. This external review panel shall be responsible for providing a score and technical review comments for record.

Assurance and certification documents will be reviewed by internal DOH personnel assigned to ascertain whether eligibility and certification requirements have been met prior to consideration of review and recommendation of award.

Applications, external review scores and technical review comments will be reviewed by an internal DOH review panel for the purpose of determining recommendations for award. The panel may be composed of DOH staff and consultants who shall be responsible for making recommendations for award, and include recommendations for funding levels, service scopes and targets, project designs, evaluation plans and budgets.

DOH reserves the right and may request an in-person presentation by an applicant or applicants within a competitive range for recommendation of award to answer questions or clarify issues raised during the review process. This is for the expressed purpose of obtaining supplemental or additional information to determine a winner or to determine any conditions of award.

The DOH Office of Grants Management receives and reviews recommendations of award by way of a DOH RFA Decision Document prepared by HAHSTA. The RFA Decision Document is reviewed by the DOH Office of Grants Management along with supporting document from the external and internal reviews. The DOH Grants Chief is responsible for certifying that all District and DOH requirements for a fair, open and competitive RFA process, including the review, were met. The DOH Director has the final approval authority of any DOH RFA Decision Document.

Pre-Award Negotiations

Applicants approved for pre-award review will receive a DOH Notice of Intent to Fund. The notice will outline pre-award requirements and propose any revisions and conditions of awards.

Successful applicants will interact with Administrative Agency staff to review draft grant terms and provisions, prepare final Table(s) A: Scope of Work, workplans, budgets with narrative justification and spending plans. Any conditions of award will be reviewed and negotiated and entered into draft agreements. The prospective Grantee must sign and accept the terms of the negotiated agreement prior to a final issuance of a Notice of Grant Award (NOGA) by DOH.

NOGA Issuance

Successful applicants will receive a fully executed Notice of Grant Award (NOGA) from the Department of Health. The NOGA shall be the only binding, authorizing document between the recipient and DOH. A hard copy of the NOGA will be mailed to the recipient fiscal officer identified in the application.

Sub-grantees must submit monthly data reports and quarterly progress and outcome reports using the tools provided by the Administrative Agency and following the procedures determined by the Administrative Agency. If your agency is funded, reporting forms will be provided during the grant negotiation process.

Continuation funding for Year 2 is dependent upon the availability of funds for the stated purposes, fiscal and program performance under the Year 1 grant agreement, and willingness to incorporate new directives, policies, or technical advancements that arise from the community planning process, evolution of best practices, or other locally relevant evidence.

Assurances for Grants

HAHSTA classifies assurances packages as two types: those required to submit applications and those required to sign grant agreements" Failure to submit the required assurance package likely make the application ineligible for funding consideration or in-eligible to execute grant agreements.

Assurances required to apply for funds detailed in this RFA.

1. Signed Federal Assurances (Attachment O).
2. A Current Business license, registration, or certificate to transact business in the relevant jurisdiction.
3. 501 (C) (3) Certification. For non-profit organizations
4. Current Certificate of Good Standing from local tax authority.
5. List of Board of Directors
6. Medicaid Certification if applicable.

Assurances required for signing grant agreements for funds awarded through this RFA.

1. Certification Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements (Attachment O)
2. Commercial General Liability
3. Professional Liability
4. Worker's Compensation Insurance
5. Comprehensive Automobile Insurance, if applicable for organizations that use company vehicles to administer programs for services funded by HAHSTA
6. Home Health/Home Hospice License, if applicable
7. Certification of current/active Articles of Incorporation from DCRA.

XVII. List of Attachments

Attachment A: RFA Checklist

Attachment B: Assurances Checklist

Attachment C: Applicant Profile

Attachment D: Client Summary

Attachment E: Linkages Summary

Attachment F: Other Sources of Funding

Attachment G: Service Categories Scopes of Work

Attachment H: Budget-and Budget Narratives

Attachment I: Notice of Intent to Apply

Attachment J: Receipt for Application for Services in the District of Columbia

Attachment L: Receipt for Assurances

Attachment M: Capacity to Provide Culturally Competent Services

Attachment N: Medicaid Eligibility Chart

Attachment O:—Certifications, Lobbying, et al.

Attachment P: Assurances

Attachment Q: DOH Certification

Attachment R: Sample Letter of Intent for EIS EMA-Wide (Tier 5)