

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



Health Resources & Services Administration

HIV/AIDS Bureau
Division of Metropolitan HIV/AIDS Programs

***Ryan White HIV/AIDS Program Part A
HIV Emergency Relief Grant Program***

Funding Opportunity Number: HRSA-22-018
Funding Opportunity Type(s): Competing Continuation
Assistance Listings (CFDA) Number: 93.914

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2022

Application Due Date: October 06, 2021

*Ensure your SAM.gov and Grants.gov registrations and passwords are current immediately!
HRSA will not approve deadline extensions for lack of registration.
Registration in all systems, including SAM.gov and Grants.gov,
may take up to 1 month to complete.*

Issuance Date: June 11, 2021

Chrissy Abrahms Woodland
Director, Division of Metropolitan HIV/AIDS Programs
Telephone: (301) 443-1373
Fax: (301) 443-5271
Email: CAbrahms@hrsa.gov

Authority: 42 USC §§ 300ff-11 to -20 and 300ff-121 (sections 2601–2610 and 2693 of the Public Health Service (PHS) Act).

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2022 Ryan White HIV/AIDS Program (RWHAP) Part A HIV Emergency Relief Grant Program. The purpose of this program is to provide direct financial assistance to an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA) that has been severely affected by the HIV epidemic. This competition is open only to Part A jurisdictions to provide RWHAP services in the geographic service areas described in [Appendix B](#). Eligible jurisdictions may apply for an amount up to the defined funding ceiling listed in [Appendix B](#), which represents a level five percent above the final FY 2021 award.

Funding Opportunity Title:	Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program
Funding Opportunity Number:	HRSA-22-018
Due Date for Applications:	October 06, 2021
Anticipated Total Annual Available FY 2022 Funding:	\$630,000,000, of which approximately \$11,200,000 will be used for priority funding, and \$51,000,000 will be available for Minority AIDS Initiative funding.*
Estimated Number and Type of Award(s):	Up to 52 grants
Estimated Award Amount:	Varies, see Appendix B
Cost Sharing/Match Required:	No
Period of Performance:	March 1, 2022, through February 28, 2025 (three years)
Eligible Applicants:	RWHAP Part A recipients that are classified as an EMA or as a TGA and continue to meet the eligibility criteria as defined in the statute are eligible to apply for these funds. See Section III-1 of this notice of funding opportunity (NOFO) for complete eligibility information.

*Estimated annual available funding level based on current projections.

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide*, available online at <http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf>, except where instructed in this NOFO to do otherwise.

Technical Assistance

All interested applicants are encouraged to participate in a technical assistance (TA) webinar for this funding opportunity. The purpose of this webinar is to assist potential applicants in preparing applications that address the requirements of this funding notice. Participation in the pre-application TA webinar is optional.

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Thursday, July 29, 2021

Time: 2 p.m. to 4 p.m. ET

Call-In Number: 1-833-568-8864

Meeting ID: 161 128 0187

Passcode: 08815036

Weblink: <https://hrsa->

[gov.zoomgov.com/j/1611280187?pwd=cU02Y0lCUkh6bnBqQ2c3eEZoZDZZZz09](https://hrsa.gov.zoomgov.com/j/1611280187?pwd=cU02Y0lCUkh6bnBqQ2c3eEZoZDZZZz09)

Playback Number: The recorded webinar will be available on the [TargetHIV website](#).

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I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for funding under the Ryan White HIV/AIDS Program (RWHAP) Part A HIV Emergency Relief Grant Program. The purpose of this program is to provide direct financial assistance to an eligible metropolitan area (EMA) or a transitional grant area (TGA) that has been severely affected by the HIV epidemic. Grant funds assist eligible jurisdictions to develop or enhance access to a comprehensive continuum of high quality, community-based care for people with HIV who are low-income through the provision of formula, supplemental, and Minority AIDS Initiative (MAI) funds. The goal is to provide optimal HIV care and treatment for people with HIV who are low-income, uninsured, and underserved, to improve their medical outcomes.

RWHAP Part A recipients must use these funds to provide comprehensive primary health care and support services throughout the entire designated geographic service area. **Your application must address the entire service area, as defined in [Appendix B](#).**

Comprehensive HIV care consists of core medical services and support services that enable people with HIV to access and remain in HIV primary medical care to improve their health outcomes. Based on an annual assessment of the services and gaps in the HIV care continuum within a jurisdiction, HIV Planning Councils/Planning Bodies (PCs/PBs) and RWHAP recipients identify specific service categories to fund. Funded service categories should facilitate improvements at specific stages of the HIV care continuum.

RWHAP Part A EMAs and TGAs must use grant funds to support, further develop, and/or expand systems of care to meet the needs of low-income people with HIV within the EMA/TGA, and strengthen strategies to reach disproportionately impacted subpopulations. The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) requires EMAs/TGAs to collect and analyze data to identify needs, set priorities, make allocations, and validate the use of RWHAP funding. A comprehensive application should reflect on how you have used those data to develop and expand the system of care in EMA/TGA jurisdictions. HRSA encourages innovation and collaboration with other agencies and organizations to maximize impact on health outcomes and effectively meet the needs of people with HIV within the EMA/TGA.

Important Notes:

- **Multi-Year Funding:** HRSA HAB has transitioned the RWHAP Part A program from an annual competitive application program to a three-year funded program effective in FY 2022. In this new three-year period of performance, eligible applicants will submit a competitive application in the first year (FY 2022), and non-competing continuation (NCC) progress reports for years 2 and 3 (FY 2023 and FY 2024, respectively). The normalized score from the objective review of the demonstration of additional need provided in the competitive application during the first year of the three-year period of performance will be utilized to

calculate the discretionary supplemental award in the second and third years. **HRSA HAB stresses the importance of this section, given its effect on the multi-year funding.** See the Summary of Funding section for additional details.

- **HIV Care Continuum:** Eligible applicants will need to provide an HIV care continuum (HCC) that is diagnosis-based using the [Centers for Disease Control and Prevention \(CDC\)](#) definitions. Data are posted on [TargetHIV](#) to facilitate the development of the diagnosis-based HIV care continuum. See the Demonstrated Need and Work Plan sections for additional details.
- **Unmet Need:** HRSA HAB updated the estimation methodology used to determine unmet need for HIV-related services. Eligible applicants will need to provide estimates using the new Unmet Need Framework with their applications. See the Demonstrated Need section for additional detail, and reference [TargetHIV](#) for training materials and tools related to estimating and reporting Unmet Need.
- **Subpopulations of Focus:** This is a new component of the Needs Assessment section in the NOFO, which requires eligible applicants to identify three subpopulations of focus using a data-driven process, including their specific needs, and subsequently discuss approaches to addressing those needs in the Methodology and Work Plan sections.
- **Integrated Plan:** The updated Integrated HIV Prevention and Care Plan guidance and plan submission for calendar years 2022 – 2027 was postponed due to the unprecedented Coronavirus Disease 2019 (COVID-19) pandemic; see the June 17, 2020 [letter](#) for additional detail. An updated Integrated HIV Prevention and Care Plan guidance was issued in June 2021, with submission of the plans targeted for December of 2022.
- **Indirect Costs:** Negotiated indirect cost rate agreement or other indirect cost documentation will only be required to be submitted in the competitive application. However, if documentation expires during the period of performance the recipient is required to submit the updated agreement.

The following information will assist you in understanding and completing your FY 2022 application:

- **Policy Clarification Notices:** Information on the RWHAP and HAB Policy Clarification Notices (PCNs) are available online at <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>. Please note that the following PCNs have been updated:
 - [15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Part A, B, C, and D](#) – updated as of 09/01/2020
 - [PCN 15-02 Clinical Quality Management](#) and [FAQs](#)- updated as of 09/01/2020

- **Allowable Services and Service Category Definitions:** Core medical services are listed in Section 2604(c)(3) of the PHS Act. Support services allowed under RWHAP Part A are limited to services that are needed for people with HIV to achieve their health outcomes, as defined by the RWHAP. The service definitions effective for awards issued on or after October 1, 2016, are listed in [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds](#).
 - **Core Medical Services Waiver:** RWHAP Part A funds are subject to Section 2604(c) of the PHS Act, which requires that not less than 75 percent of the funds remaining after reserving funds for administration and Clinical Quality Management (CQM) be used to provide core medical services. You may seek a waiver of the core medical services requirement. You may submit a waiver request prior to submission of the grant application, with this application, or up to four months after the budget period start date. Submission should be in accordance with [PCN 13-07 Uniform Standard for Waiver of Core Medical Services Requirement for Grantees Under Parts A, B, and C](#). You can find sample letters to fulfill the requirements of the Core Medical Services Waiver at <https://hab.hrsa.gov/sites/default/files/hab/Global/samplereqwaiverletters.pdf>.
- In addition, your RWHAP Part A core medical services waiver request must include funds awarded under MAI. HAB will not consider a waiver request that does not include MAI funds. If you submit the core medical services waiver request and allocation table with the application, both should be included as **Attachment 10**. The waiver request counts toward the 100-page limit.
- **Agreements and Compliance Assurances:** The agreements and assurances, found in [Appendix A](#) of this NOFO, require the signature of the Chief Elected Official (CEO), or the CEO's designee. Assurances are required to be submitted with the competitive application and the NCC progress reports. Include the assurances as **Attachment 2**.

2. Background

This program is authorized by 42 USC §§ 300ff-11 to -20 and 300ff-121 (sections 2601–2610 and 2693 of the Public Health Service (PHS) Act). The Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV. The program funds grants to states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

The RWHAP has five statutorily defined Parts (Parts A, B, C, D and F) that provide funding for core medical, support services, and medications; technical assistance; clinical training; and the development of innovative models of care to meet the needs of different communities and populations affected by HIV.

An important framework in the RWHAP is the HIV care continuum, which depicts the series of stages a person with HIV engages in from initial diagnosis through their successful treatment with HIV medication to achieve viral suppression. Supporting people with HIV to reach viral suppression not only increases their own quality of life and lifespan, it also prevents sexual transmission to an HIV-negative partner.

The HIV care continuum framework allows recipients and planning groups to measure progress and to direct HIV resources most effectively. RWHAP recipients are encouraged to assess the outcomes of their programs and should work with their community and public health partners to improve outcomes across the HIV care continuum. HRSA encourages recipients to use the [performance measures](#) developed for the RWHAP at their local level to assess the efficacy of their programs and to analyze and improve the gaps along the HIV care continuum.

Strategic Frameworks and National Objectives

National objectives and strategic frameworks like the [Healthy People 2030](#), the [HIV National Strategic Plan: A Roadmap to End the HIV Epidemic \(2021 – 2025\)](#); the [Sexually Transmitted Infections National Strategic Plan for the United States \(2021 – 2025\)](#); and the [Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination \(2021 – 2025\)](#) are crucial to addressing key public health challenges facing low-income people with HIV. These strategies detail the principles, priorities, and actions to guide the national public health response and provides a blueprint for collective action across the federal government and other sectors. The RWHAP supports the implementation of these strategies and recipients should align their organization's efforts, within the parameters of the RWHAP statute and program guidance, with these strategies to extent possible.

Expanding the Effort: Ending the HIV Epidemic

According to recent data from the [2019 Ryan White Services Report \(RSR\)](#), the RWHAP has made tremendous progress toward ending the HIV epidemic in the United States. From 2015 to 2019, HIV viral suppression among RWHAP patients who have had one or more medical visits during the calendar year and at least one viral load with a result of <200 copies/mL reported, has increased from 83.4 percent to 88.1 percent. Additionally, racial/ethnic, age-based, and regional disparities reflected in viral suppression rates have significantly decreased.¹ For example, the disparities in viral suppression rates between Black/African Americans and white clients have decreased since 2010.² These improved outcomes mean more people with HIV in the United States will live near normal lifespans and have a reduced risk of transmitting HIV to others.³

In February 2019, the [Ending the HIV Epidemic in the U.S.](#) (EHE) initiative was launched to further expand federal efforts to reduce HIV infections. This 10-year

¹ Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019. <http://hab.hrsa.gov/data/data-reports>. Published December 2020. Accessed December 2, 2020.

² Black/African American clients went from 79.4 percent viral suppression in 2015 to 85.2 percent in 2019, while 88.3 percent of white clients were virally suppressed in 2015 and 91.8 percent in 2019

³ National Institute of Allergy and Infectious Diseases (NIAID). Preventing Sexual Transmission of HIV with Anti-HIV Drugs. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2016 Mar 29]. Available from: <https://clinicaltrials.gov/> NCT00074581 NLM Identifier: NCT00074581.

initiative seeks to achieve the important goal of reducing new HIV infections in the United States to fewer than 3,000 per year by 2030. The initiative promotes and implements four strategies to substantially reduce HIV transmissions – Diagnose, Treat, Prevent, and Respond. The initiative is a collaborative effort among key HHS agencies, primarily HRSA, the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

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

Using Data Effectively: Integrated Data Sharing and Use

HRSA and CDC’s Division of HIV/AIDS Prevention support integrated data sharing, analysis, and utilization for the purposes of program planning, conducting needs assessments, determining unmet need estimates, reporting, quality improvement, enhancing the HIV care continuum, and public health action. HRSA strongly encourages RWHAP recipients to:

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

Integrated data sharing, analysis, and utilization of HIV data by state and territorial health departments can help further progress toward reaching the HIV National Strategic Plan goals and improve outcomes on the HIV care continuum.

HRSA strongly encourages complete CD4, viral load (VL) and HIV nucleotide sequence reporting to the state and territorial health departments’ HIV surveillance systems to benefit fully from integrated data sharing, analysis, and utilization. State health departments may use CD4, VL, and nucleotide sequence data to identify cases, stage of HIV disease at diagnosis, and monitor disease progression. These data can also be used to evaluate HIV testing and prevention efforts, determine entry into and retention in HIV care, measure viral suppression, monitor prevalence of antiretroviral drug resistance, detect transmission clusters and understand transmission patterns, and assess unmet health care needs. Analyses at the national level to monitor progress toward ending the HIV epidemic can only occur if all HIV-related CD4, VL, and HIV nucleotide sequence test results are reported by all jurisdictions. CDC requires the reporting to the National HIV Surveillance System (NHSS) all HIV-related CD4 results (counts and percentages), all VL results (undetectable and specific values), and HIV nucleotide sequences.

Program Resources and Innovative Models

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

An important technical assistance resource is the [RWHAP Recipient Compilation of Best Practices Intervention Strategies](#) (Best Practices Compilation). The Best Practices Compilation is currently under development, but will present strategies that have been implemented in real world settings and that improve outcomes along the HIV care continuum. The RWHAP Best Practices Compilation will be an easily searchable resource to support recipients' work and the needs of the people served by the RWHAP.

In addition, many RWHAP Special Projects of National Significance (SPNS) projects have demonstrated promising new approaches for linking and retaining priority populations into care. As resources permit, RWHAP recipients are encouraged to review and integrate these tools within their HIV system of care in accordance with the allowable service categories defined in [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds](#). Examples of these resources include:

- [E2i: Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV](#)
E2i uses an implementation science approach to evaluate and understand existing and new intervention strategies that can be used in RWHAP provider settings. Once interventions or strategies are demonstrated and evaluated using implementation science, manuals, guides, interactive online tools, publications, and instructional materials are developed and disseminated for replication and integration into RWHAP provider settings.
- [Integrating HIV Innovative Practices](#) (IHIP)
Resources on the IHIP website include easy-to-use training manuals, curricula, case studies, pocket guides, monographs, and handbooks, as well as informational handouts and infographics about SPNS generally. IHIP also hosts TA training webinars designed to provide a more interactive experience with experts, and a TA help desk exists for you to submit additional questions and share your own lessons learned.
- [Replication Resources from the SPNS Systems Linkages and Access to Care](#)
There are intervention manuals for patient navigation, care coordination, state bridge counselors, data to care, and other interventions developed for use at the state and regional levels to address specific HIV care continuum outcomes among hard-to-reach people with HIV.

- [Dissemination of Evidence Informed Interventions](#)
The Dissemination of Evidence-Informed Interventions initiative ran from 2015-2020 and disseminated four adapted linkage and retention interventions from prior SPNS and the Minority HIV/AIDS Funds (MHAF) from the HHS Secretary's Office initiatives to improve health outcomes along the HIV care continuum. The initiative produced four evidence-informed care and treatment interventions (CATIs) that are replicable, cost-effective, capable of producing optimal HIV care continuum outcomes, and easily adaptable to the changing health care environment. Manuals are currently available at the link provided and will be updated on an ongoing basis.

HRSA HAB also recognizes the importance of addressing emerging issues, as well as supporting the needs of special populations. To help recipients in responding to these critical issues, HRSA HAB funds projects to provide technical assistance and resources for recipients. Examples of projects include:

- [Building Futures: Supporting Youth Living with HIV](#)
- [The Center for Engaging Black MSM Across the Care Continuum \(CEBACC\)](#)
- [Using Community Health Workers to Improve Linkage and Retention in Care](#)

II. Award Information

1. Type of Application and Award

Type(s) of applications sought: Competing Continuation.

HRSA will provide funding in the form of a grant.

The amount of funding awarded to each RWHAP recipient will be determined according to a formula calculation for formula and MAI funding, and a normalized competitive score for discretionary awards for supplemental funding, including priority funding, as described in the Summary of Funding section below.

2. Summary of Funding

In FY 2022, HRSA estimates approximately \$630,000,000 to be available to fund 52 RWHAP Part A recipients. Approximately \$11,200,000 will be used for priority funding, and \$51,000,000 will be available for MAI funding. You may apply for no more than the published ceiling amount in [Appendix B](#). HRSA established ceiling amounts based on current funding with a five percent increase to accommodate fluctuations in formula and supplemental funding. The actual amount available will not be determined until the enactment of the final FY 2022 federal appropriation. This program notice is subject to the appropriation of funds and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds in a timely manner.

The RWHAP Part A provides non-discretionary formula grants that include MAI funds, and discretionary supplemental awards. These funds assist eligible areas in developing

or enhancing access to a comprehensive continuum of high quality, community-based care for people with HIV who are low-income within the EMA/TGA and strengthening strategies to reach minority populations. HRSA awards two-thirds of the funds available for EMAs and TGAs according to a formula that is calculated annually and based on the number of living cases of HIV/AIDS in the EMAs and TGAs. HRSA awards MAI funding that is calculated annually and based on the number of people with HIV and AIDS who are minorities in a jurisdiction. HRSA awards the remaining funds as discretionary supplemental awards based on the demonstration of additional need by the eligible EMAs and TGAs. The normalized score from the objective review of the demonstration of additional need provided in the competitive application during the first year of the three-year period of performance will be utilized to calculate the discretionary supplemental award in the second and third years. Further, if determined eligible for priority funding, HRSA will calculate the additional amount awarded, and that amount will be included in the final award annually.

HRSA HAB has transitioned the RWHAP Part A program from an annual competitive funded program to a multi-year funded program, effective FY 2022. The period of performance is three years (March 1, 2022 through February 28, 2025). A competitive application will be submitted for FY 2022, and Non-Competing Continuation (NCC) Progress Reports will be submitted for FY 2023 and FY 2024. An annual SF-424A and Budget will need to be submitted in each year of the period of performance (i.e., in FY 2022 you will only include an SF-424A and Budget covering the FY 2022 budget period, same for FY 2023, and FY 2024). Furthermore, an annual work plan and assurances will be required with the competitive application and the NCC progress reports. Additional information on the transition of the RWHAP Part A program from an annual to a multi-year period of performance is located on [TargetHIV](#).

As stated, eligible jurisdictions may apply for an amount up to the funding ceilings listed in [Appendix B](#). If the RWHAP Part A award calculation results in an amount less than the budget submitted with your application, your budget will be proportionally reduced across all budget categories to reflect the actual award amount. If your award calculation results in an amount greater than the budget submitted with the application, you may be required to submit a revised SF-424A, budget narrative, and service category plan table. Establishing realistic ceiling amounts ensures that there will be an approved project budget in place at the beginning of each budget period.

HRSA will send the Notice of Award (NOA) to the CEO or to the delegated administrative agency responsible for dispersing RWHAP Part A funds.

Please note that the HHS Secretary (Secretary) may reduce the amount of grant funds under the RWHAP Part A to an EMA/TGA for a fiscal year (FY) if, with respect to such grants for the second preceding FY, the EMA/TGA fails to prepare audits in accordance with the procedures of Section 7502 of Title 31, United States Code. See Section 2682(a) of the PHS Act.

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements at [45 CFR part 75](#).

Please see [Policy Clarification Notice 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D](#) along with the [FAQs](#) for information regarding the statutory 10 percent limitation on administrative costs.

III. Eligibility Information

1. Eligible Applicants

RWHAP Part A recipients that are classified as an EMA or as a TGA and continue to meet the status as an eligible area as defined in the statute are eligible to apply for these funds. Eligibility for RWHAP Part A grants is based in part on the number of confirmed AIDS cases within a statutorily specified “metropolitan area.” The Secretary uses the Office of Management and Budget’s (OMB) census-based definitions of a Metropolitan Statistical Area (MSA) in determining the geographic boundaries of a RWHAP metropolitan area. HHS utilizes the OMB geographic boundaries that were in effect when a jurisdiction was initially funded under RWHAP Part A. For all newly eligible areas, the boundaries are based on current OMB MSA boundary definitions.

For an EMA, this is more than 2,000 cases of AIDS reported and confirmed during the most recent five calendar years, and for a TGA, this is at least 1,000, but fewer than 2,000 cases of AIDS reported and confirmed during the most recent five calendar years for which such data are available. In addition, for three consecutive years, recipients must not have fallen below **both** the required incidence levels already specified, and required prevalence levels (cumulative total of living cases of AIDS reported to and confirmed by the Director of CDC, as of December 31 of the most recent calendar year for which such data are available). For an EMA, the required prevalence is 3,000 living cases of AIDS. For a TGA, the required prevalence is 1,500 or more living cases of AIDS. However, for a TGA with five percent or less of the total amount from grants awarded to the area under Part A unobligated, as of the end of the most recent FY, the required prevalence is at least 1,400 (and fewer than 1,500) living cases of AIDS.

This competition is open to eligible Part A jurisdictions to provide comprehensive primary health care and support services for people with HIV who are low income, uninsured, and underserved in their service areas as listed in [Appendix B](#).

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

HRSA will consider any application that exceeds the ceiling amount non-responsive and will not consider it for funding under this notice.

HRSA will consider any application that exceeds the page limit referenced in [Section IV](#) non-responsive and will not consider it for funding under this notice.

HRSA will consider any application that fails to satisfy the deadline requirements referenced in [Section IV.4](#) non-responsive and will not consider it for funding under this notice.

Maintenance of Effort (MOE)

The recipient must agree to maintain non-federal funding for award activities at a level that is not less than expenditures for such activities maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives the award, as required by Section 2605(a)(1)(B) of the PHS Act. Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation. Complete the MOE information and submit as **Attachment 12**.

NOTE: Multiple applications from an organization are not allowable.

HRSA will only accept your **last** validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA **requires** you to apply electronically. HRSA encourages you to apply through [Grants.gov](#) using the SF-424 workspace application package associated with this notice of funding opportunity (NOFO) following the directions provided at <http://www.grants.gov/applicants/apply-for-grants.html>.

The NOFO is also known as “Instructions” on Grants.gov. You must select “Subscribe” and provide your email address for each NOFO you are reviewing or preparing in the workspace application package in order to receive notifications including modifications, clarifications, and/or republications of the NOFO on Grants.gov. You will also receive notifications of documents placed in the RELATED DOCUMENTS tab on Grants.gov that may affect the NOFO and your application. *You are ultimately responsible for reviewing the [For Applicants](#) page for all information relevant to this NOFO.*

2. Content and Form of Application Submission

Section 4 of HRSA’s [SF-424 Application Guide](#) provides instructions for the budget, budget narrative, staffing plan, and personnel requirements, assurances, certifications, etc. You must submit the information outlined in the Application Guide in addition to the program-specific information below. You are responsible for reading and complying with the instructions included in HRSA’s [SF-424 Application Guide](#) except where instructed in the NOFO to do otherwise. You must submit the application in the English language and in the terms of U.S. dollars (45 CFR § 75.111(a)).

See Section 8.5 of the *Application Guide* for the Application Completeness Checklist.

Application Page Limit

The total size of all uploaded files included in the page limit shall not exceed the equivalent of **100 pages** when printed by HRSA. The page limit includes the project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this NOFO. Please note: Effective April 22, 2021, the abstract is no longer an attachment that counts in the page limit. The abstract is the standard form "Project_Abstract Summary." Standard OMB-approved forms that are included in the workspace application package do not count in the page limit. Note: If you use an OMB-approved form that is not included in the workspace application package for HRSA-22-018 it may count against the page limit. Therefore, we strongly recommend you only use Grants.gov workspace forms associated with this NOFO to avoid exceeding the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) do not count in the page limit. **It is therefore important to take appropriate measures to ensure your application does not exceed the specified page limit. Any application exceeding the page limit of 100 will not be read, evaluated, or considered for funding.**

Applications must be complete, within the maximum specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

- 1) You certify on behalf of the applicant organization, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
- 2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. § 3321).
- 3) Where you are unable to attest to the statements in this certification, an explanation shall be included in *Attachment 14: Other Relevant Documents*.

See Section 4.1 viii of HRSA's [SF-424 Application Guide](#) for additional information on all certifications.

Temporary Reassignment of State and Local Personnel during a Public Health Emergency

Section 319(e) of the PHS Act provides the Secretary of HHS with discretion upon request by a state or tribal organization to authorize the temporary reassignment of state, tribal, and local personnel during a declared federal public health emergency. The temporary reassignment provision is applicable to state, tribal, and local public health department or agency personnel whose positions are funded, in full or part, under PHS programs and allows such personnel to immediately respond to the public health emergency in the affected jurisdiction. Funds provided under the award may be used to support personnel who are temporarily reassigned in accordance with § 319(e). Please reference detailed information available on the HHS Office of the Assistant Secretary for Preparedness (ASPR) website via <http://www.phe.gov/Preparedness/legal/pahpa/section201/Pages/default.aspx>.

Program-Specific Instructions

In addition to application requirements and instructions in Section 4 of HRSA's [SF-424 Application Guide](#) (including the budget, budget narrative, staffing plan, and personnel requirements, assurances, certifications, and abstract), include the following:

i. **Project Abstract**

Use the Standard OMB-approved Project Abstract Summary Form 2.0 that is included in the workspace application package. Do not upload the abstract as an attachment. For information content required in the Project Abstract Summary Form, see Section 4.1.ix of HRSA's [SF-424 Application Guide](#). Your abstract should be limited to one page and include the following information in this order:

- A general overview of the HIV epidemic in the EMA/TGA, including epidemiologic, demographic, and geographic information. You may present this information as a table.
- A description of the comprehensive system of care in the entire EMA/TGA, including the available core medical and support services funded by RWHAP Part A and by other sources, where services are located, and how clients access those services, including services for disproportionately impacted subpopulation(s) supported by MAI funds.
- The overall viral suppression rate for the EMA/TGA. Use HIV surveillance data on [TargetHIV](#).

ii. **Project Narrative**

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

If any request for information is not applicable, state “Not Applicable” and provide justification.

Successful applications will contain the information below. Please use the following section headers for the narrative:

- **INTRODUCTION** -- [Corresponds to Section V's Review Criterion #1 \(Need\)](#)
This section must briefly describe how the EMA/TGA will utilize RWHAP Part A grant funds in support of a comprehensive continuum of high-quality care and treatment for people with HIV in the RWHAP Part A service area, as defined in [Appendix B](#).
- **NEEDS ASSESSMENT** -- [Corresponds to Section V's Review Criterion #1 \(Need\)](#)
The purpose of this section is to demonstrate the severity of the HIV epidemic in the EMA/TGA. Include quantifiable data on HIV epidemiology, the HIV care continuum, unmet need, co-occurring conditions, complexity of providing care, and the early identification of individuals with HIV/AIDS. Also, include the identification of subpopulations of focus.

A. Demonstrated Need

The Demonstrated Need section includes Epidemiologic Overview, HIV Care Continuum, Unmet Need, Co-occurring Conditions, and Complexities of Providing Care sub-sections.

RWHAP Part A recipients should conduct a comprehensive needs assessment to determine service needs in the jurisdiction. Based on the comprehensive needs assessment, recipients must set priorities and allocate resources to meet these needs as directed by the planning council (PC) or recommended by the planning body (PB).

HAB will direct supplemental funds to eligible areas where epidemiologic data demonstrate that HIV infection prevalence rates are increasing, where there is documented demonstrated need and service gaps, and where there is a demonstrated disproportionate impact on vulnerable populations.

1) Epidemiologic Overview

An epidemiologic overview provides a description of the demonstrated need for HIV care in the population of an area in terms of the socio-demographic characteristics of persons newly diagnosed with HIV, people with HIV, and persons at higher risk for HIV. Understanding the populations affected by HIV provides the basis for setting priorities, identifying appropriate interventions and services, allocating funding to HIV care services, implementing appropriate service standards, and evaluating programs and policies.

The epidemiologic overview should focus on the most recent year for which data are available. When presenting trends, HRSA recommends a minimum of three years of data. Please cite data sources. Submit the HIV/AIDS Demographics Table, including socioeconomic data, as **Attachment 3**.

- a)** Provide a brief summary of the HIV epidemic in your EMA/TGA geographic area.
- b)** Describe the socio-demographic characteristics of (1) persons newly diagnosed, (2) people with HIV, and (3) persons at higher risk for HIV in the service area. Include the following, as available in the geographical region of the jurisdiction:
 - i.** Demographic data (e.g., race, age, sex, transmission category, current gender identity) and
 - ii.** Socioeconomic data (e.g., percentage of federal poverty level (FPL), income, education, health insurance status, language barriers).
- c)** Describe the relative rates of increase in HIV diagnosed cases within new and emerging populations, as applicable.
 - i.** Include information on how you identified emerging populations, any unique challenges, and estimated costs to the RWHAP Part A program, if applicable, and
 - ii.** Describe the increasing need for HIV-related services based on the relative increase of HIV cases.

2) HIV Care Continuum

The ultimate goal of HIV treatment is to achieve viral suppression. This is important for people with HIV to stay healthy, have improved quality of life, and live longer. People with HIV who maintain viral suppression have effectively no risk of passing HIV to others.

The HIV care continuum is a public health model that outlines the steps or stages that people with HIV go through from diagnosis to achieving and maintaining viral suppression. There are two approaches to monitor the HIV care continuum—the prevalence-based approach and the diagnosis-based approach. The prevalence-based HIV care continuum describes the number of people who are at each step of the continuum as a percentage of the total number of people with HIV (known as HIV prevalence). Prevalence includes both people whose infection has been diagnosed and those who have HIV but do not know it. The diagnosis-based HIV care continuum depicts each step as a percentage of the number of people with diagnosed HIV. For the purposes of this NOFO, a diagnosis-based HIV care continuum will be utilized.

To be able to monitor progress across the HIV care continuum in a meaningful way, it is important to have standardized data elements that are both practical and feasibly implemented in RWHAP Part A recipient jurisdictions. Each step of the diagnosis-based HIV care continuum outlined below includes specific definitions, including descriptions of the numerators and denominators, as described in the [CDC HIV Prevention Progress Report, 2019](#). Each step of the HIV care continuum is listed below:

- **Diagnosed:** Number of persons aged ≥ 13 years with HIV infection in the jurisdiction at the end of the calendar year.
- **Receipt of Care:** Percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year.
 - Numerator: Number of persons aged ≥ 13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load.
 - Denominator: Number of persons aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.
- **Retained in Care:** Percentage of persons with documentation of two or more CD4 or viral load tests performed at least three months apart during the calendar year.
 - Numerator: Number of persons aged ≥ 13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load.
 - Denominator: Number of persons aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.

- **Viral Suppression:** Percentage of persons aged ≥ 13 years with HIV infection who had a viral load test result of < 200 copies/mL at the most recent viral load test during the calendar year.
 - Numerator: Number of persons aged ≥ 13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed.
 - Denominator: Number of persons aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.
 - **Linked to Care:** Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load.
 - Numerator: Number of persons aged ≥ 13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load.
 - Denominator: Number of persons aged ≥ 13 years with newly diagnosed HIV infection during the calendar year.
- a) Using the CDC definition for a diagnosis-based HIV care continuum, and the numerators and denominator descriptions above, provide a graphic depiction (i.e., bar chart) of the HIV care continuum for the jurisdiction. [TargetHIV](#) contains the data for each step of the care continuum for each eligible RWHAP Part A jurisdiction.

3) Unmet Need

Unmet need is defined as the number of individuals with HIV in a jurisdiction who are *aware* of their HIV/AIDS status and are *not in care*. RWHAP legislation indicates that RWHAP Part A recipients need to address unmet need by identifying, determining the needs, and facilitating interventions for individuals with unmet need.

HAB has developed a new framework for recipients to report unmet need. This new Unmet Need Framework includes three components (late diagnosed, unmet need, and in care, but not virally suppressed) aimed at more broadly characterizing unmet need. In reporting estimates across each component of the unmet need framework, recipients must submit estimates using HIV surveillance data (the required method). In addition, recipients may submit estimates using RWHAP data (the enhanced method). Detailed information, training materials, and reporting tools, on the new unmet need framework are located on [TargetHIV](#).

The three components of the Unmet Need Framework are:

- a) Late Diagnosed: (Required method only, HIV surveillance data) the number of late diagnoses based on first CD4 test performed or documentation of an AIDS-defining condition less than or equal to three months after a new HIV diagnosis.
- b) Unmet Need:
 - 1) (Required method, HIV surveillance data): Number/percent of people with HIV/aware with no CD4 or VL test in the most recent calendar year.
 - 2) (Enhanced method, RWHAP data): Number/percent of RWHAP clients with no CD4 or VL test or outpatient/ambulatory health services (OAHs) visit⁴ in the most recent calendar year.
- c) Not Virally Suppressed:
 - 1) (Required method, HIV surveillance data): Number/percent of people with HIV/aware and in care that have a viral load ≥ 200 copies/mL at most recent test.
 - 2) (Enhanced method, RWHAP data): Number/percent of RWHAP clients in care that have a viral load ≥ 200 copies/mL at most recent test.

Submit Unmet Need Framework estimates as **Attachment 4** in your application. Tools developed to facilitate calculating and reporting the Unmet Need Framework estimates and the unmet need priority populations are located on [TargetHIV](#).

Based on the Unmet Need Framework estimates provided in Attachment 4, provide responses to the following:

- a) Identify whether the enhanced method was utilized (in addition to the required method) to provide the Unmet Need Framework estimates. Describe any data system and/or other limitations that impacted your ability to provide these estimates.
- b) Based on the estimates included in Attachment 4, describe the need(s) of the estimated number of people in your jurisdiction that are 1) late-diagnosed, 2) have unmet need, and 3) are in care but not virally suppressed.

4) Co-occurring Conditions

Using the list below, provide the incidence and prevalence estimates for each of the following conditions co-occurring with HIV in the EMA/TGA in a table format (submit as **Attachment 5**) and document the data sources used. Use most recently available data. If data are not available, provide a justification.

⁴ Jurisdictions may choose to use other services to reflect HIV primary medical care. Any variation from the definitions should be clearly stated in documentation that accompanies the estimates.

The table must include:

- a) Hepatitis C virus
- b) Sexually transmitted infection rates, including syphilis, gonorrhea, and chlamydia
- c) Mental illness
- d) Substance use disorder
- e) Homeless/unstably housed
- f) Former incarceration

Note: You may include additional conditions unique to your jurisdiction, as applicable.

5) Complexities of Providing Care

- a) If the EMA/TGA experienced a reduction in RWHAP Part A formula funding last year (FY 2021), provide a narrative that addresses both the impact and response to the funding reduction, as outlined below.
 - i. Impact: The specific services that were eliminated or reduced, and by how much.
 - ii. Response: Any cost containment measures implemented (e.g., waiting lists, client cost sharing, or other measures), PC/PB response to the reduction in funding, and any transitional plans implemented for clients who received services that were either eliminated or reduced.
- b) Provide an overall description of health care coverage options available to all people with HIV in the jurisdiction.
 - i. Explain how coverage options in the jurisdiction negatively or positively influence access to direct health care services and health outcomes.
- c) Describe any relevant factors that limit access to health care including geographic variation, adequacy of health insurance coverage, language barriers, or other major social determinants of health, as applicable.

B. Early Identification of Individuals with HIV/AIDS (EIIHA)

The purpose of this section is to describe the data and information associated with ensuring that individuals who are unaware of their HIV status are identified, informed of their status, referred to supportive services, and linked to medical care if HIV test is positive. The goals of the EIIHA plan are to present a strategy for: (1) identifying individuals with HIV who do not know their HIV status; (2) making such individuals aware of their status and enabling them to use the health and support services; and (3) reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities. See Section 2603(b)(2)(A) of the PHS Act.

- 1) Describe the planned EMA/TGA EIIHA activities for the three-year period of performance. Include the following information:
 - a) The primary activities that will be undertaken, including system-level interventions that will positively impact HIV outcomes (e.g., routine testing in clinical settings, expanding partner services);
 - b) Major collaborations with other programs and agencies, including HIV prevention and surveillance programs and the Ending the HIV Epidemic in the U.S. effort in your jurisdiction (if applicable); and

- c) The anticipated outcomes of the jurisdiction's overall EIIHA strategy. Specifically provide anticipated outcomes for each of the four required EIIHA components: 1.) identification of individuals unaware of their HIV status; 2.) informing individuals that tested positive of their HIV diagnosis; 3.) referral to care of newly diagnosed individuals; and, 4.) linkage to care of newly diagnosed individuals.
- 2) As applicable, describe any planned efforts to remove legal barriers, including state laws and regulations that increase HIV stigma and discrimination and can pose complex barriers for people with or at risk for HIV, preventing them from seeking prevention tools, learning their HIV status, and accessing medical care, treatment, and supportive service. Also, include program/policy efforts to expand implementation of routine HIV testing.

Note: The EIIHA activities will remain the same for the three-year period of performance. Outcomes will be reported in the FY 2023 and FY 2024 NCC progress reports.

C. Subpopulations of Focus

Although HIV affects millions of Americans nationwide and from all social, economic, and racial and ethnic groups, and in all parts of the country, it disproportionately affects certain populations. The disproportionate prevalence of HIV in specific populations increases the risk for HIV transmission with each sexual or injection drug use encounter within those populations. In addition, a range of social, economic, and demographic factors—such as stigma, discrimination, socio-economic status, income, education, age, and geographic region— affect people's risk for HIV or their ability to access or remain engaged in prevention or care services.

Subpopulations of focus are specific groups of people with HIV within RWHAP Part A jurisdictions that are disproportionately affected by HIV, as a result of specific needs.

A data driven process should be used to identify subpopulations of focus disproportionately affected by HIV. This should include an analysis of the jurisdictional needs assessment, outcomes along the HIV care continuum, data from the unmet need framework, epidemiological data (i.e., incidence of new HIV infections and trends, prevalence of HIV), and potential impact of other major public health threats (e.g., opioid epidemic, COVID-19, etc.).

The PC/PB should determine the needs of subpopulations, with particular attention to identifying disparities in access and services among the affected subpopulations and historically underserved communities. See Section 2602(b)(4) of the PHS Act for a description of the PC/PB's duties.

- 1) Identify three (3) subpopulations with disparities in health outcomes in your jurisdiction (e.g., subpopulations with disparities in viral suppression, receipt of care, retention in care, late diagnosis, HIV incidence, etc.), and describe the specific needs for each subpopulation.

- 2) How do the data in the unmet need framework inform the process for identifying the subpopulations of focus for the jurisdiction?
- 3) As applicable, identify activities for each required EIIHA component (identification of individuals unaware of HIV status; informing newly diagnosed individuals of HIV status; referral to care of newly diagnosed individuals; and, linkage to care of newly diagnosed individuals) and describe how the activities align with the needs of the identified subpopulations of focus for the jurisdiction.

Note: The subpopulations of focus will remain the same for the three-year period of performance. Updates will be reported in the FY 2023 and FY 2024 NCC progress reports.

- **METHODOLOGY** -- [Corresponds to Section V's Review Criteria #2 \(Response\) & #4 \(Impact\)](#)

A. Planning Responsibilities

The purpose of this section is to document the existence of a functioning planning process in the EMA/TGA that is consistent with RWHAP and HRSA program requirements. Section 2602(b)(1)-(4) of the PHS Act delineates the responsibilities of the PC/PB. A planning process is imperative for effective local and state decision making to develop systems of prevention and care that are responsive to the needs of persons at risk for HIV and people with HIV. HRSA and CDC support activities that facilitate collaboration and/or develop a joint planning body to address prevention and care. Community engagement is an essential component for planning comprehensive, effective HIV prevention and care programs in the United States.

The composition of the PC/PB must reflect the demographics of the HIV epidemic in the EMA/TGA and be representative of various required categories of membership as cited in Sec. 2602(b)(1)-(2) of the PHS Act. PC/PB members must be trained regarding their legislatively mandated responsibilities and other competencies necessary for full participation in collaborative decision-making. PCs/PBs are encouraged to educate members about service issues related to the prevention of intimate partner violence, opioid and other drug use, and trauma-informed care as part of their ongoing training. PCs/PBs should also consider recruiting members who are knowledgeable about these issues.

1) Letter of Assurance from Planning Council Chair(s) or Letter of Concurrence from Planning Body

Provide a letter of assurance signed by the PC chair(s) or a letter of concurrence signed by PB leadership as **Attachment 6**. The letter must address the following:

- a) Planning:
 - i. When (i.e., the year) your most recent comprehensive needs assessment was conducted
 - ii. Participation in comprehensive planning process (i.e., integrated HIV prevention and care plan) for the jurisdiction, including the statewide coordinated statement of need (SCSN)

b) Priority Setting and Resource Allocation (PSRA):

- i. Data (e.g., comprehensive needs assessment, HIV care continuum, unmet need framework estimates, and epi profile) were used in the FY 2022 priority setting and allocation process to ensure that:
 - a. Needs of the populations with HIV (including those with unmet need for HIV-related services, disparities in access and services among affected subpopulations and historically underserved communities, and those unaware of their HIV status) are addressed
 - b. Resources were allocated in accordance with the local demographic incidence of AIDS including appropriate allocations for services for women, infants, children, and youth
- ii. People with HIV were involved in the planning and allocation processes and how their priorities were considered in the process
- iii. FY 2021 period of performance formula, supplemental, and MAI funds awarded to the EMA/TGA were expended according to the priorities established by the PC or PB

c) Training:

- i. Ongoing, annual membership training occurred, including the date(s)

d) Assessment of Administrative Mechanism:

- i. Assessment of grant recipient activities ensured timely allocation/contracting of funds and payments to contractors

Note: The Letter of Assurance from Planning Council Chair(s) or Letter of Concurrence from Planning Body will be required with the FY 2023 and FY 2024 NCC progress reports.

2) Resource Inventory

RWHAP Part A EMA/TGA planning efforts should expand the availability of services, reduce duplication of services, coordinate with all other public funding for HIV, and bring newly diagnosed people with HIV into care or engage people with HIV who know their status but are not presently in HIV care. RWHAP Part A planning efforts should also consider service needs not currently being met (defined as service gaps).

a) Coordination of Services and Funding Streams

- i. Provide, in a table format, a jurisdictional HIV resources inventory that includes (1) public funding sources for HIV prevention, care, and treatment services in the jurisdiction (RWHAP Parts B-D and F, Ending the HIV Epidemic in the U.S. (as applicable), CARES Act funding (as applicable), federal/state and local); (2) the dollar amount and the percentage of the total available funds in the FY 2021 period

of performance for each funding source; and 3) how the resources are being used (i.e., services delivered). Submit as **Attachment 7**.

- **WORK PLAN** -- [Corresponds to Section V's Review Criteria #2 \(Response\) & #4 \(Impact\)](#)

The purpose of this section is to provide tables and a narrative summary describing the EMA/TGA service provision proposed for the FY 2022 budget period. The narrative should describe how RWHAP Part A funded services are used to have a positive impact on the HIV care continuum. Under RWHAP Part A, MAI formula funding provides core medical and related support services to improve access and reduce disparities in health outcomes. The services have to be consistent with the epidemiologic data. Note that similar information for the remainder of the period of performance will be required through the NCC, and that core medical services waivers, if applicable, are required annually.

Similar to other components of the RWHAP, the goal of the MAI is improved health outcomes among people with HIV who are racial and ethnic minorities as demonstrated by viral suppression. MAI funds must be used to deliver services designed to address the unique barriers and challenges faced by hard-to-reach, disproportionately impacted individuals within the EMA/TGA.

A. HIV Care Continuum Services Table and Narrative

1) FY 2022 HIV Care Continuum Services Table

Resources and a suggested format for completing the HIV Care Continuum Services Table can be found at [TargetHIV](#). Submit as **Attachment 8**.

a) Using [CDC HIV Care Continuum](#) definitions and CDC surveillance data, develop a diagnosis-based HIV Care Continuum Services Table. You must include baseline and target indicators as a numerator and denominator, as well as a percentage for each step. List the service categories funded by RWHAP Part A that will aid in achieving the desired target outcomes to be achieved during the FY 2022 budget period (one year).

Regardless of the format used for the HIV Care Continuum Table, use the provided CDC definitions for each step of the diagnosis-based HIV care continuum, the CDC definitions for the numerator and denominator for each step, and ensure that the goals and objectives for each step are the same as in the suggested format on [TargetHIV](#) since they align with the National HIV Strategic Plan (2021-2025).

2) HIV Care Continuum Narrative

Please provide a narrative of your HIV care continuum addressing the following:

a) Any changes in your HIV care continuum from CY 2017 to CY 2019, or the most current three (3) years for which data are available, the impact those changes had on your program, and how you responded or addressed those identified changes.

B. Funding for Core and Support Services

RWHAP Part A funds are subject to Section 2604(c) of the PHS Act, which requires that RWHAP Part A recipients expend 75 percent of RWHAP Part A funds **remaining after reserving funds for administration and CQM** on core medical services for individuals with HIV who are identified and eligible under the RWHAP.

1) Service Category Plan

Please provide a Service Category Plan in table format, as described below, that utilizes core medical and support service categories as prioritized and funded by the PC/PB or through local community planning processes. The plan should consist of both RWHAP Part A and MAI funds. **Please indicate if you have already submitted, submitted with this application, or intend to submit a core medical services waiver for the FY 2022 budget period. Allocations in the Service Category Plan should match the submitted or intended waiver. If you are not submitting a core medical services waiver for the FY 2022 budget period, the allocations must align with the 75 percent core medical services requirement.** The Service Category Plan must also correlate with the budget and budget narrative sections of the application. Please note that pending waiver requests that are not approved will necessitate the submission of a revised budget and Service Category Plan that adheres to the 75/25 legislative requirement.

a) Service Category Plan Table

The Service Category Plan Table illustrates how you fund RWHAP Part A and MAI core medical and support services in the EMA/TGA. It is comprised of service categories, priority number as directed by the PC or recommended by the PB, funding amount, unduplicated clients served, service unit definition, number of service units, and MAI Subpopulations of Focus (MAI service category table only). In FY 2021 applications, recipients indicated which MAI services were provided to identified priority populations in the 2021 budget period. In FY 2022, recipients will be required to identify which applicable Subpopulations of Focus, as outlined in the Demonstrated Need section, will receive MAI services in the 2022 budget period.

For every service category funded by RWHAP Part A in the jurisdiction, provide the following in table format (submit as **Attachment 9**). See [TargetHIV](#) for a suggested template to utilize.

i. RWHAP Part A

- a) FY 2021 budget period Part A service categories with priority number, expended amount, number of unduplicated clients served, service unit definitions, and number of service units provided. Include total dollar amounts for core medical services, support services, a total of the combined core medical and support services, and the percentages of expenditures for Part A core medical and Part A support services.

- b) FY 2022 budget period Part A service categories with priority number, anticipated funding amount, projected number of unduplicated clients to be served, service unit definitions, and projected number of service units. Include total dollar amounts for core medical services, support services, a total of the combined core medical and support services, and the percentages of allocations for Part A core medical and Part A support services.

ii. MAI

- a) FY 2021 budget period MAI service categories with a priority number, expended amount, number of unduplicated clients served, service unit definitions, number of service units provided, and for each MAI funded service, indicate which priority population(s) was served. Include total dollar amounts for core medical services, support services, a total of the combined core medical and support services, and the percentages of expenditures for MAI core medical and MAI support services.
- b) FY 2022 budget period MAI service categories with a priority number, anticipated funding amount, projected number of unduplicated clients to be served, service unit definitions, projected number of service units, and for each projected MAI service, indicate which applicable Subpopulation(s) of Focus is anticipated to be served. Include total dollar amounts for core medical services, support services, a total of the combined core medical and support services, and the percentages of allocations for MAI core medical and MAI support services.

b) MAI Service Category Plan Narrative

Section 2693(b)(2)(A) of the PHS Act stipulates that MAI funds under RWHAP Part A are to be used to improve HIV-related health outcomes, and to reduce existing racial and ethnic health disparities. More specifically, MAI funds address the disproportionate impact of HIV (i.e., the disparities in access, treatment, care, and health outcomes) on racial and ethnic minorities, by providing core medical and related support services to address the unique barriers and challenges faced by hard-to-reach minority subpopulations in metropolitan areas hardest hit by the epidemic.

In order to improve the health outcomes of minority subpopulations most disproportionately impacted by HIV, MAI services must be consistent with the epidemiologic data and the identified need, and be culturally appropriate. Furthermore, effective MAI service provision should employ the use of population-tailored, innovative approaches or interventions by specifically addressing the unique needs of MAI subpopulations most disproportionately impacted by HIV. Similar to the other components of

RWHAP Part A, the goal of the MAI is viral suppression among identified minority subpopulations.

- i. Describe how MAI services will be implemented to address the needs of (each population identified in) the Subpopulations of Focus section.
- ii. Describe how MAI services to be implemented may prevent new HIV infections, improve health outcomes, and decrease health disparities and inequities among the identified subpopulations of focus.

c) Unmet Need

- i. Identify specific interventions that are focused on improving the outcomes for individuals with unmet need that 1) are late diagnosed, 2) have unmet need, and 3) are in care but not virally suppressed, as outlined in Attachment 4. This information can be provided as a table.
- ii. If applicable, describe how activities related to re-engaging individuals with unmet need into care (along with how activities addressing the needs for the late-diagnosed and not virally suppressed populations) intersect with plans or strategies in your jurisdiction, such as Ending the HIV Epidemic in the U.S., Getting to Zero, and/or 90/90/90 efforts.

d) Core Medical Services Waiver (if applicable – not scored, counts toward page limit) Submit as Attachment 10.

You must provide a separate allocation table that is reflective of the results of the priority setting and resource allocation process, **only if you submit a core medical services waiver with this application.** The allocation table must be consistent with the waiver request. Include the allocation table and the core medical services waiver request as **Attachment 10**

▪ **RESOLUTION OF CHALLENGES** -- [Corresponds to Section V's Review Criterion #2 \(Response\)](#)

The purpose of this section is to identify challenges you are likely to encounter in designing and implementing the activities described in the work plan, and approaches you will use to resolve such challenges.

A. Resolution of Challenges Table

In lieu of a narrative for this section, HAB suggests providing information on resolving challenges with implementing RWHAP Part A activities, including HIV care continuum activities, in table format with the following headers:

Challenges/Barriers, Proposed Resolutions, Intended Outcomes, and Current Status.

Describe at least three potential challenges/barriers when completing your table, which may include the following:

- 1) Challenges and barriers anticipated in the larger context of implementing RWHAP Part A activities (e.g., changes in the health care landscape, community engagement, barriers for populations experiencing inequities in health outcomes).

- 2) Challenges and barriers that may be encountered with integrating the HIV care continuum into planning and implementing the RWHAP Part A program (e.g., linkage to care and retention in care strategies).
- 3) Anticipated challenges with implementing activities for the Subpopulations of Focus.

▪ **EVALUATION AND TECHNICAL SUPPORT CAPACITY** -- [Corresponds to Section V's Review Criterion #3 \(Evaluative Measures\)](#)

The purpose of this section is to describe the plan for the program performance evaluation that will contribute to continuous quality improvement.

A. Clinical Quality Management (CQM) Program

Section 2604(h)(5)(A) of the PHS Act requires RWHAP Part A recipients to establish a CQM program to:

- Assess the extent to which HIV health services provided to clients under the grant are consistent with the most recent HHS Guidelines for the treatment of HIV disease and related opportunistic infections; and
- Develop strategies for ensuring that such services are consistent with the HHS Guidelines for improvement in the access to and quality of HIV services.

Please describe:

- 1) What changes have been made to your current clinical quality management program based on previous years' experience, outcomes, etc.
- 2) How CQM data improved patient care, health outcomes, patient satisfaction, and/or changed service delivery in the jurisdiction, including strategic long-range service delivery planning.

Note: You will be required to submit an updated Quality Management Plan as a reporting requirement in Year 2 of the Non-Competing Continuation progress report.

You can find more information about the HRSA RWHAP expectations for CQM programs in:

- [PCN 15-02 Clinical Quality Management](#) and [Frequently Asked Questions](#)
- [HIV/AIDS Bureau Performance Measures](#)
- [HHS HIV/AIDS Clinical Guidelines](#)
- [HIV/AIDS Bureau RWHAP Part A Monitoring Standards](#) (RWHAP Part A specific, Universal Monitoring Standards, and Frequently Asked Questions)
- [Part A Manual](#)

▪ **ORGANIZATIONAL INFORMATION** -- [Corresponds to Section V's Review Criterion #5 \(Resources/Capabilities\)](#)

A. Grant Administration

The purpose of this section is to demonstrate the extent to which the CEO or designee in the EMA/TGA has met the legislative requirements to disburse funds quickly, closely monitor their use, and ensure the RWHAP is the payor of last resort. RWHAP stresses the importance of timely obligation of RWHAP

funds. Timely obligation of RWHAP funds ensures that services can be provided as rapidly as possible and decreases the possibility that unobligated funds will remain at the end of the budget period. Please refer to Section 2603(c) of the PHS Act regarding the RWHAP Part A formula and supplemental unobligated balance (UOB) requirement, as well as [PCN 12-02 Part A and Part B Unobligated Balances and Carryover](#). The UOB requirement does not apply to MAI funds. **If the recipient reports unobligated formula funds of five percent or less, HRSA does not impose penalties, although a future year award may be subject to an offset.**

Note: UOB Penalties (applies to each year in the three-year period of performance)

If the UOB of a formula award exceeds five percent, two penalties are imposed:

- The future year award is reduced by the amount of the UOB, less the amount of approved carryover; and
- The grant recipient is not eligible for a future year supplemental award.

Note: The amount of the UOB not approved for carryover is subject to an offset.

Supplemental Funds

Under the RWHAP legislation, unobligated supplemental funds cannot be carried over, but are subject to an offset. If a grant recipient has a UOB of supplemental funds, the recipient remains eligible for a future year RWHAP Part A award, including supplemental funds.

1) Program Organization

- a) Describe how RWHAP Part A funds are administered within the EMA/TGA with reference to the staff positions, including program and fiscal staff, described in the budget narrative and the program organizational chart included as **Attachment 11**. The narrative should describe the local agency responsible for the grant and identify the entity responsible for administering the RWHAP Part A, including the department, unit, staffing levels (full-time equivalent staff [FTE], including any vacancies), fiscal agents, PC/PB staff, and in-kind support staff. Please note: HRSA expects the staff person responsible for management of the RWHAP Part A grant (i.e., the Project Director or Program Coordinator) have at least 0.5 FTE allocated to the Part A program (this can be a combination of budgeted grant funds and/or other sources) to ensure sufficient oversight and monitoring of all grant activities conducted by recipients and subrecipients. Submit a staffing plan (including vacant positions, job descriptions, and biographical sketches for key personnel) as **Attachment 1**.
- b) If you administer the RWHAP Part A funds by a contractor or fiscal agent, describe the staffing, fiscal agent scope of work or services to be provided, and how you will evaluate the performance of the work or services being provided.

2) Grant Recipient Accountability

HRSA holds recipients accountable for the expenditure of funds awarded under RWHAP Part A and requires recipients to monitor subrecipient fiscal and programmatic compliance. Recipients also are required to have on file a copy of each subrecipient's procurement document (contract) and fiscal, program, and site visit reports. Also see the requirements outlined in the [Uniform Administrative Requirements, Cost Principles, and Audit Requirement for HHS Awards \(45 CFR part 75\)](#) - Subrecipient Monitoring and Management (45 CFR § 75.351 and 352) and [National Monitoring Standards](#).

a) Monitoring - Provide a narrative that describes the following:

- i. Describe how subrecipient monitoring was performed during the FY2021 period of performance to ensure fiscal and program compliance. Describe on-site or other monitoring practices if on-site visits did not occur (i.e., virtual).
- ii. The process for ensuring subrecipient compliance with the single audit requirement in Subpart F of the [Uniform Administrative Requirements, Cost Principles, and Audit Requirement for HHS Awards \(45 CFR part 75\)](#); and
- iii. If there were findings in any subrecipient single audit or program-specific audit reports, describe what you have done to ensure that subrecipients have taken appropriate corrective action. Corrective actions may include, but are not limited to, HRSA-sponsored TA and training requests from the grant recipient of record.

Note: Due to the COVID-19 pandemic, HRSA HAB waived the annual subrecipient site visit monitoring requirement in FY 2021; see the HRSA HAB letter dated February 10, 2021. However, as outlined in Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, [45 CFR § 75.352](#), RWHAP Part A recipients must continue to monitor the activities of subrecipients to ensure that funding is used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved.

b) Third Party Reimbursement

The RWHAP is the payor of last resort and you must vigorously pursue alternate sources of payments. You must certify client eligibility every 12 months/annually and recertify client eligibility at least every six months (see [PCN 13-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements](#)). Recipients and subrecipients are required to use effective strategies to coordinate between RWHAP Part A and third-party payers who are ultimately responsible for covering the cost of services provided to eligible or covered persons. Subrecipients providing Medicaid eligible services must be Medicaid certified.

Provide a narrative that describes the following:

- i. The process used to ensure that subrecipients are pursuing third party reimbursement and utilizes contract language or another mechanism to ensure that this takes place;
- ii. Indicate the federal poverty level (FPL) to determine client eligibility within the jurisdiction and methods used to conduct screening and eligibility to ensure the RWHAP is the payor of last resort; and
- iii. How you monitor and track the source and use of any program income earned at the recipient and subrecipient levels.

c) Fiscal Oversight - Provide a narrative that describes the following:

- i. The process used by program and fiscal staff to coordinate activities, ensuring adequate reporting, reconciliation, and tracking of program expenditures (e.g., meeting schedule, information sharing regarding subrecipient expenditures, UOB, and program income);
- ii. The process used to separately track formula, supplemental, MAI, and carryover funds, including information on the data systems utilized; and
- iii. The process for reimbursing subrecipients, from the time a voucher/invoice is received to payment.

B. Maintenance of Effort (MOE)

The RWHAP legislation requires RWHAP Part A recipients to maintain, as a condition of award, EMA/TGA expenditures for HIV-related core medical services and support services at a level equal to the Fiscal Year (FY) preceding the FY for which the recipient is applying to receive a RWHAP Part A grant. Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the PHS Act and in [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds](#). RWHAP Part A recipients must document that they will meet the MOE requirement annually.

You must submit the following information as **Attachment 12**:

- 1) A table that identifies the baseline aggregate for actual non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services during your most recently completed FY prior to the application deadline, and an estimate for your next FY, and
- 2) A description of the process and elements used to determine the amount of expenditures in the MOE calculations.
- 3) If applicable, indicate if a waiver was received for MOE requirement.

iii. Budget

The directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Follow the instructions in Section 4.1.iv of HRSA's [SF-424 Application Guide](#) and the additional budget instructions provided below. A budget that follows the Application Guide will ensure that, if HRSA selects the application for funding, you will have a well-organized plan and, by carefully following the approved plan, may avoid audit issues during the implementation phase.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) you incur to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by you to satisfy a matching or cost-sharing requirement, as applicable.

In addition, the RWHAP Part A HIV Emergency Relief Grant Program requires the following:

Complete Sections A, B, E, and F of the SF-424A Budget Information – Non-Construction Programs form for the year of the project period, and then provide a line item budget using Section B Object Class Categories of the SF-424A. The **three** required rows, in Section A, and columns, in Section B, are:

- 1) Administrative (Part A + MAI),
- 2) CQM (Part A + MAI), and
- 3) HIV Services (Part A + MAI).

In Section E, include budget estimates for future funding periods. Note: use your requested FY 2022 budget amount to complete Section E. The formula funded portions of the award will be calculated annually based on updated data supplied by CDC. In Section F, include your direct and indirect costs based on your FY 2022 budget.

Caps on expenses: RWHAP Part A grant administration costs (including PC or PB support) may **not** exceed ten percent of the grant award. The aggregate total of administrative expenditures for subrecipients, including all indirect costs, may **not** exceed ten percent of the aggregate amount of all subawards. Please see [PCN 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D](#) along with the [Frequently Asked Questions](#) for information regarding the statutory ten percent limitation on administrative costs.

Recipients are allowed to allocate up to five percent of the total grant award or \$3,000,000 (whichever is less) for CQM activities.

The Consolidated Appropriations Act, 2021 (P.L. 116-260), Division H, Section 202 states, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." See Section 4.1.iv Budget – Salary Limitation of HRSA's [SF-424 Application Guide](#) for additional information. Note that these or other salary limitations may apply in the following fiscal years, as required by law.

iv. Budget Narrative

See Section 4.1.v. of HRSA's [SF-424 Application Guide](#).

In addition, the RWHAP Part A HIV Emergency Relief Grant Program requires the following:

In order to evaluate your adherence to RWHAP Part A legislative budget requirements, you must submit a program-specific budget narrative/justification. The

budget period is for one year. To reduce the burden of recipient reporting that previously required multiple post-award budget revisions, you must submit a budget that does not exceed the ceiling amounts listed for the service area in [Appendix B](#). In addition, the total amount requested on the SF-424A and the total amount listed on the budget narrative/justification must match. The budget allocations must relate to the activities proposed in the project narrative and the work plan.

You should submit the budget narrative/justification in table format. When completing the budget narrative/justification submit an overall summary table and a separate table for each of the cost categories. It should list separately by funding type (Part A and MAI), the program cost categories: Administrative, CQM, and HIV Services across the top and object class categories (i.e., Personnel, Fringe Benefits, Travel, Equipment, Supplies, Contractual, Other, and Indirect Charges) in a column down the left-hand side. If the EMA/TGA is administered by a contractor or fiscal agent, clearly detail the costs for administering the grant in the budget narrative/justification. You must also show a separate PC/PB support budget narrative/justification.

Each of the specific budget narrative/justification tables should clearly describe and justify how every item with a cost associated under each object class category makes a contributing impact and supports the overall RWHAP Part A HIV service delivery system. Reference HRSA's [SF-424 Application Guide](#), specifically the Budget Narrative section, for the specific criteria to include for the justification of line item costs for each object class category. Recipients that do not include the justification of costs across object class categories will be required to submit a revised budget narrative.

Additional cost category information to use when completing the RWHAP Part A grant budget narrative/justification tables is as follows:

- A. Administrative Costs** are costs associated with the administration of the RWHAP Part A grant. By law, no more than **10 percent** of the RWHAP Part A budget can be spent on administrative costs. You should allocate staff activities that are administrative in nature to administrative costs. Please note that it is expected that the staff person responsible for management of the RWHAP Part A grant (i.e., the Project Director or Program Coordinator) should have at least 0.50 FTE allocated to the Part A Program (this can be a combination of budgeted grant funds and/or other sources) to ensure sufficient oversight and monitoring of all grant activities including subrecipients. All costs associated with grant administration and PC/PB support are all subject to the 10 percent limit on costs associated with administering the award. Recipients must determine the amounts necessary to cover all administrative and program support activities. The RWHAP Part A recipient must also ensure adequate funding for PC/PB mandated functions within the administrative line item. PC/PB support should cover *reasonable and necessary costs* associated with carrying out legislatively mandated functions.

If a RWHAP Part A grant recipient has contracted with an entity to provide regional RWHAP management and fiscal oversight (i.e., the entity is acting

on behalf of the recipient), the cost of that contract, exclusive of subawards to providers, would count toward the recipient's 10 percent administrative cap. Providers that have contracted to provide health care services for the lead agency are considered subrecipients of the recipient and are subject to the aggregate 10 percent administrative cap for subrecipients. Likewise, recipients who provide services directly should apply administrative costs related to the provision of such service to the aggregate 10 percent administrative cost cap.

The aggregate total of administrative expenditures for subrecipients, including all indirect costs, may **not** exceed 10 percent of the aggregate amount of all subawards. Subrecipient administrative activities include:

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

If indirect costs are included in the grant application budget, submit a current (i.e., not expired) indirect cost documentation (e.g., negotiated indirect cost rate agreement, indirect cost rate proposal, cost allocation plan, or a request to use the de minimis rate) as **Attachment 13**. As a reminder: All indirect costs charged by the subrecipient are considered an administrative cost subject to the 10 percent aggregate limit.

For further guidance on the treatment of costs under the 10 percent administrative limit, refer to [PCN 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D](#) and [Frequently Asked Questions](#).

B. CQM Costs are costs required to maintain a CQM program to assess the extent to which services are consistent with the current HHS Guidelines for the treatment of HIV and to develop strategies to improve access to and quality of services. No more than 5 percent or \$3,000,000 (whatever is less) of the RWHAP Part A budget can be spent on CQM costs. Examples of CQM costs include:

- Implementation of CQM program;
- CQM activities;
- Data collection for CQM purposes (collect, aggregate, analyze, and report on performance measurement data on a quarterly basis at a minimum);
- Recipient CQM staff training/TA (including travel and registration) - this includes HRSA-sponsored or HRSA-approved training on CQM; and
- Training of subrecipients on CQM.

Please note that quality assurance activities are **not** considered CQM costs.

For further guidance on CQM, refer to [PCN 15-02 Clinical Quality Management](#).

- C. HIV Services Costs** are associated with the provision of core medical and support services to RWHAP eligible clients. Core medical and support services are important to assist in the diagnosis of HIV infection, linkage to care for people with HIV, retention in care, and the provision of HIV treatment. To be an allowable cost under the RWHAP, all services must relate to HIV diagnosis, care, and support, and must adhere to established HIV clinical practice standards consistent with HHS Guidelines. In addition, all providers must be appropriately licensed and in compliance with state and local regulations. Recipients are required to have service standards for all RWHAP-funded services.

For further guidance on core medical and support services, refer to [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds](#).

1) Core Medical Services Costs

At least 75 percent of the award (minus amounts for administrative and CQM costs) must be used to provide core medical services. If a core medical services waiver is submitted prior to the application, with the application or will be submitted, your budget must be consistent with the core medical services waiver request. For further guidance on core medical services waiver requests, refer to [PCN 13-07 Uniform Standard for Waiver of Core Medical Services Requirement for Grantees Under Parts, A, B, and C](#).

2) Support Services Costs

Support services are those services needed by people with HIV to achieve optimal HIV medical outcomes.

Object Class Category Details

The budget narrative/justification should explain how the amounts requested support the overall service delivery system and include a thorough justification for any of the following applicable object class categories: Personnel, Fringe Benefits, Travel, Equipment, Supplies, Contractual, Construction, Other, and Indirect Charges. For all employees who are less than one FTE on the award, provide the complete salary distribution of all funding sources outside of RWHAP Part A funding for personnel and fringe benefits costs.

Personnel: All costs must include the name, position title, the annual salary, program FTE, and program salary subtotal for each staff position. Provide a written justification that clearly explains how the roles have an impact on the RWHAP Part A HIV service delivery system and/or program outcomes/goals. List personnel separately by position title and name. Also, note if a position is vacant or if a position is in-kind. Descriptions must be specific to the cost category. A general description for personnel repeated across the categories is not acceptable. You may be required to submit a revised budget narrative if a

general personnel description across categories is provided. For personnel whose duties occur across categories, the FTE allocation must not exceed 1.0.

Contractual: Provide a clear explanation of the purpose of each contract, how you estimated the costs, and the specific contract deliverables. List the amounts allocated for personnel or services contracted to outside providers for all HIV services (subrecipients). Show the amount allocated to any activities that are not conducted “in-house” on the Contractual line. All RWHAP Part A legislative requirements, outlined in [45 CFR part 75](#), and program expectations that apply to recipients also apply to subrecipients providing services under this award. Your organization is accountable for your subrecipients’ performance of the project, program, activity, and appropriate expenditure of funds under the award.

Remaining object class categories should include all the criteria, as outlined in HRSA’s [SF-424 Application Guide](#), in the justification for each line item. You may be required to submit a revised budget narrative if you do not adhere to the criteria to include with the justification of costs across object class categories.

NOTE: HRSA recommends that the budgets be converted or scanned into PDF format for submission (landscape format optimizes legibility). Do NOT submit Excel spreadsheets.

NARRATIVE GUIDANCE	
To ensure that you fully address the review criteria, this table provides a crosswalk between the narrative language and where each section falls within the review criteria. Any attachments referenced in a narrative section may be considered during the objective review.	
<u>Narrative Section</u>	<u>Review Criteria</u>
Introduction	(1) Need
Needs Assessment • Demonstrated Need • Early Identification of Individuals with HIV/AIDS • Subpopulations of Focus	(1) Need
Methodology • Planning Responsibilities	(2) Response and (4) Impact
Work Plan • FY 2022 HIV Care Continuum Services Table and Narrative • Funding for Core and Support Services	(2) Response and (4) Impact

Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity Clinical Quality Management	(3) Evaluative Measures
Organizational Information Grant Administration	(5) Resources/Capabilities
Budget and Budget Narrative	(6) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.

v. Attachments

Provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Clearly label each attachment.**

Attachment 1: Staffing Plan, Job Descriptions, and Biographical Sketches for Key Personnel (required; see Section 4.1.vi. of the HRSA's [SF-424 Application Guide](#)).

Attachment 2: FY 2022 Agreements and Compliance Assurances, Certifications (required).

Submit the RWHAP Part A Grant Program FY 2022 Agreements and Compliance Assurances signed by the CEO or the CEO's designee (see [Appendix A](#)).

Attachment 3: HIV/AIDS Demographics Table (required).

Attachment 4: Unmet Need Framework (required)

Attachment 5: Co-occurring Conditions Table (required).

Attachment 6: Letter of Concurrence from Planning Council Chair/Letter of Concurrence from Planning Body (required).

Attachment 7: Coordination of Services and Funding Streams Table (required).

Attachment 8: HIV Care Continuum Services Table (required).

Attachment 9: Service Category Plan Table(s) (required).

Attachment 10: Core Medical Services Waiver Request and Allocation Table (if applicable).

Attachment 11: Program Organizational Chart (required).

Provide a one-page illustration that depicts the organizational structure of the program. Include the names of department and/or

program managers and coordinators.

Attachment 12: Maintenance of Effort Documentation (required).

Provide a baseline aggregate for actual non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services during the most recently completed FY prior to the application deadline and an estimate for the next FY using a table similar to the one below. Also, include a description of the process and elements used to determine the amount of expenditures in the MOE calculations. [See Section 2605(a)(1)(B) of the PHS Act. Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation and HRSA service definitions distributed to all recipients.] HRSA will enforce statutory MOE requirements through all available mechanisms.

NON-FEDERAL EXPENDITURES	
FY Prior to Application (Actual) Actual prior FY non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services. Amount: \$ _____	Current FY of Application (Estimated) Estimated current FY non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services. Amount: \$ _____

Attachment 13: Federally Negotiated Indirect Cost Rate Agreement, Cost Allocation Plan, 10 percent de minimis, etc. (if applicable, not counted in the page limit).

Attachment 14: Other Relevant Documents – Letters of Agreement, Memorandum of Understanding, Intergovernmental Agreements, and Other Relevant Documents (optional—will count toward page limit).

Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.).

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number Transition to the Unique Entity Identifier (UEI) and System for Award Management (SAM)

You must obtain a valid DUNS number, also known as the Unique Entity Identifier (UEI), and provide that number in the application. In April 2022, the *DUNS number will be replaced by the UEI, a “new, non-proprietary identifier” requested in, and assigned by, the System for Award Management (SAM.gov). For more details, visit the following

webpages: [Planned UEI Updates in Grant Application Forms](#) and [General Service Administration's UEI Update](#).

You must also register with SAM and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or has an exception approved by the agency under 2 CFR § 25.110(d)).

If you are chosen as a recipient, HRSA would not make an award until you have complied with all applicable DUNS (or UEI) and SAM requirements and, if you have not fully complied with the requirements by the time HRSA is ready to make an award, you may be deemed not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If you have already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

*Currently, the Grants.gov registration process requires information in three separate systems:

Dun and Bradstreet (<http://www.dnb.com/duns-number.html>)

System for Award Management (SAM) (<https://www.sam.gov>)

Grants.gov (<http://www.grants.gov/>)

For further details, see Section 3.1 of HRSA's [SF-424 Application Guide](#).

SAM.GOV ALERT: For your SAM.gov registration, you must submit a [notarized letter](#) appointing the authorized Entity Administrator. The review process changed for the Federal Assistance community on June 11, 2018.

In accordance with the Federal Government's efforts to reduce reporting burden for recipients of federal financial assistance, the general certification and representation requirements contained in the Standard Form 424B (SF-424B) – Assurances – Non-Construction Programs, and the Standard Form 424D (SF-424D) – Assurances – Construction Programs, have been standardized federal-wide. Effective January 1, 2020, the forms themselves are no longer part of HRSA's application packages and the updated common certification and representation requirements will be stored and maintained within SAM. Organizations or individuals applying for federal financial assistance as of January 1, 2020, must validate the federally required common certifications and representations annually through SAM located at [SAM.gov](#).

If you fail to allow ample time to complete registration with SAM or Grants.gov, you will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Submission Dates and Times

Application Due Date

The due date for applications under this NOFO is *October 06, 2021, at 11:59 p.m. ET*. HRSA suggests submitting applications to Grants.gov at least **3 calendar days before the deadline** to allow for any unforeseen circumstances. See Section 8.2.5 – Summary of emails from Grants.gov of HRSA's [SF-424 Application Guide](#) for additional information.

5. Intergovernmental Review

The RWHAP Part A Emergency Relief Grant Program is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

See Section 4.1 ii of HRSA's [SF-424 Application Guide](#) for additional information.

6. Funding Restrictions

You may request funding for a program period of up to one year, at no more than ceiling amounts as posted in [Appendix B](#) (inclusive of direct **and** indirect costs).

The General Provisions in Division H of the Consolidated Appropriations Act, 2021 (P.L. 116-260) apply to this program. Please see Section 4.1 of HRSA's *SF-424 Application Guide* for additional information. Note that these or other restrictions will apply in the following fiscal years, as required by law.

You cannot use funds under this notice for the following purposes:

- Cash payment to intended recipients of RWHAP services;
- Construction (minor alterations and renovations to an existing facility to make it more suitable for the purpose of the program are allowable with prior HRSA approval);
- International travel;
- Pre-exposure prophylaxis (PrEP) or Post-Exposure Prophylaxis (PEP) medications or the related medical services (see the [June 22, 2016, RWHAP and PrEP program letter](#));
- [Syringe Services Programs](#) (SSPs). Some aspects of SSPs are allowable with HRSA's prior approval and in compliance with HHS and HRSA policy;
- Payment for any item or service to the extent that payment has been made (or reasonably can be expected to be made), with respect to that item or service, under any state compensation program, insurance policy, federal or state benefits program, or any entity that provides health services on a prepaid basis, (except for a program administered by or providing the services of the Indian Health Service); and
- Development of materials designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

Please see [PCN 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D](#) and [Frequently Asked Questions](#) for information regarding the statutory ten (10) percent limitation on administrative costs. You can find other non-allowable costs in [45 CFR part 75 – Subpart E Cost Principles](#).

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

Be aware of the requirements for HRSA recipients and subrecipients at 2 CFR § 200.216 regarding prohibition on certain telecommunications and video surveillance services or equipment. For details, see the [HRSA Grants Policy Bulletin Number: 2021-01E](#).

All program income generated as a result of awarded funds must be used for approved project-related activities. The program income alternative applied to the award(s) under the program will be the addition/additive alternative. You can find post-award requirements for program income at [45 CFR § 75.307](#).

For RWHAP Part A, allowable costs are limited to core medical services, support services, CQM, and administrative expenses [Section 2604(a)(2) of the PHS Act]. Program income may be utilized for elements of the program that are otherwise limited by statutory provisions, such as administrative and CQM activities that might exceed statutory caps, or unique services that are needed to maintain a comprehensive program approach, but that would still be considered allowable under the award. (See [PCN 15-03 Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income](#).)

V. Application Review Information

1. Review Criteria

HRSA has procedures for assessing the technical merit of applications to provide for an objective review and to assist you in understanding the standards against which your application will be reviewed. HRSA has critical indicators for each review criterion to assist you in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation.

The RWHAP Part A HIV Emergency Relief Grant Program is both a formula-based and competitive program. These criteria are the basis upon which the reviewers will evaluate and score the merit of the application. The entire proposal will be considered during objective review.

Review criteria are used to review and rank applications. The RWHAP Part A HIV Emergency Relief Grant Program has six review criteria. **See the review criteria outlined below with specific detail and scoring points. If any request for information is not applicable, state “Not Applicable” and provide justification.**

Criterion 1: NEED (66 points) – [Corresponds to Section IV ii, Project Narrative: Introduction, Needs Assessment, Demonstrated Need, including the Epidemiologic Overview, HIV Care Continuum, Unmet Need, Co-occurring Conditions, Complexities of Providing Care, and Subpopulations of Focus and associated attachments. Note: This section includes ELIHA, which is worth 33 points, per Section 2603\(b\)\(2\)\(A\) of the PHS Act.](#)

The extent to which the application demonstrates the problem and associated contributing factors to the problem.

A. Demonstrated Need (33 points)

Provides a description of the demonstrated needs of people with HIV, both those in care and not in care. The needs assessment provides information on the size, geographic distribution, and the socio-demographics of the HIV population within the EMA/TGA. It also provides information on strategies for reducing barriers to accessing care as well as services focused on individuals who are aware of and those unaware of their HIV status.

1) Epidemiological Profile (12 points)

- a) Clarity and completeness of the HIV/AIDS Demographics Table(s) (**Attachment 3**), including use of the most recent data available and clearly cited sources of data.
- b) Provides a brief description of the HIV epidemic in the EMA/TGA geographic area.
- c) Identifies the socio-demographic characteristics of (1) persons newly diagnosed, (2) people with HIV, and (3) persons at higher risk for HIV in the service area and includes demographic and socioeconomic data, as available.
- d) Clearly describes any increases in rates of HIV cases within new and emerging populations, how emerging populations were identified, and justifies the need for HIV-related services.

2) HIV Care Continuum (4 points)

- a) Provides a clear graphic depiction for each step of the diagnosis-based HIV care continuum of the jurisdiction using the CDC surveillance data on [TargetHIV](#).

3) Unmet Need (6 points)

- a) Completeness of Unmet Need Framework estimates (**Attachment 4**).
- b) Identifies method utilized for the Unmet Need Framework estimates.
- c) Describes the need(s) of the populations that are late-diagnosed, have unmet need, and are in care but not virally suppressed.

4) Co-occurring Conditions (2 points)

Completeness of table that quantifies the co-occurring conditions required by the NOFO and includes incidence and prevalence estimates and clear citations for the data sources used (**Attachment 5**). Provides justification if data are not available.

5) Complexities of Providing Care (3 points)

- a) Demonstrates a thorough understanding of both the impact and response to a funding reduction. Provides a clear description of cost containment measures, PC/PB response to the reduction in funding, and any transitional planning for clients receiving services that were either eliminated or reduced.
- b) Provides a description of health care coverage options available and demonstrates thorough understanding of these options that affect access to direct health care services and health outcomes.
- c) Demonstrates a thorough understanding of relevant factors that limit access to health care in the jurisdiction.

6) Subpopulations of Focus (6 points)

- a) Identifies three subpopulations of focus and clearly describes the specific needs for each.
- b) Clearly identifies how data in the unmet need framework inform the process of identifying the subpopulations of focus.

B. Early Identification of Individuals with HIV/AIDS (EIIHA) (33 points)

- 1) Clearly describes primary EIIHA activities, including system-level interventions, to be undertaken to positively impact HIV outcomes.
- 2) Describes major collaborations with other programs and agencies, including HIV prevention and surveillance programs and the Ending the HIV Epidemic in the U.S. effort, if applicable.
- 3) Provides comprehensive description of the anticipated outcomes for each of the four EIIHA components.
- 4) Provides clarity and completeness of plans to address legal barriers that increase HIV stigma and discrimination and that can pose complex barriers for people with or at risk for HIV, including program/policy efforts to expand implementation of routine HIV testing, if applicable.
- 5) Identifies EIIHA activities for each required component and describes how they align with the needs of the subpopulations of focus.

Criterion 2: RESPONSE (12 points) – [Corresponds to Section IV ii. Project Narrative: Methodology/Planning Responsibilities, Work Plan/Funding for Core and Support Services, Resolution of Challenges, and associated attachments.](#)

The extent to which the proposed project responds to the “Purpose” included in the program description.

A. Methodology (4 points)

- 1) Signed Letter from PC Chair(s) or PB (**Attachment 6**) that provides assurance/concurrence that the PC/PB have met the legislative responsibilities including Planning, PSRA, Training, and Assessment of Administrative Mechanism. Includes the year of the most recent comprehensive needs assessment and the date of annual membership training.

2) Coordination of Services and Funding Streams table (Attachment 7)

Completeness of the Coordination of Services and Funding Streams table that includes (1) public funding sources for HIV prevention, care, and treatment services in the jurisdiction (RWHAP Parts B-D and F, Ending the HIV Epidemic in the U.S. (as applicable), CARES Act funding (as applicable), federal/state and local); (2) the dollar amount and the percentage of the total available funds in the FY 2021 period of performance for each funding source; and 3) how the resources are being used.

B. Work Plan (6 points)

Funding for Core Medical and Support Services

1) Service Category Plan Table (Attachment 9) (2 points)

Completeness of the Service Category Plans that illustrates how RWHAP Part A and MAI core medical and support services are funded in the EMA/TGA as evidenced by the inclusion of complete data on service categories, priority number, funding amount (actual for 2021 and anticipated for 2022), number of unduplicated clients (actual for 2021 and anticipated for 2022), service unit definition, number of service units, and priority populations/subpopulations of focus (for MAI services only) for FY 2021 and FY 2022.

2) MAI Service Category Plan Narrative (2 points)

- a) Clearly describes how the unique needs of the three subpopulations of focus, identified in the Demonstrated Need section, will be met via specific, population-tailored services included in the MAI Service Category Plan Table.
- b) Clearly describes how specific MAI services may prevent new HIV infections, improve health outcomes, and decrease health disparities and inequities among the identified subpopulations of focus.

3) Unmet Need (2 points)

- a) Identifies specific interventions for individuals with unmet need (i.e., late diagnosed, unmet need, and in care but not virally suppressed) as outlined in Attachment 4.
- b) Describes how activities related to re-engaging individuals with unmet need into care intersect with plans or strategies identified in the jurisdiction's Ending the HIV Epidemic in the U.S., Getting to Zero, and/or 90/90/90 efforts.

C. Resolution of Challenges (2 points)

Completeness of Resolution of Challenges Table (Challenges/Barriers, Proposed Resolutions, Intended Outcomes, and Current Status) that identifies three challenges/barriers and the strength and feasibility of approaches to resolve these barriers when implementing RWHAP Part A activities.

Criterion 3: EVALUATIVE MEASURES (2 points) – [Corresponds to Section IV ii. Project Narrative: Evaluation and Technical Support Capacity/CQM](#)

Clinical Quality Management (CQM) Program

- 1) Clearly identifies the changes that have been made to the clinical quality management program.
- 2) Describes how CQM data have improved patient care, health outcomes, patient satisfaction, and/or changes to service delivery.

Criterion 4: IMPACT (10 points) – [Corresponds to Section IV ii. Project Narrative: Methodology/Impact of Funding, Work Plan/HIV Care Continuum Services Table, and associated attachments.](#)

HIV Care Continuum Services Table and Narrative

- 1) Strength and completeness of HIV Care Continuum Services Table which includes each step as a percentage of the number of people with diagnosed HIV, baseline indicators for each step, desired target outcome to be achieved during the budget period, and how RWHAP-funded services will aid in achieving the desired target outcomes (**Attachment 8**).
- 2) Clearly demonstrates an understanding of changes over a three (3) year period in the HIV care continuum, while describing the impact on the program and how the impact was addressed.

Criterion 5: RESOURCES/CAPABILITIES (5 points) – [Corresponds to Section IV ii. Project Narrative: Organizational Information/Grant Administration and associated attachments.](#)

The extent to which project personnel are qualified by training and/or experience to implement and carry out the project. The capabilities of the applicant organization and the quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project.

1) Program Organization (2 points)

Completeness and appropriateness of the Staffing Plan, Job Descriptions, and Biographical Sketches for Key Personnel (**Attachment 1**) and Program Organizational Chart (**Attachment 11**). Demonstrates the capacity of the department/unit to carry out the project. Attachments include names of staff, staffing levels (FTEs, including any vacancies), fiscal and/or management agents, planning and evaluation bodies, and in-kind support staff.

2) Recipient Accountability (3 points)

a) Monitoring

Clearly describes how subrecipient monitoring was performed to ensure fiscal and program compliance. Describes process for ensuring compliance with single audit requirements.

b) Third Party Reimbursement

Provides clear description of the process used to ensure pursuance of third party reimbursement. Includes FPL level to determine eligibility and methods used to ensure RWHAP is the payor of last resort. Describes monitoring, tracking and use of program income.

c) Fiscal Oversight

Identifies and describes the process used to ensure adequate reporting, reconciliation and tracking of program expenditures separately by formula, supplemental, MAI, and carryover funds, and timely subrecipient reimbursement.

Criterion 6: SUPPORT REQUESTED (5 points) – [Corresponds to Section IV ii. Project Narrative: Organizational Information/MOE, Budget and associated attachments.](#)

The reasonableness of the proposed budget for the budget period in relation to the objectives, the complexity of the activities, and the anticipated results.

- 1) The extent to which costs, as outlined in the budget, are reasonable given the scope of work, and aligned with demonstrated need and the Service Category Table. The budget narrative clearly justifies each line item to illustrate the impact and support to the overall program.
- 2) The extent to which the budget reflects that key personnel have adequate time (FTEs) devoted to the project and allocated to appropriate budget categories.

2. Review and Selection Process

The objective review process provides an objective evaluation to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3, below. See Section 5.3 of HRSA's [SF-424 Application Guide for more details](#).

3. Assessment of Risk

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory or other requirements ([45 CFR § 75.205](#)).

HRSA reviews applications receiving a favorable objective review for other considerations that include past performance, as applicable, cost analysis of the project/program budget, assessment of your management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. HRSA may ask you to submit additional programmatic or administrative information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that HRSA will make an award. Following review of all

applicable information, HRSA's approving and business management officials will determine whether HRSA can make an award, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

HRSA is required to review and consider any information about your organization that is in the [Federal Awardee Performance and Integrity Information System \(FAPIIS\)](#). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider any of your comments, in addition to other information in [FAPIIS](#) in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

HRSA will report to FAPIIS a determination that an applicant is not qualified ([45 CFR § 75.212](#)).

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award (NOA) prior to the start date of March 1, 2022. See Section 5.4 of HRSA's [SF-424 Application Guide](#) for additional information.

2. Administrative and National Policy Requirements

See Section 2.1 of HRSA's [SF-424 Application Guide](#).

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

Accessibility Provisions and Non-Discrimination Requirements

Federal funding recipients must comply with applicable federal civil rights laws. HRSA supports its recipients in preventing discrimination, reducing barriers to care, and promoting health equity. For more information on recipient civil rights obligations, visit the HRSA Office of Civil Rights, Diversity, and Inclusion [website](#).

Requirements of Subawards

The terms and conditions in the NOA apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NOA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients.

under awards, and it is the recipient's responsibility to monitor the compliance of all funded subrecipients. See [45 CFR § 75.101 Applicability](#) for more details.

3. Reporting

Award recipients must comply with Section 6 of HRSA's [SF-424 Application Guide](#) and the following reporting and review activities:

- 1) **Program Terms Report and Program Submission.** The recipient must submit a Program Terms Report and Program Submission to HRSA 60 days after the final award is issued. Further information will be available in the NOA.
- 2) **Estimated Unobligated Balance (UOB).** The recipient must submit an estimate of anticipated UOB and an estimate of anticipated carryover funding to HRSA no later than December 31, 2022. Further information will be available in the NOA.
- 3) **RWHAP Part A & MAI Final Expenditure Report.** The recipient must submit a RWHAP Part A & MAI Final Expenditure Report no later than 90 days after the end of the FY 2022 budget period. Further information will be available in the NOA.
- 4) **RWHAP Part A Progress Report.** The recipient must submit a RWHAP Part A Progress Report no later than 90 days after the end of the FY 2022 budget period. Further information will be available in the NOA.
- 5) **Carryover Request.** If applicable, the recipient must submit a Carryover Request no later than 30 days after the Federal Financial Report (FFR) submission deadline. Further information will be available in the NOA.
- 6) **Ryan White HIV/AIDS Program Services Report (RSR).** Acceptance of this award indicates that you assure that you will comply with data requirements of the RSR and that you will mandate compliance by each of your subrecipients. The RSR captures information necessary to demonstrate program performance and accountability. All RWHAP core medical and support service providers are required to submit client-level data as instructed in the RSR manual. Please refer to the Ryan White HIV/AIDS Program Client Level Data website at <http://hab.hrsa.gov/manageyourgrant/clientleveldata.html> for additional information. Further information will be available in the NOA.
- 7) **Integrity and Performance Reporting.** The NOA will contain a provision for integrity and performance reporting in [FAPIS](#), as required in [45 CFR part 75 Appendix XII](#).

Please note that the OMB revisions to Guidance for Grants and Agreements termination provisions located at [2 CFR § 200.340 - Termination](#) apply to all federal awards effective August 13, 2020.

VII. Agency Contacts

You may request additional information and/or technical assistance regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Olusola Dada
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: (301) 443-0195
Email: ODada@hrsa.gov

You may request additional information regarding the overall program issues and/or TA related to this NOFO by contacting:

Chrissy Abrahms Woodland
Director, Division of Metropolitan HIV/AIDS Programs
Attn: HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 09W12
Rockville, MD 20857
Telephone: (301) 443-1373
Fax: (301) 443-5271
Email: CAbrahms@hrsa.gov

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, 7 days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
Email: support@grants.gov
Self-Service Knowledge Base:
<https://grants-portal.psc.gov/Welcome.aspx?pt=Grants>

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Contact Center, Monday–Friday, 8 a.m. to 8 p.m. ET, excluding federal holidays at:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
Web: <http://www.hrsa.gov/about/contact/ehbhelp.aspx>

VIII. Other Information

Technical Assistance

HRSA has scheduled following technical assistance:

Webinar

Day and Date: Thursday, July 29, 2021

Time: 2 p.m. to 4 p.m. ET

Call-In Number: 1-833-568-8864

Meeting ID: 161 128 0187

Passcode: 08815036

Web link: <https://hrsa->

[gov.zoomgov.com/j/1611280187?pwd=cU02Y0lCUkh6bnBqQ2c3eEZoZDZZZz09](https://hrsa.gov.zoomgov.com/j/1611280187?pwd=cU02Y0lCUkh6bnBqQ2c3eEZoZDZZZz09)

Playback Number: Recorded webinar will be available on the [TargetHIV website](#).

Tips for Writing a Strong Application

See Section 4.7 of HRSA's [SF-424 Application Guide](#).

508 Compliance Disclaimer

Note: Persons using assistive technology may not be able to fully access information in this file. For assistance, please email or call one of the HRSA staff above in [Section VII. Agency Contacts](#).

Appendix: A
FY 2022 AGREEMENTS AND COMPLIANCE ASSURANCES
Ryan White HIV/AIDS Program
Part A HIV Emergency Relief Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area
_____, (hereinafter referred to as the EMA/TGA) assure that:

Pursuant to Section 2602(a)(2)^{5, 6}

The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)

The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last 5 years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2602(b)(4)

The EMA/TGA Planning Council will determine the size and demographics of the population of people with HIV, as well as the size and demographics of the estimated population of people with HIV who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying people with HIV who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

Pursuant to Section 2603(c)

The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)

The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council/Planning Body.

Pursuant to Section 2604(a)

The EMA/TGA will expend funds according to priorities established by the Planning Council/Planning Body, and for core medical services, support services, and administrative expenses only.

⁵ All statutory references are to the Public Health Service Act, unless otherwise specified.

⁶ TGAs are exempted from the requirement related to Planning Councils, but must provide a process for obtaining community input as described in **section 2609(d)(1)(A)** of the PHS Act. TGAs that have currently operating Planning Councils are strongly encouraged to maintain that structure.

Pursuant to Section 2604(c)

The EMA/TGA will expend not less than 75 percent of service dollars for core medical services, unless waived by the Secretary.

Pursuant to Section 2604(f)

The EMA/TGA will, for each of such populations in the eligible area expend, from the grants made for the area under Section 2601(a) for a FY, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of people with HIV, unless a waiver from this provision is obtained.

Pursuant to Section 2604(g)

The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)

The EMA/TGA will expend no more than 10 percent of the grant on administrative costs (including Planning Council or planning body expenses), and in accordance with the legislative definition of administrative activities, and the allocation of funds to subrecipients will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)

The EMA/TGA will establish a CQM Program that meets HRSA requirements, and that funding for this program shall not exceed the lesser of five percent of program funds or \$3 million.

Pursuant to Section 2604(i)

The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)

With regard to the use of funds,

- a. funds received under Part A of Title XXVI of the Act will be used to supplement, not supplant, state funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease;
- b. during the period of performance, political subdivisions within the EMA/TGA will maintain at least their prior FY's level of expenditures for HIV related services for individuals with HIV disease;
- c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV related services as required in the above paragraph; and
- d. documentation of this MOE will be retained.

Pursuant to Section 2605(a)(3)

The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the health care system for the purpose of facilitating EIS for individuals diagnosed with HIV infection.

Pursuant to Section 2605(a)(5)

The EMA/TGA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)

Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any state compensation program, insurance policy, or any Federal or state health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)

Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)

Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)

A program of outreach services will be provided to low-income individuals with HIV disease to inform them of the HIV primary medical care and support services.

Pursuant to Section 2605(a)(8)

The EMA/TGA has participated in the Statewide Coordinated Statement of Need (SCSN) process initiated by the state, and the services provided under the EMA/TGA comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)

The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)

The EMA/TGA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

Pursuant to Section 2605(e)

The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)

Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684

No funds shall be used to fund AIDS programs, or to develop materials, designed to directly promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual.

Signature_____ Date_____

Appendix: B

Geographic Service Areas

Applications must propose to serve the entire service area, as defined here in Appendix B.

The “Funding Ceiling” column identifies the total funding available for the delivery of comprehensive primary health care and support services for low income, uninsured and underserved people with HIV for each service area. The Total Funding Ceiling includes the MAI Funding Ceiling; therefore do not combine these amounts when developing your budget.

EMA	City	State	Total Funding Ceiling	MAI Funding Ceiling	Service area
Atlanta EMA	Atlanta	GA	\$29,599,128	\$2,767,944	Barrow County, Bartow County, Carroll County, Cherokee County, Clayton County, Cobb County, Coweta County, DeKalb County, Douglas County, Fayette County, Forsyth County, Fulton County, Gwinnett County, Henry County, Newton County, Paulding County, Pickens County, Rockdale County, Spalding County, and Walton County
Baltimore EMA	Baltimore	MD	\$16,379,484	\$1,557,179	Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Harford County, Howard County, and Queen Anne's County

Boston EMA*	Boston	MA	\$15,701,855	\$1,074,921	MA: Bristol County, Essex County, Middlesex County, Norfolk County, Plymouth County, Suffolk County, and Worcester County NH: Hillsborough County, Rockingham County, and Strafford County
Chicago EMA	Chicago	IL	\$28,882,503	\$2,456,210	Cook County, DeKalb County, DuPage County, Grundy County, Kane County, Kendall County, Lake County, McHenry County, and Will County
Dallas EMA	Dallas	TX	\$19,379,742	\$1,589,277	Collin County, Dallas County, Denton County, Ellis County, Henderson County, Hunt County, Kaufman County, and Rockwall County
Detroit EMA	Detroit	MI	\$10,067,461	\$859,579	Lapeer County, Macomb County, Monroe County, Oakland County, St. Clair County, and Wayne County
Fort Lauderdale EMA	Fort Lauderdale	FL	\$16,511,090	\$1,312,622	Broward County
Houston EMA	Houston	TX	\$25,664,273	\$2,383,866	Chambers County, Fort Bend County, Harris County, Liberty County, Montgomery County, and Waller County
Los Angeles EMA	Los Angeles	CA	\$46,176,072	\$3,814,344	Los Angeles County
Miami EMA	Miami	FL	\$27,754,540	\$2,733,660	Miami-Dade County

Nassau-Suffolk EMA	Mineola	NY	\$5,700,311	\$449,068	Nassau County and Suffolk County
New Haven EMA	New Haven	CT	\$5,539,970	\$448,472	Fairfield County and New Haven County
New Orleans EMA	New Orleans	LA	\$8,135,706	\$657,056	Jefferson Parish, Orleans Parish, Plaquemines Parish, St. Bernard Parish, St. Charles Parish, St. James Parish, St. John the Baptist Parish, and St. Tammany Parish
New York EMA	New York	NY	\$95,184,657	\$8,646,965	Bronx County, Kings County, New York County, Putnam County, Queens County, Richmond County, Rockland County, and Westchester County
Newark EMA	Newark	NJ	\$12,764,340	\$1,236,502	Essex County, Morris County, Sussex County, Union County, and Warren County
Orlando EMA	Orlando	FL	\$10,967,467	\$877,168	Lake County, Orange County, Osceola County, and Seminole County
Philadelphia EMA*	Philadelphia	PA	\$23,744,330	\$2,007,042	PA: Bucks County, Chester County, Delaware County, Montgomery County, and Philadelphia County NJ: Burlington County, Camden County, Gloucester County, and Salem County
Phoenix EMA	Phoenix	AZ	\$10,239,470	\$645,926	Maricopa County and Pinal County
San Diego EMA	San Diego	CA	\$11,903,092	\$779,286	San Diego County

San Francisco EMA	San Francisco	CA	\$15,590,728	\$789,223	Marin County, San Francisco County, and San Mateo County
San Juan EMA	San Juan	PR	\$11,025,271	\$1,175,686	Aguas Buenas Municipality, Barceloneta Municipality, Bayamón Municipality, Canóvanas Municipality, Carolina Municipality, Cataño Municipality, Ceiba Municipality, Comerío Municipality, Corozal Municipality, Dorado Municipality, Fajardo Municipality, Florida Municipality, Guaynabo Municipality, Humacao Municipality, Juncos Municipality, Las Piedras Municipality, Loíza Municipality, Luquillo Municipality, Manatí Municipality, Morovis Municipality, Naguabo Municipality, Naranjito Municipality, Río Grande Municipality, San Juan Municipality, Toa Alta Municipality, Toa Baja Municipality, Trujillo Alto Municipality, Vega Alta Municipality, Vega Baja, and Yabucoa Municipality
Tampa-St. Petersburg EMA	Tampa	FL	\$10,869,868	\$715,289	Hernando County, Hillsborough County, Pasco County, and Pinellas County

Washington, DC EMA*	Washington	DC	\$33,053,503	\$2,978,616	District of Columbia MD: Calvert County, Charles County, Frederick County, Montgomery County, and Prince George's County VA: Alexandria City, Arlington County, Clarke County, Culpeper County, Fairfax City, Fairfax County, Falls Church City, Fauquier County, Fredericksburg City, King George County, Loudoun County, Manassas City, Manassas Park City, Prince William County, Spotsylvania County, Stafford County, and Warren County WV: Berkeley County and Jefferson County
West Palm Beach EMA	West Palm Beach	FL	\$7,669,870	\$655,169	Palm Beach County

*Service area crosses state lines

Current TGA Recipient	City	State	Total Funding Ceiling	MAI Funding Ceiling	Service area
Austin TGA	Austin	TX	\$5,406,954	\$384,575	Bastrop County, Caldwell County, Hays County, Travis County, and Williamson County
Baton Rouge TGA	Baton Rouge	LA	\$4,697,727	\$459,999	Ascension Parish, East Baton Rouge Parish, East Feliciana Parish, Iberville Parish, Livingston Parish, Pointe Coupee Parish, St. Helena Parish, West Baton Rouge Parish, and West Feliciana Parish
Bergen-Passaic TGA	Paterson	NJ	\$4,027,421	\$349,894	Bergen County and Passaic County
Charlotte-Gastonia TGA*	Charlotte	NC	\$6,603,156	\$607,271	NC: Anson County, Cabarrus County, Gaston County, Mecklenburg County, and Union County SC: York County
Cleveland-Lorain-Elyria TGA	Cleveland	OH	\$4,856,204	\$389,444	Ashtabula County, Cuyahoga County, Geauga County, Lake County, Lorain County, and Medina County
Columbus TGA	Columbus	OH	\$4,795,162	\$302,393	Delaware County, Fairfield County, Franklin County, Licking County, Madison County, Morrow County, Pickaway County, and Union County
Denver TGA	Denver	CO	\$7,846,263	\$404,251	Adams County, Arapahoe County, Denver County, Douglas County, and Jefferson County

Fort Worth TGA	Fort Worth	TX	\$5,082,007	\$410,015	Hood County, Johnson County, Parker County, and Tarrant County
Hartford TGA	Hartford	CT	\$3,171,274	\$255,489	Hartford County, Middlesex County, and Tolland County
Indianapolis TGA	Indianapolis	IN	\$4,740,346	\$325,944	Boone County, Brown County, Hamilton County, Hancock County, Hendricks County, Johnson County, Marion County, Morgan County, Putnam County, and Shelby County
Jacksonville TGA	Jacksonville	FL	\$6,181,002	\$526,083	Clay County, Duval County, Nassau County, and St. Johns County
Jersey City TGA	Jersey City	NJ	\$5,019,080	\$461,788	Hudson County
Kansas City TGA*	Kansas City	MO	\$4,458,466	\$287,387	MO: Cass County, Clay County, Clinton County, Jackson County, Lafayette County, Platte County, Ray County, and Johnson County KS: Leavenworth County, Miami County, and Wyandotte County
Las Vegas TGA*	Las Vegas	NV	\$6,945,761	\$498,059	NV: Clark County and Nye County AZ: Mohave County
Memphis TGA*	Memphis	TN	\$7,111,304	\$715,886	TN: Fayette County, Shelby County, and Tipton County AR: Crittenden County MS: DeSoto County, Marshall County, Tate County, and Tunica County
Middlesex-Hunterdon-Somerset TGA	New Brunswick	NJ	\$2,913,504	\$243,564	Hunterdon County, Middlesex County, and Somerset County

Minneapolis–St. Paul TGA*	Minneapolis	MN	\$6,137,019	\$394,611	MN: Anoka County, Carver County, Chisago County, Dakota County, Hennepin County, Isanti County, Ramsey County, Scott County, Sherburne County, Washington County, and Wright County WI: Pierce County and St. Croix County
Nashville TGA	Nashville	TN	\$4,635,975	\$319,982	Cannon County, Cheatham County, Davidson County, Dickson County, Hickman County, Macon County, Robertson County, Rutherford County, Smith County, Sumner County, Trousdale County, Williamson County, and Wilson County
Norfolk TGA*	Norfolk	VA	\$6,043,710	\$548,342	VA: Chesapeake City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Suffolk City, Virginia Beach City, Williamsburg City, and York County NC: Currituck County
Oakland TGA	Oakland	CA	\$7,350,499	\$596,141	Alameda County and Contra Costa County
Orange County TGA	Santa Ana	CA	\$6,606,637	\$476,097	Orange County

Portland TGA*	Portland	OR	\$4,149,703	\$152,936	OR: Clackamas County, Columbia County, Multnomah County, Washington County, and Yamhill County WA: Clark County
Riverside-San Bernardino TGA	San Bernardino	CA	\$8,538,528	\$601,904	Riverside County and San Bernardino County
Sacramento TGA	Sacramento	CA	\$3,548,834	\$215,938	El Dorado County, Placer County, and Sacramento County
Saint Louis TGA*	St. Louis	MO	\$6,523,550	\$493,487	MO: Franklin County, Jefferson County, Lincoln County, St. Charles County, St. Louis City, St. Louis County, and Warren County IL: Clinton County, Jersey County, Madison County, Monroe County, and St. Clair County
San Antonio TGA	San Antonio	TX	\$6,010,982	\$567,521	Bexar County, Comal County, Guadalupe County, and Wilson County
San Jose TGA	San Jose	CA	\$3,368,231	\$260,160	Santa Clara County
Seattle TGA	Seattle	WA	\$7,227,581	\$386,265	Island County, King County, and Snohomish County

*Service area crosses state lines