U.S. Department of Health and Human Services

HRSA
Health Resources & Services Administration

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2025

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-25-054

Funding Opportunity Type(s): Competing Continuation

Assistance Listing Number: 93.914

Application Due Date: October 1, 2024

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

Issuance Date: July 3, 2024

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See Section VII for a complete list of agency contacts.

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

508 COMPLIANCE DISCLAIMER

Persons using assistive technology may not be able to fully access information in this file. For assistance, email or call one of the HRSA staff listed in Section VII Agency Contacts.

SUMMARY

Funding Opportunity Title:	Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program
Funding Opportunity Number:	HRSA-25-054
Assistance Listing Number:	93.914
Due Date for Applications:	October 1, 2024
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, high quality, community-based care for people with HIV through the provision of grant funds. The goal is to provide optimal HIV care and treatment for people with HIV and 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.
Program Objective(s):	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 people with HIV within the EMA/TGA and strengthen strategies to reach disproportionately impacted subpopulations.

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.
Anticipated FY 2025 Total Available Funding:	$654,000,000 of which approximately $10,300,000 will be used for priority funding, and $52,000,000 will be available for Minority AIDS Initiative (MAI) funding. *(**Note:** Estimated annual available funding level based on current projections.)*
Estimated Number and Type of Award(s):	Up to 52: competing continuation grants.
Estimated Award Amount:	Varies, see Appendix B, subject to the availability of appropriated funds
Cost Sharing or Matching Required:	No
Period of Performance:	March 1, 2025, through February 29, 2028 (3 years)
Agency Contacts:	**Business, administrative, or fiscal issues:** Olusola Dada Grants Management Specialist Division of Grants Management Operations, Office of Federal Assistance Management Email: ODada@hrsa.gov **Program issues or technical assistance:** Chrissy Abrahms Woodland Director, Division of Metropolitan HIV/AIDS Programs HIV/AIDS Bureau Email: CAbrahmswoodland@hrsa.gov

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in this NOFO and in *HRSA Application Guide (Application Guide)*. Visit HRSA's How to Prepare Your Application page for more information.

Technical Assistance

We have scheduled the following technical assistance (TA) webinar to assist potential applicants in preparing applications that address the requirements of this notice of funding opportunity. Participation is optional.:

Day and Date: Thursday, July 18, 2024
Time: 2 p.m. – 4 p.m. ET
Weblink: https://hrsa-gov.zoomgov.com/meeting/register/vJIsc-yopj4pG8D6XLCWgnjRaxHHko58xoc

Attendees without computer access or computer audio can use the following dial-in information:

Call-In Number: 833-568-8864
Meeting ID: 161 450 8531
Passcode: 47707377

We will record the webinar. 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 transitional grant area (TGA) that has been severely affected by the HIV epidemic. Grant funds assist eligible jurisdictions to develop or enhance access to comprehensive, high quality, community-based care for people with HIV through the provision of grant funds. The goal is to provide optimal HIV care and treatment for people with HIV and 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. Activities in each funded service category should lead to improvements in HIV care continuum outcomes.

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 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. Your application should describe how you have used data to develop and enhance the system of care in your jurisdiction. 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.

For more details, see Program Requirements and Expectations.

2. Background

The Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program is authorized by 42 USC §§ 300ff-11 to -20 and 300ff-121 (sections 2601–2610 and 2693 of the PHS Act).

The Ryan White HIV/AIDS Program

The HRSA Ryan White HIV/AIDS Program has five statutory funding parts that provide a comprehensive system of medical care, support, and medications for low-income people with HIV. The goal is better health results, and lower HIV spread in priority groups.

The HIV care continuum is key to the program. It shows the journey of someone with HIV from diagnosis to effective treatment, leading to viral suppression. Achieving viral suppression boosts the patient's quality of life and prevents HIV spread.

This continuum also helps programs and planners measure progress and use resources effectively. We encourage you to assess your outcomes and work with your community and public health partners to improve. To assess your program, learn more at HRSA's Performance Measure Portfolio.

Strategic Frameworks and National Objectives

To address health challenges faced by low-income people with HIV, using national objectives and strategic frameworks is crucial. These frameworks include:

Healthy People 2030

National HIV/AIDS Strategy (NHAS) (2022–2025)

Sexually Transmitted Infections National Strategic Plan for the United States (2021–2025)

Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025)

These strategies offer guidance on the main principles, priorities, and steps for our national health response. They serve as a blueprint for collective action.

Expanding the Effort

There have been significant accomplishments:

- From 2017 to 2021, HIV viral suppression among Ryan White program patients improved from 85.9% to 89.7%. For more, see the 2021 Ryan White Services Report (RSR).
- Racial, ethnic, age-based, and regional disparities in viral suppression rates have significantly reduced. For more, see the Annual Client-Level Data Report 2021.

- 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. 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 and in care but not yet virally suppressed, to the essential HIV care, treatment, and support services needed to help them reach viral suppression.

Using Data Effectively

HRSA and CDC promote integrated data sharing and use for program planning, quality improvement, and public health action.

We encourage you to:

- Follow the Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs.
- Create data-sharing agreements between surveillance and HIV programs.
- Progress towards NHAS goals through integrated data sharing, analysis, and use of HIV data by health departments.
- Complete CD4, viral load, and HIV nucleotide sequence reporting to the state and territorial health departments' HIV surveillance systems. CDC mandates the reporting of all such data to the National HIV Surveillance System (NHSS).
- Use HRSA's interactive RWHAP Compass Dashboard to visualize reach, impact, and outcomes of the Ryan White program and to inform planning and decision making. The dashboard gives you a look at national, state, and metro area data and displays client demographics, services, outcomes, and viral suppression. It also includes data about clients using the AIDS Drug Assistance Program (ADAP).
- Develop data-sharing strategies with others to reduce administrative burden.
- Use electronic data sources to verify client eligibility when you can. See Policy Clarification Notice 21-02, Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program.

Program Resources and Innovative Models

HRSA offers multiple projects and resources to help you. A full list of resources is available on TargetHIV. We urge you to learn about them and use them in your project. For some examples, see Helpful Websites.

Helpful Websites

Consider using these in Helpful Websites section of Contacts and Support.

Examples include:

- Access, Care, and Engagement Technical Assistance Center (ACE TA)
- Best Practices Compilation
- Center for Innovation and Engagement (CIE)
- Center for Quality Improvement and Innovation (CQII)
- Dissemination of Evidence-Informed Interventions (DEII)
- Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i)
- Ending Stigma through Collaboration and Lifting All to Empowerment (ESCALATE)
- Engage Leadership through Employment, Validation, and Advancing Transformation and Equity for persons with HIV (ELEVATE)
- Integrating HIV Innovative Practices (IHIP)
- AIDS Education Training Center Program – National Coordinating Resource Center

II. Award Information

1. Type of Application and Award

Application type: Competing Continuation.

We will fund you via a grant.

We will decide the amount of a recipient's funding using a formula to calculate RWHAP Part A formula and MAI funding, and a separate calculation using normalized competitive application scores for determining discretionary awards for supplemental funding, including priority funding, as described in the Summary of Funding section below.

2. Summary of Funding

We estimate $654,000,000 will be available to fund 52 RWHAP Part A recipients. Approximately $10,300,000 will be used for priority funding, and $52,000,000 will be available for MAI funding.

Notes:

- This program includes priority funding, as authorized by section 2603(b)(2)(C) of the PHS Act. Section 2603(b)(2)(C) of the PHS Act directs the Secretary to provide funds to eligible areas to address the decline or disruption of services related to the decline in the amount of formula funding. HRSA sets aside a portion of the RWHAP Part A supplemental funding to award priority funds in conformance with this statutory requirement. Applicants eligible for Part A supplemental funding that received more than a 20 percent reduction in their current RWHAP Part A formula award when compared to their FY 2006 formula award are eligible for priority funding. If determined eligible for priority funding, HRSA will calculate the additional amount to be awarded, and that amount will be included in the final award.
- 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 2025 federal appropriation. 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.
- The Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program is an annually funded program with a three-year period of performance. The period of performance is March 1, 2025, to February 29, 2028 (three years).

  Eligible applicants will submit a competitive application in the first year (FY 2025), and non-competing continuation (NCC) progress reports for years two and three (FY 2026 and FY 2027, 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.
- An annual SF-424A and Budget will need to be submitted in each year of the period of performance (i.e., in FY 2025 you will only include an SF-424A and Budget covering the FY 2025 budget period, same for FY 2026, and FY 2027).

Furthermore, assurances will be required with the competitive application and the NCC progress reports.

- 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.
- HRSA will send the Notice of Award (NOA) to the CEO or to the delegated administrative agency responsible for dispersing RWHAP Part A funds.
- 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.
- 45 CFR part 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, or any superseding regulation applies to all HRSA awards.
- If you have never received a negotiated indirect cost rate, you may elect to charge a *de minimis* rate of 10 percent of modified total direct costs (MTDC)*. You may use this for the life of the award. If you choose this method, you must use it for all federal awards until you choose to negotiate for a rate. You may apply to do so at any time. See Section 4.1.v. Budget Narrative in the *Application Guide*.

  ***Note:** One exception is that a governmental department or agency unit that receives more than $35 million in direct federal funding must negotiate an indirect cost rate.

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.

EMA Status:

EMAs must have more than 2,000 cases of AIDS reported and confirmed during the most recent five calendar years, and have a population of at least 50,000. For three consecutive years, the recipients must not have fallen below the required incidence levels already specified and required prevalence level of 3,000 living cases of AIDS.

TGA Status:

TGAs must have 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 and have a population of at least 50,000. For three consecutive years, recipients must not have fallen below **both** the required incidence levels already specified and required prevalence level of 1,500 or more living cases of AIDS. 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 in their service areas as listed in Appendix B. The supplemental portion of the award is open to all eligible Part A jurisdictions that did not have an unobligated balance of greater than five percent in a previous fiscal year, which will be determined annually and communicated to applicable recipients.

Native American tribal governments and tribal organizations are not eligible.

2. Cost Sharing or Matching

Cost sharing or matching is not required for this program.

3. Other

We may not consider an application for funding if it contains any of the following non-responsive criteria:

- Exceeds the funding ceiling amount
- Fails to satisfy the deadline requirements referenced in Section IV.4

Maintenance of Effort

You must agree to maintain non-federal funding for award activities. This must be at least at the same spending level for the fiscal year prior to the fiscal year for which you receive the award, as Section 2605(a)(1)(B) of the PHS Act requires.

Federal funds should add to, not replace, existing non-federal spending for such activities. Complete the Maintenance of Effort (MOE) information and submit as **Attachment 3**.

We will enforce statutory MOE requirements through all available mechanisms.

Multiple Applications

We will only review your **last** validated application before the Grants.gov due date.

IV. Application and Submission Information

1. Address to Request Application Package

We ***require*** you to apply online through Grants.gov. Use the SF-424 workspace application package associated with this notice of funding opportunity (NOFO). Follow these directions: How to Apply for Grants. If you choose to submit using an alternative online method, see Applicant System-to-System for additional guidance.

Note: Grants.gov calls the NOFO "Instructions."

Select "Subscribe" and enter your email address for HRSA-25-054 to receive emails about changes, clarifications, or instances where we republish the NOFO. You will also be notified by email of documents we place in the RELATED DOCUMENTS tab that may affect the NOFO and your application. *You are responsible for reviewing all information that relates to this NOFO.*

2. Content and Form of Application Submission

Application Format Requirements

Submit your information as the *Application Guide* and this program specific NOFO state. **Do so in English and budget figures expressed in U.S. dollars.** There is an Application Completeness Checklist in the *Application Guide* to help you.

Application Page Limit

The total number of pages that count toward the page limit shall be no more than **80 pages** when we print them. We will not review any pages that exceed the page limit. Using the pages within the page limit, HRSA will determine eligibility using Section III. Eligibility Information of the NOFO.

These items do not count toward the page limit:

- Standard OMB-approved forms you find in the NOFO's workspace application package
- Abstract (standard form (SF) "Project_Abstract Summary")
- Indirect Cost Rate Agreement

If there are other items that do not count toward the page limit, we will make this clear in Section IV.2.vi Attachments.

If you use an OMB-approved form that is not in the HRSA-25-054 workspace application package, it may count toward the page limit.

Applications must be complete and validated by Grants.gov under HRSA-25-054 before the deadline.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

- When you submit your application, you certify that you and your principals[1] (for example, program director, principal investigator) can participate in receiving award funds to carry out a proposed project. That is, no federal department or agency has debarred, suspended, proposed for debarment, claimed you ineligible, or you have voluntarily excluded yourself from participating.
- If you fail to make mandatory disclosures, we may take action as described in 45 CFR § 75.371. This includes suspending or debarring you.[2]
- If you cannot certify this, you must include an explanation in ***Attachment 14****: Other Relevant Documents*.

(See Section 4.1 viii "Certifications" of the *Application Guide*)

Program Requirements and Expectations

- **Policy Clarification Notices:** Information on the RWHAP and HAB Policy Clarification Notices (PCNs) are available online at https://ryanwhite.hrsa.gov/grants/policy-notices.

- **Program Letters:** Information on the RWHAP and HAB Program Letters are available online at https://ryanwhite.hrsa.gov/grants/program-letters. The following program letters have been updated recently:
  - Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations Letter
  - RWHAP Parts A and B Annual Site Visit Exemption
  - Supporting Community Engagement in the Ryan White HIV/AIDS Program

Program-Specific Instructions

In addition to application requirements and instructions in Section 4 of the SF 424 Application Guide (including the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract), also follow these program specific instructions:

[1] See definitions at eCFR :: 2 CFR 180.995 -- Principal. and eCFR :: 2 CFR 376.995 -- Principal (HHS supplement to government-wide definition at 2 CFR 180.995).
[2] See also 2 CFR parts 180 and 376, 31 U.S.C. § 3354, and 45 CFR § 75.113.

i. *Project Abstract*

Use the Standard OMB-approved Project Abstract Summary Form that you will find in the workspace application package. Do not upload the abstract as an attachment or it may count toward the page limit. For information you must include in the Project Abstract Summary Form, see Section 4.1.ix of the *Application Guide.*

- 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.

NARRATIVE GUIDANCE

The following table provides a crosswalk between the narrative sections and where each section falls within the review criteria. Make sure you address all information requested in each narrative section. We may consider other forms or attachments you reference in a narrative section during the merit review.

Narrative Section	**Review Criteria**
Introduction	*Criterion 1: NEED*
Organizational Information	*Criterion 5: RESOURCES/CAPABILITIES*
Needs Assessment	*Criterion 1: NEED*
Approach	*Criterion 2: RESPONSE*
Work Plan	*Criterion 2: RESPONSE* and *Criterion 4: IMPACT*
Resolution of Challenges	*Criterion 2: RESPONSE*
Evaluation and Technical Support Capacity	*Criterion 3: EVALUATIVE MEASURES* and *Criterion 5: RESOURCES/CAPABILITIES*
Budget Narrative	*Criterion 6: SUPPORT REQUESTED*

ii. *Project Narrative*

This section must describe all aspects of the proposed project. Make it brief and clear.

Provide the requested information in the following order, using the narrative section headers. This ensures reviewers can understand your proposed project.

- *INTRODUCTION – Corresponds to Section V's Review Criterion(a) #1 (Need)*
  This section must briefly describe how the EMA/TGA will utilize RWHAP Part A grant funds, as defined in Appendix B, to support a comprehensive continuum of high-quality care and treatment for people with HIV in the RWHAP Part A service area.
- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion(a) #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.

Unobligated Balance (UOB) Penalties

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 Policy Notice 12-02 Part A and Part B Unobligated Balances and Carryover.

Formula 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 formula 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.

MAI Funds

The UOB requirement does not apply to MAI 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 1***. 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. Submit a staffing plan (including vacant positions, job descriptions, and biographical sketches for key personnel) as ***Attachment 2***.

> **Note:** We expect 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.

b) If you administer the RWHAP Part A funds through a fiscal agent, describe the staffing, fiscal agent scope of work or services to be provided, and how you will monitor the performance of the work or services provided.

2) Grant Recipient Accountability

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 Part A National Monitoring Standards, which requires recipients to monitor the activities of subrecipients to ensure funding is used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward, as well as to ensure that performance goals are achieved. To meet the monitoring requirements, RWHAP Part A recipients must conduct annual subrecipient site visits.

a) **Monitoring** – Provide a narrative that describes your planned subrecipient monitoring process for the FY 2025 – FY 2027 period of performance.

   Note: see the RWHAP Parts A and B Annual Site Visit Exemption for guidance on requesting an exemption from this requirement.

b) **Payor of Last Resort** – Describe how your program complies with the requirements stated in PCN 21-02 Determining Client Eligibility and Payor of Last Resort in the Ryan White HIV/AIDS Program and PCN 15-03 Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income.

   Note: The RWHAP is the payor of last resort, and you must vigorously pursue alternate sources of payments. Recipients and subrecipients are required to use effective strategies to coordinate between RWHAP Part A and third-party payors 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.

c) **Fiscal Oversight** – Provide a narrative that describes the process used to coordinate fiscal activities, to include ensuring adequate reporting, reconciling, and tracking program expenditures by funding stream, and the process for timely invoice payments to subrecipients.

B. Maintenance of Effort (MOE)

RWHAP Part A funds are not intended to be the sole source of support for HIV care and treatment services in the EMA/TGA. 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 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 meet the MOE requirement annually.

You must submit the following information as ***Attachment 3***:

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 current FY.

2) A description of the process, methodology, and elements used to determine the amount of expenditures in the MOE calculations.

- *NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion(a) #1 (Need)*
  The purpose of this section is to demonstrate the severity of the HIV epidemic in the EMA/TGA.

A. Demonstrated Need

The Demonstrated Need section includes Epidemiologic Overview, Unmet Need, HIV care continuum, Early Identification of Individuals with HIV/AIDS (EIIHA).

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 people we have not yet successfully maintained in care.

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 4***.

a) Provide a summary of the HIV epidemic in your EMA/TGA jurisdiction, not to exceed one page.

b) Provide a brief description of the socio-demographic characteristics of (1) persons newly diagnosed, (2) people with HIV, and (3) persons at

higher risk for HIV in the EMA/TGA jurisdiction. This description should not exceed two pages.
Include the following, as available:

- **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) 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. Include estimates for the most recent three years of data available. If data are not available, provide a justification. The table must include:

- **i.** Hepatitis C virus
- **ii.** Sexually transmitted infection rates, including syphilis, gonorrhea, and chlamydia
- **iii.** Mental illness
- **iv.** Substance use disorder
- **v.** Homeless/unstably housed
- **vi.** Justice involved

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

d) Provide an overall description of health care coverage options available to all people with HIV in the jurisdiction, not to exceed one page.

2) 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.

The Unmet Need Framework broadly characterizes unmet need by including three components: (1) late diagnosed, (2) unmet need, and (3) in care, but not virally suppressed. In reporting estimates across each component of the unmet need framework, recipients must submit estimates using jurisdictional HIV surveillance data (i.e., required method). Additionally, recipients may also include estimates using RWHAP data

(i.e., enhanced method). Submit Unmet Need Framework estimates as ***Attachment 6*** in your application, and clearly identify the method utilized for the unmet need framework. Detailed information, training materials, and reporting tools of the unmet need framework are located on TargetHIV.

Based on the Unmet Need Framework estimates provided in ***Attachment 6,*** provide responses to the following:

a) 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.

3) HIV Care Continuum

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. For the purposes of this NOFO, you will use a diagnosis-based HIV care continuum. A diagnosis-based HIV care continuum depicts each step as a percentage of the number of people with diagnosed HIV.

The CDC data set provided on TargetHIV must be used to complete the HIV care continuum from FY 2025 – 2027. Detailed information, training materials, and reporting tools for the HIV care continuum are also located on TargetHIV.

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.

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

The purpose of this section is to provide 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) A brief description of the overall EIIHA strategy for your jurisdiction, including any adjustments to the strategy based on lessons learned from the prior period of performance.

b) Provide a description (can be in table format) of 1) activities, 2) anticipated outcomes, and 3) primary collaborators (e.g., other programs and agencies, including HIV prevention and surveillance programs) for each of the four EIIHA components listed below:

i. Identification of individuals unaware of their HIV status;

ii. Informing individuals that tested positive of their HIV diagnosis;

iii. Referral to care of newly diagnosed individuals; and,

iv. Linkage to care of newly diagnosed individuals.

Note: The EIIHA activities will remain the same for the three-year period of performance. Outcomes will be reported in FY 2026 and FY 2027 Reporting Requirements.

C) Subpopulations of Focus

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

A data driven process should be used to identify subpopulations of focus disproportionally affected by HIV. This should include an analysis of the jurisdictional needs assessment, outcomes in 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, monkeypox, 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 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 briefly describe the specific needs for each subpopulation.

2) Briefly describe how the 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) align with the needs of the identified subpopulations of focus for the jurisdiction. Indicate which EIIHA activities are not applicable.

Note: The subpopulations of focus will remain the same for the three-year period of performance. Updates will be reported in FY 2026 and FY 2027 Reporting Requirements.

This section will help reviewers understand whom you will serve with the proposed project.

- *APPROACH -- Corresponds to Section V's Review Criterion(a) #2 (Response)*

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, and further clarification is provided in Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations Letter.

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. Moreover, community engagement is an essential component for planning comprehensive, effective HIV prevention and care programs. HRSA and CDC support activities that facilitate collaboration and/or develop a joint planning body to address HIV prevention and care.

The PC/PB must be representative of various required categories of membership as cited in Sec. 2602(b)(1)-(2) of the PHS Act. The composition of the PC/PB must reflect the demographics of the HIV epidemic in the EMA/TGA, as indicated in most recent CDC surveillance data. HRSA HAB recognizes and understands the value of clients who receive RWHAP Part A services actively participating and being involved in the planning process for HIV service delivery, as this drives services that are tailored to the needs of clients in the jurisdiction. The Ryan White HIV/AIDS Program Part A Guidance for Planning Councils and Planning Bodies on Supporting People with Lived Experience program letter provides guidance on how to support the participation and meaningful engagement of people with lived experience in the PC/PB.

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 7***. The letter must address the following:

a) Planning:
- **i.** Include 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 2025 priority setting and allocation process to ensure that:
  - **a.** Needs of the populations with HIV are addressed (including identified subpopulations in the Subpopulations of Focus section)
  - **b.** Resources were allocated in accordance with the local demographic incidence of AIDS including appropriate allocations for women, infants, children, and youth
- **ii.** People with HIV were involved in the planning and allocation processes and how the input was considered in the process.
- **iii.** FY 2023 budget period formula, supplemental, and MAI funds awarded to the EMA/TGA were expended according to the priorities established by the PC or PB.

c) Training:

Ongoing, annual membership training occurred, include the date(s).

d) Assessment of the Efficiency of the Administrative Mechanism:
- **i.** Assessment of grant recipient activities compliance with 45 CFR 75.305(b) 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 2025 and FY 2026 NCC progress reports.

2) Resource Inventory

RWHAP Part A EMA/TGA planning efforts should expand the availability of services, reduce duplication of services, demonstrate coordination with all other HIV providers. Services should align with the HIV care continuum stages. 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:

a. 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), federal/state and local);

b. The dollar amount and the percentage of the total available funds in the FY 2024 period of performance for each funding source;

c. How the resources are being used (i.e., services delivered). Submit as ***Attachment 8***.

- *WORK PLAN -- Corresponds to Section V's Review Criterion(a) #2 (Response) & #4 (Impact)*

The purpose of this section is to provide tables and a narrative summary describing the EMA/TGA service provision and outcomes proposed for the FY 2025 budget period and three-year period of performance.

A. HIV Care Continuum Services Table and Narrative

1) 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 9***.

a) Using CDC HIV care continuum definitions and CDC surveillance data, develop a three-year diagnosis-based HIV care continuum Services Table that includes the following:

i. Baseline and FY 2027 target numerators and denominators

ii. Percentage for each step

iii. Service categories funded by RWHAP Part A that will aid in achieving the desired target outcomes.

iv. Methodology utilized to determine the FY 2027 targets projected to be achieved by the end of the three-year period of performance

Regardless of the format used for the HIV Care Continuum Services Table, use the provided CDC data and definitions, 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) How will planned service categories aid in addressing:

i. Significant issues and core service needs identified in the Integrated HIV Prevention and Care Plan; and

ii. impact the steps of the HIV care continuum.

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. The plan should consist of both RWHAP Part A and MAI funds.

Please indicate if you have submitted with this application a core medical services waiver for the FY 2025 budget period via the drop-down box on the suggested template. If you are not submitting a core medical services waiver for the FY 2025 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 a pending waiver request that is 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.

For every service category funded by RWHAP Part A in the jurisdiction, provide the following in table format (submit as ***Attachment 10***).

Service unit definitions must be provided. Also provide an explanation of service unit costs if amount differs from the average cost for the jurisdiction. See TargetHIV for a suggested template to utilize.

i. RWHAP Part A

a. FY 2024 budget period Part A service categories with priority number, allocated amount, projected number of unduplicated clients served, and projected 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 allocated expenditures for Part A core medical and Part A support services.

b. FY 2025 budget period Part A service categories with priority number, estimated funding amount, projected number of unduplicated clients to be served, 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 2024 budget period MAI service categories with a priority number, allocated amount, projected number of unduplicated clients served, projected number of service units provided, and for each MAI funded service, indicate which Subpopulation(s) of Focus will 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 allocated expenditures for MAI core medical and MAI support services.

b. FY 2025 budget period MAI service categories with a priority number, estimated funding amount, projected number of unduplicated clients to be served, 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.

iii. Service Unit Definitions

a. Provide service unit definitions and indicate funding stream (RWHAP Part A or MAI), when applicable. You may have multiple service unit definitions for a service category.

iv. Unit Cost Reasonableness Explanations (if applicable – not scored, counts toward page limit)
The average cost per service unit column will automatically populate based on the estimated expenditure amount and service units entered on the provided spreadsheet template.

a. If applicable, provide an explanation if the average service unit cost appears low or high for the EMA/TGA.

b) MAI Service Category Plan Narrative
HRSA HAB strongly encourages PCs and PBs to ensure that MAI funded services are prioritized to meet the specific needs of MAI subpopulations with the greatest need. Resources are available in the Background section and on TargetHIV to assist with using MAI funds effectively by tailoring services for locally identified MAI subpopulations.

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 minority subpopulations in metropolitan areas hardest hit by the epidemic.

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

i. Describe how the proposed MAI services will address the needs of any MAI population identified in the Subpopulations of Focus section.
ii. Describe how the MAI services may prevent new HIV infections, improve health outcomes, and decrease health disparities and inequities among the identified Subpopulations of Focus.

2) **Unmet Need**

a) 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 6.*** This information can be provided as a table.

3) **Core Medical Services Waiver (if applicable – not scored, counts toward page limit)** Submit as ***Attachment 11.***

a) If you are planning to request a HRSA RWHAP Core Medical Services Waiver for FY 2025, the "HRSA RWHAP Core Medical Services Waiver Request Attestation Form" must be included as ***Attachment 11.*** Submission must be in accordance with the PCN 21-01 Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement.

> **Note:** If applicable, the Core Medical Services Waiver Attestation Forms will only be accepted on an annual basis for each budget period in the three-year period of performance, either with the application or NCC Progress Report.

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion(a) #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(a) #3 (Evaluative Measures) and #5 (Resources/Capabilities)*

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.

Quality improvement entails the development and implementation of activities to make changes to the program in response to the performance data results. Quality Improvement activities aimed at improving client care, health outcomes, and client satisfaction. Recipients are expected to implement quality improvement activities using a defined approach or methodology.

1) Provide information for at least one quality improvement activity for FY 2025, in table format, with the following headers: methodology used, related service category, key activities, timeline, person(s)/organization(s) responsible and intended outcome/impact.

If key activities are not well defined by the application submission deadline, indicate this in the table and provide detailed information for each table header, as available.

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

iii. *Budget*

The *Application Guide* directions may differ from those on Grants.gov.

Follow the instructions in Section 4.1.iv Budget of the *Application Guide* and any specific instructions listed in this section. Your budget should show a well-organized plan.

Reminder: The total project or program costs are all allowable (direct and indirect) costs used for the HRSA activity or project. This includes costs charged to the award and non-federal funds used to satisfy a matching or cost-sharing requirement (which may include MOE, if applicable).

Program Income

You must use any program income you generate from awarded funds for approved project-related activities. Use program income under the addition alternative (45 CFR § 75.307(e)(2)). Find post-award requirements for program income at 45 CFR § 75.307.

Specific Instructions

The RWHAP Part A HIV Emergency Relief Grant Program requires 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. Sections A, B, D, E, and F of SF-424A should be completed as outlined below:

a. Section A – Budget Summary

   i. Complete the "Grant Program Function of Activity", column (a), with the three required headings listed below:

      1. Row 1 should be titled "Administrative (Part A + MAI)"
      2. Row 2 should be titled "CQM (Part A + MAI)"
      3. Row 3 should be titled "HIV Services (Part A + MAI)".

   ii. Input the Catalog of Federal Domestic Assistance Number (CFDA) in column (b). The CFDA for the RWHAP Part A is: 93.914.
   iii. Enter amounts for each row (Administration, CQM, HIV Services) in Federal column (c). These amounts should correspond to applicable amounts on the budget narrative.
   iv. Ensure the totals in column (g), which auto-populate, do not exceed the published funding ceiling amounts located in Appendix B.
   v. Do not enter amounts in column (c), (d), and (f).

b. Section B – Budget Categories

   i. Complete columns (1), (2), and (3) in Section B with the following headings:

      1. Column 1 should be titled: "Administrative (Part A + MAI)"
      2. Column 2 should be titled: "CQM (Part A + MAI)"
      3. Column 3 should be titled: "HIV Services (Part A + MAI)"

ii. Provide the budgeted amounts for each object class category listed, as applicable. Amounts entered should correspond to applicable amounts in the budget narrative.
iii. Ensure the total in row k (5), which auto-populates, matches the total in Section A row 5 (g) and does not exceed the published ceiling amounts found in Appendix B.
Ensure that amounts in row k, columns 1, 2, 3, match the amounts in Section A column (g), rows 1, 2, 3.

c. Section C – Non-Federal Resources
   i. Do not enter any amounts

d. Section D – Forecasted Cash Needs
   i. Complete only line 13, "Federal", in the first column titled "Total for 1st Year" since no cost sharing/matching is required.

e. Section E – Budget Estimates of Federal Funds Needed for Balance of the Project
   i. Complete line 16 of the Future Funding Periods columns for the outyears, with (b) First being the 2nd year, (c) Second being the 3rd year.

f. Section F – Other Budget Information
   i. Include the Direct Charges, line 21, and Indirect Charges (i.e., indirect costs), line 22. Amounts entered should correspond to applicable amounts in the budget narrative.
   ii. Ensure direct charge amounts reconcile with the amount in Section B row (i), column (5); and that the indirect charge amounts reconcile with the amount in Section B row (j), column (5).

As required by the Further Consolidated Appropriations Act, 2024 (P.L. 118-47), Division D, § 202, "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." Effective January 2024, the salary rate limitation is $221,900. As required by law, salary rate limitations may apply in future years and will be updated.

iv. *Budget Narrative*

See Section 4.1.v. of the *Application Guide.*

In addition, the RWHAP Part HIV Emergency Relief Grant Program requires 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 section (i.e., HIV Service Category Table, HIV Care Continuum Services Table and Narrative, and MAI Service Category Plan Narrative). 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. Additionally, you must show a separate CQM contractual budget narrative/justification if the EMA/TGA contracts with a third party to provide CQM for the program.

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 the *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. All costs charged to the RWHAP Part A must be reasonable, allowable, and allocable[3]. **In order for HRSA HAB to determine reasonableness, allowability, and allocability of budgeted amounts, recipients will be required to submit a revised budget narrative if the budget narrative does not include a justification of costs, and cost breakdown, across all object class categories as prescribed in *Section v of the Application Guide*.**

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

[3] Reasonable, allowable, and allocable definitions can be found in 45 CFR Part 75

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.

> **Note:** Negotiated indirect cost rate agreement or other indirect cost documentation is only required to be submitted in the competitive application, as applicable. If documentation expires during the three-year period of performance or if indirect costs are included in the budget for the first time in the second- or third-year budget periods, the recipient is required to submit a current (i.e., not expired) agreement.

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.

Note: 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 applicable, a core medical services waiver must be submitted with the application and your budget must be consistent with the core medical services waiver request. For further guidance on core medical services waiver requests,

refer to PCN 21-02 Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement.

2) **Support Services Costs**
Support services are those services needed by people with HIV to achieve optimal HIV medical outcomes.

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

v. *Attachments*

Provide the following attachments in the order we list them.

Most attachments count toward the application page limit. Indirect cost rate agreement and proof of non-profit status (if it applies) are the only exceptions. They will not count toward the page limit.

Clearly label each attachment. Upload attachments into the application. Reviewers will not open any attachments you link to.

Attachment 1: 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 2: Staffing Plan, Job Descriptions, and Biographical Sketches for Key Personnel (required; see Section 4.1.vi. of the Application Guide*).*

Attachment 3: 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 current FY using a table like 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)	Current FY of Application (Estimated)
Actual prior FY non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services Amount: $	Estimated current FY non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services Amount: $

Attachment 4: HIV/AIDS Demographics Table (required).

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

Attachment 6: Unmet Need Framework (required).

Attachment 7: Letter of Assurance from Planning Council Chair/Letter of Concurrence from Planning Body (required).

Attachment 8: Coordination of Services and Funding Streams Table (required).

Attachment 9: HIV Care Continuum Services Table (required).

Attachment 10: Service Category Plan Table(s) (required).

Attachment 11: Core Medical Services Waiver Request Attestation Form (if applicable)

Attachment 12: FY 2025 Agreements and Compliance Assurances, Certifications (required).

Submit the RWHAP Part A Grant Program FY 2025 Agreements and Compliance Assurances signed by the CEO or the CEO's designee (see Appendix A).

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. Unique Entity Identifier (UEI) and System for Award Management (SAM)

A UEI is required to apply for this funding. You must register in the SAM.gov to receive your UEI.

You cannot use a DUNS number to apply. For more details, visit the following webpage: General Service Administration's UEI Update

After you register with SAM, maintain it. Keep your information updated when you have: an active federal award, application, or plan that an agency is considering.[4]

When you register, you must submit a notarized letter naming the authorized Entity Administrator.

We will not make an award until you comply with all relevant SAM requirements. If you have not met the requirements by the time we are ready to make an award, we will deem you unqualified and award another applicant.

If you already registered on Grants.gov, confirm that the registration is active and that the Authorized Organization Representative (AOR) has been approved.

To register in Grants.gov, submit information in two systems:

- System for Award Management (SAM) (SAM Knowledge Base)
- Grants.gov

Effective March 3, 2023, individuals assigned a SAM.gov Entity Administrator role must be an employee, officer, or board member, and cannot be a non-employee. This change is to ensure entities are in control of who has permission to control roles within their entity.

Here is what this means:

- Entity Administrators assigning roles to non-employees will only be able to assign a Data Entry role or lower.

[4] Unless 2 CFR § 25.110(b) or (c) exempts you from those requirements or the agency approved an exemption for you under 2 CFR § 25.110(d)).

- Any entities assigning Entity Administrator roles using an Entity Administrator Role Request Letter (formerly called "notarized letter") will no longer be able to assign the Entity Administrator role to a non-employee.
- Entity Administrator roles assigned to non-employees will be converted to Data Entry roles. With a Data Entry role, non-employees can still create and manage entity registration data entry but cannot manage roles.

If you are an entity using a non-employee or if you are a non-employee working with an entity to manage registrations, please read (and share) more about this change on the BUY.GSA.gov blog to know what to expect.

For more details, see Section 3.1 of the *Application Guide.*

> **Note:** Allow enough time to register with SAM.gov and Grants.gov. We do not grant application extensions or waivers if you fail to register in time.

4. Submission Dates and Times

Application Due Date

Your application is due on *October 1, 2024, at 11:59 p.m. ET*. We suggest you submit your application to Grants.gov at least 3 calendar days before the deadline to allow for any unexpected events. See the *Application Guide's* Section 8.2.5 – Summary of emails from Grants.gov.

5. Intergovernmental Review

The RWHAP Part A Emergency Relief Grant Program must follow the terms of Executive Order 12372 in 45 CFR part 100.

See Section 4.1 ii of the *Application Guide* for more 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 D that reference the Further Consolidated Appropriations Act, 2024 (P.L. 118-47) apply to this program. See Section 4.1 of the *Application Guide* for information. Note that these and other restrictions will apply in fiscal years that follow, as the law requires.

Program-specific Restrictions

You cannot use funds under this notice for the following:

- 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 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 must have policies, procedures, and financial controls in place. Anyone who receives federal funding must comply with legal requirements and restrictions, including those that limit specific uses of funding.

- Follow the list of statutory restrictions on the use of funds in Section 4.1 (**Funding Restrictions**) of the *Application Guide.* We may audit the effectiveness of these policies, procedures, and controls.
- 2 CFR § 200.216 prohibits 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

We review your application on its technical merit. Our process helps you understand the criteria we use in our review. We have measures for each review criterion to help you present information and to help reviewers evaluate the applications.

The RWHAP Part A HIV Emergency Relief Grant Program is both a formula-based and competitive program. We review your application on its technical merit. Our process also helps you understand the criteria we use in our review.

We distribute RWHAP Part A HIV Emergency Relief Grant Program funds among eligible jurisdictions with complete applications (see Eligibility Information section for reference). Funding is determined using 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.

We use six review criteria to review and rank RWHAP Part A HIV Emergency Relief Grant Program applications. Here are descriptions of the review criteria and their scoring points.

Criterion 1: NEED (66 points) – Corresponds to Section IV's, Project Narrative: Introduction, Needs Assessment, Demonstrated Need, including the Epidemiologic Overview, HIV care continuum, Unmet Need, Co-occurring Conditions, and Subpopulations of Focus and associated attachments. **Note:** *This section includes EIIHA, 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 of the jurisdiction, 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 4**), including use of the most recent data available and clearly cited sources of data.
- **b)** Clarity and completeness of the overall description of health care coverage options available to all people with HIV in the jurisdiction that does not exceed one page.

c) In less than two pages, clearly describes 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) 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.

2) Unmet Need (4 points)

a) Completeness of Unmet Need Framework estimates (**Attachment 6**).

b) Clearly describes the need(s) of the populations that are 1) late diagnosed, 2) have unmet need, and 3) are in care but not virally suppressed.

3) HIV Care Continuum (5 points)

a) Clarity of graphic depiction for each step of the diagnosis-based HIV care continuum of the jurisdiction using the CDC surveillance data on TargetHIV.

4) Subpopulations of Focus (12 points)

a) Identifies three subpopulations of focus and clearly describes the specific needs of each.

b) Provides a description of how activities for required of EIIHA components align with the needs of the identified subpopulations of focus. Indicates which EIIHA activities are not applicable.

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

1) Clearly describes the overall EIIHA strategy for the three-year period of performance, to include potential adjustments based on lessons learned from the previous period of performance.

2) Clarity and completeness of the EIIHA table that includes (1) the four EIIHA components, (2) activities for each component, (3) anticipated outcomes for each component, and (4) identification of primary collaborators.

Criterion 2: RESPONSE (12 points) – Corresponds to Section IV's, Project Narrative: Approach, Work Plan, and Resolution of Challenges

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

A. Approach (4 points)

1) Signed Letter from PC Chair(s) or PB (**Attachment 7**) **(2 points)**
Completeness of assurance/concurrence that the PC/PB have met the legislative responsibilities including Planning, PSRA, Training, and

Assessment of the Efficiency of the 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 8) (2 points)**
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), federal/state and local); (2) the dollar amount and the percentage of the total available funds in the FY 2024 period of performance for each funding source; and 3) how the resources are being used.

B. Work Plan (8 points)
Funding for Core Medical and Support Services

1) **Service Category Plan Table (Attachment 10) (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 (allocated for FY 2024 and estimated for FY 2025), number of unduplicated clients (allocated for FY 2024 and estimated for FY 2025), number of service units, average cost per service unit, subpopulations of focus (for MAI services only) for FY 2024 and FY 2025, and service unit definitions.

2) **MAI Service Category Plan Narrative (2 points)**
   a) Clearly describes how the proposed services included in the MAI Service Category Plan Table will address the needs of any MAI population identified in the Demonstrated Need Subpopulations of Focus section.

   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 6.

C. Resolution of Challenges (2 points)
Completeness of Resolution of Challenges Table (RWHAP Part A Activities, Challenges/Barriers, and Proposed Resolutions) that identifies at least three challenges/barriers.

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

Clinical Quality Management (CQM) Program (2 points)

1) Provides one quality improvement activity for FY 2025, in table format that includes the following elements: (1) Methodology Used, (2) Key Activities, (3) Timeline, (4) Person(s) Responsible and (5) Intended Outcome/Impact.

Criterion 4: IMPACT (10 points) – Corresponds to Section IV's, Project Narrative: Work Plan.

HIV Care Continuum Services Table and Narrative

1) HIV Care Continuum Services Table (6 points)

a) Strength and completeness of HIV care continuum Services Table utilizing CDC data and definitions 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 three-year period of performance, the RWHAP-funded services that will aid in achieving the desired target outcomes, and the methodology utilized to determine target outcomes (**Attachment 9**).

2) HIV Care Continuum Narrative (4 points)

a) Clearly demonstrates an understanding of how the RWHAP service categories can address issues identified in the Integrated HIV Prevention and Care Plan and impact the HIV care continuum steps.

Criterion 5: RESOURCES/CAPABILITIES (5 points) – Corresponds to Section IV's, Project Narrative: Organizational Information and Evaluation and Technical Support
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 2**) and Program Organizational Chart (**Attachment 1)**. 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 is planned to ensure fiscal and program compliance.

b) **Payor of Last Resort**

Provides clear description of the process used to ensure pursuance of third-party reimbursement, including 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 invoice payments to subrecipients.

Criterion 6: SUPPORT REQUESTED (5 points) – Corresponds to Section IV's , Project Narrative: Budget Narrative

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. Review and Selection Process

Subject matter experts provide an impartial evaluation of your application. Then, they pass along the evaluations to us, and we decide who receives awards. See Section 5.3 of the *Application Guide* for details. When we make award decisions, we consider the following when selecting applications for award:

- How high your application ranks
- Funding availability
- Risk assessments
- Other pre-award activities, as described in Section V.3 of this NOFO

3. Assessment of Risk

If you have management or financial instability that directly relates to your ability to carry out statutory, regulatory, or other requirements, we may decide not to fund your high-risk application (45 CFR § 75.205).

First, your application must get a favorable merit review. Then we:

- Review past performance (if it applies)
- Analyze the cost of the project/program budget
- Assess your management systems
- Ensure you continue to be eligible
- Make sure you comply with any public policies.

We may ask you to submit additional information (for example, an updated budget) or to begin activities (for example, negotiating an indirect cost rate) as you prepare for an award.

However, even at this point, we do not guarantee that you will receive an award. After a full review we will decide whether to make an award, and if so, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and final. You cannot appeal them to any HRSA or HHS official or board.

We review information about your organization in the Federal Awardee Performance and Integrity Information System (FAPIIS). You may comment on anything that a federal awarding agency previously entered about your organization. We will consider your comments, and other information in FAPIIS. We will use this to judge your organization's integrity, business ethics, and record of performance under federal awards when we complete the review of risk. We will report to FAPIIS if we decide not to make an award because we have determined you do not meet the minimum qualification standards for an award (45 CFR § 75.212).

VI. Award Administration Information

1. Award Notices

The Notice of Award (NOA) is issued on or around the start date listed in the NOFO. See Section 5.4 of the *Application Guide* for more information.

2. Administrative and National Policy Requirements

See Section 2.1 of the *Application Guide*.

If you receive an NOA and accept the award, you agree to conduct the award activities in compliance/accordance with:

- All provisions of 45 CFR part 75, or any superseding regulation.
- Other federal regulations and HHS policies in effect at the time of the award or started during the award period. In particular, the following provision of 2 CFR

part 200, which became effective on or after August 13, 2020, is incorporated into this NOFO: 2 CFR § 200.301 Performance measurement.

- Any statutory provisions that apply.

Accessibility Provisions and Non-Discrimination Requirements

If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS-690). To learn more, see the HHS Office for Civil Rights website.

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws or call 1-800-368-1019 or TDD 1-800-537-7697.

The HRSA Office of Civil Rights, Diversity, and Inclusion (OCRDI) offers technical assistance, individual consultations, trainings, and plain language materials to supplement OCR guidance and assist HRSA recipients in meeting their civil rights obligations. Visit OCRDI's website to learn more about how federal civil rights laws and accessibility requirements apply to your programs, or contact OCRDI directly at HRSACivilRights@hrsa.gov.

Executive Order on Worker Organizing and Empowerment

Executive Order on Worker Organizing and Empowerment (E.O. 14025) encourages you to support worker organizing and collective bargaining. Bargaining power should be equal between employers and employees.

This may include developing policies and practices that you could use to promote worker power. Describe your plans and activities to promote this in the application narrative.

Subaward Requirements

If you receive an award, you must follow the terms and conditions in the NOA. You will also be responsible for how the project, program, or activity performs; how you and others spend award funds; and all other duties.

In general, subrecipients must comply with the award requirements (including public policy requirements) that apply to you. You must make sure your subrecipients comply with these requirements. 45 CFR § 75.101 Applicability gives details.

3. Reporting

Award recipients must comply with Section 6 of the *Application Guide* **and** the following reporting and review activities:

1) **Federal Financial Report**. The Federal Financial Report (SF-425) is required. The report is an accounting of expenditures under the project that year.

Financial reports must be submitted electronically. Visit Reporting Requirements | HRSA. More specific information will be included in the NOA.

2) **Progress Report(s).** The non-competing continuation (NCC) renewal is used to capture changes to specific information provided in the competitive application and to reaffirm certain agreements and assurances. A progress report will be submitted at the end of each budget period in the three-year period of performance, as outlined in the RWHAP Part A Annual Progress Report below.

3) **Other Required Reports and Products**:

   a. **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.

   b. **Estimated Unobligated Balance (UOB)/Estimated Carryover.** The recipient must indicate if UOB is projected and indicate the intended use of anticipated carryover funding to HRSA no later than December 31, 2025. Further information will be available in the NOA.

   c. **RWHAP Part A & MAI Expenditure Report.** The recipient must submit a RWHAP Part A & MAI Expenditure Report no later than 90 days after the end of the FY 2025 budget period. Further information will be available in the NOA.

   d. **RWHAP Part A Annual Progress Report.** The recipient must submit a RWHAP Part A Progress Report no later than 90 days after the end of the FY 2025 budget period. Further information will be available in the NOA.

   e. **Final UOB Report and Carryover Request.** If applicable, the recipient must submit a Final UOB Report and Carryover Request no later than 30 days after the Federal Financial Report (FFR) submission deadline. Further information will be available in the NOA.

   f. **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 (i.e., subrecipients) 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 https://ryanwhite.hrsa.gov/grants/manage/reporting-requirements/rsr for additional information. Further information will be available in the NOA.

4) **Integrity and Performance Reporting.** The NOA will contain a provision for integrity and performance reporting in FAPIIS, as 45 CFR part 75 Appendix I, F.3. and 45 CFR part 75 Appendix XII require.

VII. Agency Contacts

Business, administrative, or fiscal issues:

Olusola Dada
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
Call: 301-443-0195
Email: ODada@hrsa.gov

Program issues or technical assistance:

Chrissy Abrahms Woodland
Director, Division of Metropolitan HIV/AIDS Programs
Attn: HIV/AIDS Bureau
Health Resources and Services Administration
Call: 301-443-1373
Email: CAbrahmswoodland@hrsa.gov

You may need help applying through Grants.gov. Always get a case number when you call.

Grants.gov Contact Center (24 hours a day, 7 days a week, excluding federal holidays)
Call: 1-800-518-4726 (International callers: 606-545-5035)
Email: support@grants.gov
Search the Grants.gov Knowledge Base

Once you apply or become an award recipient, you may need help submitting information and reports through HRSA's Electronic Handbooks (EHBs). Always get a case number when you call.

HRSA Contact Center (Monday – Friday, 7 a.m. – 8 p.m. ET, excluding federal holidays)
Call: 877-464-4772 / 877-Go4-HRSA
TTY: 877-897-9910
Electronic Handbooks Contact Center

The EHBs login process changed on May 26, 2023, for applicants, recipients, service providers, consultants, and technical analysts. To enhance EHBs' security, the EHBs now uses **Login.gov** and **two-factor authentication**. Applicants, recipients, service providers, consultants, and technical analysts must have a Login.gov account for the new login process. For step-by-step instructions on creating a Login.gov account refer to the EHBs Wiki Help page.

VIII. Other Information

Technical Assistance

See TA details in Summary.

Tips for Writing a Strong Application

See Section 4.7 of the *Application Guide*.

Appendix: A

FY 2025 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.

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[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(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.

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

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

The "Total Funding Ceiling" column identifies the total funding available for the delivery of comprehensive HIV primary health care and support services for people with HIV for each service area.

The Total Funding Ceiling includes the Part A Funding Ceiling and MAI Funding Ceiling; do not combine these amounts when developing your budget.

EMA	City	State	Service area	FY 2025 Part A Funding Ceiling (Formula + Supplemental)	FY 2025 MAI Funding Ceiling	FY 2025 Total Funding Ceiling
Atlanta EMA	Atlanta	GA	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	$30,893,716	$2,993,579	$33,887,295
Baltimore EMA	Baltimore	MD	Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Harford County, Howard County, and Queen Anne's County	$15,328,837	$1,469,316	$16,798,153

EMA	City	State	Service area	FY 2025 Part A Funding Ceiling (Formula + Supplemental)	FY 2025 MAI Funding Ceiling	FY 2025 Total Funding Ceiling
Boston EMA*	Boston	MA	**MA**: Bristol County, Essex County, Middlesex County, Norfolk County, Plymouth County, Suffolk County, and Worcester County **NH**: Hillsborough County, Rockingham County, and Strafford County	$14,754,589	$1,054,398	$15,808,987
Chicago EMA	Chicago	IL	Cook County, DeKalb County, DuPage County, Grundy County, Kane County, Kendall County, Lake County, McHenry County, and Will County	$26,764,473	$2,444,305	$29,208,778
Dallas EMA	Dallas	TX	Collin County, Dallas County, Denton County, Ellis County, Henderson County, Hunt County, Kaufman County, and Rockwall County	$20,273,070	$1,724,841	$21,997,911
Detroit EMA	Detroit	MI	Lapeer County, Macomb County, Monroe County, Oakland County, St. Clair County, and Wayne County	$9,841,899	$867,007	$10,708,906
Fort Lauderdale EMA	Fort Lauderdale	FL	Broward County	$15,648,980	$1,318,906	$16,967,886
Houston EMA	Houston	TX	Chambers County, Fort Bend County, Harris County, Liberty County, Montgomery County, and Waller County	$25,948,562	$2,537,858	$28,486,420
Los Angeles EMA	Los Angeles	CA	Los Angeles County	$44,914,743	$3,856,573	$48,771,316

EMA	City	State	Service area	FY 2025 Part A Funding Ceiling (Formula + Supplemental)	FY 2025 MAI Funding Ceiling	FY 2025 Total Funding Ceiling
Miami EMA	Miami	FL	Miami-Dade County	$26,051,291	$2,730,600	$28,781,891
Nassau-Suffolk EMA	Mineola	NY	Nassau County and Suffolk County	$5,550,554	$446,164	$5,996,718
New Haven EMA	New Haven	CT	Fairfield County and New Haven County	$5,290,014	$432,882	$5,722,896
New Orleans EMA	New Orleans	LA	Jefferson Parish, Orleans Parish, Plaquemines Parish, St. Bernard Parish, St. Charles Parish, St. James Parish, St. John the Baptist Parish, and St. Tammany Parish	$7,966,186	$649,515	$8,615,701
New York EMA	New York	NY	Bronx County, Kings County, New York County, Putnam County, Queens County, Richmond County, Rockland County, and Westchester County	$88,435,319	$8,249,232	$96,684,551
Newark EMA	Newark	NJ	Essex County, Morris County, Sussex County, Union County, and Warren County	$12,027,627	$1,201,082	$13,228,709
Orlando EMA	Orlando	FL	Lake County, Orange County, Osceola County, and Seminole County	$11,189,511	$929,503	$12,119,014
Philadelphia EMA*	Philadelphia	PA	**PA**: Bucks County, Chester County, Delaware County, Montgomery County, and Philadelphia County **NJ:** Burlington County, Camden County, Gloucester County, and Salem County	$22,095,704	$1,947,207	$24,042,911

EMA	City	State	Service area	FY 2025 Part A Funding Ceiling (Formula + Supplemental)	FY 2025 MAI Funding Ceiling	FY 2025 Total Funding Ceiling
Phoenix EMA	Phoenix	AZ	Maricopa County and Pinal County	$10,724,991	$707,806	$11,432,797
San Diego EMA	San Diego	CA	San Diego County	$11,879,324	$824,101	$12,703,425
San Francisco EMA	San Francisco	CA	Marin County, San Francisco County, and San Mateo County	$14,923,564	$782,342	$15,705,906
San Juan EMA	San Juan	PR	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,	$10,063,826	$1,113,645	$11,177,471

EMA	City	State	Service area	FY 2025 Part A Funding Ceiling (Formula + Supplemental)	FY 2025 MAI Funding Ceiling	FY 2025 Total Funding Ceiling
			and Yabucoa Municipality			
Tampa-St. Petersburg EMA	Tampa	FL	Hernando County, Hillsborough County, Pasco County, and Pinellas County	$10,599,743	$740,678	$11,340,421
Washington, DC EMA*	Washington	DC	**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	$31,253,330	$2,934,142	$34,187,472
West Palm Beach EMA	West Palm Beach	FL	Palm Beach County	$7,423,262	$651,521	$8,074,783

*Service area crosses state lines

Current TGA Recipient	City	State	Service area	FY 2025 Part A Funding Ceiling (Formula + Supplemental)	FY 2025 MAI Funding Ceiling	FY 2025 Total Funding Ceiling
Austin TGA	Austin	TX	Bastrop County, Caldwell County, Hays County, Travis County, and Williamson County	$5,459,538	$417,880	$5,877,418
Baton Rouge TGA	Baton Rouge	LA	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	$4,382,265	$452,090	$4,834,355
Bergen-Passaic TGA	Paterson	NJ	Bergen County and Passaic County	$3,848,120	$348,600	$4,196,720
Charlotte-Gastonia TGA*	Charlotte	NC	**NC:** Anson County, Cabarrus County, Gaston County, Mecklenburg County, and Union County **SC:** York County	$6,470,722	$638,334	$7,109,056
Cleveland-Lorain-Elyria TGA	Cleveland	OH	Ashtabula County, Cuyahoga County, Geauga County, Lake County, Lorain County, and Medina County	$4,732,075	$398,576	$5,130,651
Columbus TGA	Columbus	OH	Delaware County, Fairfield County, Franklin County, Licking County, Madison County, Morrow County, Pickaway County, and Union County	$4,855,129	$322,607	$5,177,736
Denver TGA	Denver	CO	Adams County, Arapahoe County, Denver County, Douglas County, and Jefferson County	$7,642,615	$415,395	$8,058,010

Current TGA Recipient	City	State	Service area	FY 2025 Part A Funding Ceiling (Formula + Supplemental)	FY 2025 MAI Funding Ceiling	FY 2025 Total Funding Ceiling
Fort Worth TGA	Fort Worth	TX	Hood County, Johnson County, Parker County, and Tarrant County	$5,318,190	$458,875	$5,777,065
Hartford TGA	Hartford	CT	Hartford County, Middlesex County, and Tolland County	$2,879,163	$242,911	$3,122,074
Indianapolis TGA	Indianapolis	IN	Boone County, Brown County, Hamilton County, Hancock County, Hendricks County, Johnson County, Marion County, Morgan County, Putnam County, and Shelby County	$4,784,902	$353,090	$5,137,992
Jacksonville TGA	Jacksonville	FL	Clay County, Duval County, Nassau County, and St. Johns County	$5,979,511	$537,806	$6,517,317
Jersey City TGA	Jersey City	NJ	Hudson County	$4,701,233	$459,830	$5,161,063
Kansas City TGA*	Kansas City	MO	**MO:** Cass County, Clay County, Clinton County, Jackson County, Lafayette County, Platte County, and Ray County **KS:** Johnson County, Leavenworth County, Miami County, and Wyandotte County	$4,450,237	$298,908	$4,749,145
Las Vegas TGA*	Las Vegas	NV	**NV:** Clark County and Nye County **AZ:** Mohave County	$7,210,857	$557,013	$7,767,870
Memphis TGA*	Memphis	TN	**TN:** Fayette County, Shelby County, and Tipton County **AR:** Crittenden County	$6,623,786	$719,082	$7,342,868

Current TGA Recipient	City	State	Service area	FY 2025 Part A Funding Ceiling (Formula + Supplemental)	FY 2025 MAI Funding Ceiling	FY 2025 Total Funding Ceiling
			MS: DeSoto County, Marshall County, Tate County, and Tunica County			
Middlesex-Hunterdon-Somerset TGA	New Brunswick	NJ	Hunterdon County, Middlesex County, and Somerset County	$2,740,472	$247,210	$2,987,682
Minneapolis –St. Paul TGA*	Minneapolis	MN	**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	$6,097,438	$415,109	$6,512,547
Nashville TGA	Nashville	TN	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	$4,560,048	$330,921	$4,890,969
Norfolk TGA*	Norfolk	VA	**VA:** Chesapeake City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport	$5,759,157	$554,146	$6,313,303

Current TGA Recipient	City	State	Service area	FY 2025 Part A Funding Ceiling (Formula + Supplemental)	FY 2025 MAI Funding Ceiling	FY 2025 Total Funding Ceiling
			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	Alameda County and Contra Costa County	$7,158,567	$614,636	$7,773,203
Orange County TGA	Santa Ana	CA	Orange County	$6,618,663	$505,603	$7,124,266
Portland TGA*	Portland	OR	**OR:** Clackamas County, Columbia County, Multnomah County, Washington County, and Yamhill County **WA:** Clark County	$4,154,402	$163,597	$4,317,999
Riverside-San Bernardino TGA	San Bernardino	CA	Riverside County and San Bernardino County	$8,780,773	$680,094	$9,460,867
Sacramento TGA	Sacramento	CA	El Dorado County, Placer County, and Sacramento County	$3,686,579	$239,375	$3,925,954
Saint Louis TGA*	St. Louis	MO	**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	$6,281,706	$502,258	$6,783,964
San Antonio TGA	San Antonio	TX	Bexar County, Comal County, Guadalupe County, and Wilson County	$5,962,036	$596,384	$6,558,420

Current TGA Recipient	City	State	Service area	FY 2025 Part A Funding Ceiling (Formula + Supplemental)	FY 2025 MAI Funding Ceiling	FY 2025 Total Funding Ceiling
San Jose TGA	San Jose	CA	Santa Clara County	$3,314,159	$276,452	$3,590,611
Seattle TGA	Seattle	WA	Island County, King County, and Snohomish County	$7,302,440	$409,852	$7,712,292

*Service area crosses state lines

Appendix C: Page Limit Worksheet

The purpose of this worksheet is to give you a tool to ensure the number of pages uploaded into your application is within the specified page limit. (Do not submit this worksheet as part of your application.)

The Standard Forms listed in column 1 do not count against the page limit; however, attachments to the Standard Forms listed in column 2 do count toward the page limit. For example, the Budget Narrative Attachment Form does not count, however the attachment uploaded in that form does count against the page limit.

Standard Form Name ***(Forms themselves do not count against the page limit)***	**Attachment File Name** ***(Unless otherwise noted, attachments count against the page limit)***	**# of Pages** *Applicant Instruction – enter the number of pages of the attachment to the Standard Form*
Application for Federal Assistance (SF-424 - Box 14)	Areas Affected by Project (Cities, Counties, States, etc.)	*My attachment = ___ pages*
Application for Federal Assistance (SF-424 - Box 16)	Additional Congressional District	*My attachment = ___ pages*
Application for Federal Assistance (SF-424 - Box 20)	Is the Applicant Delinquent On Any Federal Debt?	*My attachment = ___ pages*
Attachments Form	Attachment 1: Program Organizational Chart (required)	*My attachment = ___ pages*
Attachments Form	Attachment 2: Staffing Plan, Job Descriptions, and Biographical Sketches for Key Personnel (required)	*My attachment = ___ pages*
Attachments Form	Attachment 3: Maintenance of Effort Documentation (required)	*My attachment = ___ pages*
Attachments Form	Attachment 4: HIV/AIDS Demographics Table (required)	*(Does not count against the page limit)*
Attachments Form	Attachment 5: Co-occurring Conditions Table (required)	*My attachment = ___ pages*
Attachments Form	Attachment 6: Unmet Need Framework (required)	*My attachment = ___ pages*

Standard Form Name *(Forms themselves do not count against the page limit)*	**Attachment File Name** *(Unless otherwise noted, attachments count against the page limit)*	**# of Pages** *Applicant Instruction – enter the number of pages of the attachment to the Standard Form*
Attachments Form	Attachment 7: Letter of Assurance from Planning Council Chair/Letter of Concurrence from Planning Body (required)	*My attachment =___ pages*
Attachments Form	Attachment 8: Coordination of Services and Funding Streams Table (required)	*My attachment =___ pages*
Attachments Form	Attachment 9: HIV Care Continuum Services Table (required)	*My attachment =___ pages*
Attachments Form	Attachment 10: Service Category Plan Table(s) (required).	*My attachment =___ pages*
Attachments Form	Attachment 11: Core Medical Services Waiver Request Attestation Form (if applicable, counts towards page limit)	*My attachment =___ pages*
Attachments Form	Attachment 12: FY 2025 Agreements and Compliance Assurances, Certifications (required).	*My attachment =___ pages*
Attachments Form	Attachment 13: Federally Negotiated Indirect Cost Rate Agreement, Cost Allocation Plan, 10 percent de minimis, etc. (if applicable, not counted in the page limit).	*My attachment =___ pages*

Standard Form Name *(Forms themselves do not count against the page limit)*	**Attachment File Name** *(Unless otherwise noted, attachments count against the page limit)*	**# of Pages** *Applicant Instruction – enter the number of pages of the attachment to the Standard Form*
Attachments Form	Attachment 14: Other Relevant Documents – Letters of Agreement, Memorandum of Understanding, Intergovernmental Agreements, and Other Relevant Documents **(optional**—will count toward page limit**)**.	*My attachment =* ___ *pages*
Project/Performance Site Location Form	Additional Performance Site Location(s)	*My attachment =* ___ *pages*
Project Narrative Attachment Form	Project Narrative	*My attachment =* ___ *pages*
Budget Narrative Attachment Form	Budget Narrative	*My attachment =* ___ *pages*
# of Pages Attached to Standard Forms		Applicant Instruction: Total the number of pages in the boxes above.
Page Limit for HRSA-25-054 is 80 pages		**My total =** ____ **pages**