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Part I. Overview

Applicants must go to the synopsis page of this announcement at www.grants.gov and click on the "Subscribe" button link to ensure they receive notifications of any changes to CDC-RFA-PS22-2203. Applicants also must provide an e-mail address to www.grants.gov to receive notifications of changes.

A. Federal Agency Name:

Centers for Disease Control and Prevention (CDC) / Agency for Toxic Substances and Disease Registry (ATSDR)

B. Notice of Funding Opportunity (NOFO) Title:

Comprehensive High-Impact HIV Prevention Programs for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color

C. Announcement Type: New - Type 1:

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be considered. For this purpose, research is defined at https://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol1/pdf/CFR-2007-title42-vol1-sec52-2.pdf. Guidance on how CDC interprets the definition of research in the context of public health can be found at https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html (See section 45 CFR 46.102(d)).

D. Agency Notice of Funding Opportunity Number:

CDC-RFA-PS22-2203

E. Assistance Listings Number:

93.939

F. Dates:

1. Due Date for Letter of Intent (LOI):

The LOI date will generate once the Synopsis is published if Days or a Date are entered.

2. Due Date for Applications:

11/19/2021

11:59 p.m. U.S. Eastern Standard Time, at www.grants.gov.

3. Due Date for Informational Conference Call:

To obtain a schedule of the pre-application and technical assistance activities or additional information related to this notice of funding opportunity, please visit (https://www.cdc.gov/hiv/funding/announcements/ps22-2203/index.html).

G. Executive Summary:

1. Summary Paragraph

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year 2022 funds for a cooperative agreement program for community-based organizations (CBOs) to develop and implement high-impact human immunodeficiency virus (HIV) prevention programs in the following two categories:

Category A: HIV prevention services for Young Men of Color Who Have Sex with Men (YMSM of color) and their partners regardless of age, gender, and race/ethnicity

Category B: HIV prevention services for Young Transgender Persons of Color (YTG persons of color) and their partners regardless of age, gender, and race/ethnicity

NOTE: Throughout this funding opportunity announcement, "young" and "youth" are defined as individuals between the ages of 13-34 years.

The purpose is to implement comprehensive high-impact HIV prevention programs to address health disparities among YMSM of color, YTG persons of color, and their partners with the goal of reducing HIV transmission and HIV-associated morbidity and mortality. This program aligns with the goals of the HIV National Strategic Plan, 2021-2025 (HIV Plan)[1], Division of HIV/AIDS Prevention (DHAP) Strategic Plan 2017-2020[2], and supports the goals of reducing all new HIV infections by 75% by 2025 and 90% by 2030. This program also complements the Ending the HIV Epidemic in the US (EHE)[3] initiative and supports the HIV Plan health equity goals of addressing social determinants of health (SDH) and syndemics affecting HIV-related outcomes.

a. Eligible Applicants:

Open Competition

b. Funding Instrument Type:

CA (Cooperative Agreement)

c. Approximate Number of Awards

30

d. Total Period of Performance Funding:

$55,000,000

- Category A - $41,250,000

- Category B - $13,750,000

e. Average One Year Award Amount:

$350,000

f. Total Period of Performance Length:

5

g. Estimated Award Date:

April 01, 2022

h. Cost Sharing and / or Matching Requirements:

No

Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

Part II. Full Text

A. Funding Opportunity Description

1. Background

a. Overview

For over 40 years, the human immunodeficiency virus (HIV) has affected millions of Americans throughout the United States. In recent years, deaths among persons with HIV (PWH) have declined, while the population of PWH has grown due to the impact of HIV treatment on disease progression and death. According to the CDC, an estimated 1.2 million persons are living with HIV and approximately 13% are unaware they have HIV.[4] Unless effectively treated to achieve viral suppression, HIV can be transmitted to others and lead to premature death. However, PWH who use antiretroviral therapy (ART) and reach and maintain an undetectable viral load can have normal life expectancy, improved quality of life, and essentially no risk of transmitting HIV to others through sex.[5]

Since the late 1980s, CDC has formally partnered with CBOs to expand the impact and reach of HIV prevention in affected communities. Due to their accessibility, history, and credibility in communities, CBOs are recognized and remain important, trusted partners in providing comprehensive high-impact HIV prevention services. Building individual competencies, organizational capacities, and supportive structural environments among these partners are key strategies for the effective promotion, delivery, and sustainability of HIV prevention programs, particularly for people with and at greatest risk for acquiring HIV, including Black/African-American and Hispanic/Latino persons; all races/ethnicities of gay, bisexual, and other men who have sex with men (MSM); people who inject drugs (PWIDs); and transgender persons. This new funding cycle seeks to develop new and enhance existing strategies for CBO HIV prevention programs that aim to achieve the goals and objectives of the HIV Plan by preventing new HIV diagnoses; rapidly diagnosing, linking, and treating PWH to improve HIV-related outcomes; reducing HIV-related disparities and health inequities; and achieving an integrated and coordinated response to address the HIV epidemic for Categories A (YMSM of color) and B (YTG persons of color).

Problem Statement

Despite prioritizing racial/ethnic minority groups in HIV prevention programs, these populations continue to experience the most disproportionate burden of HIV. Black/African-American and Hispanic/Latino persons represent a small percentage of the US population, but accounted for 41% and 29%, respectively of persons newly diagnosed with HIV in 2019.[4] While recent HIV trend data indicate reduction or stabilization of new HIV diagnoses among individuals ages > 13 years, persons between ages 13–34 years represented more than 50% of all new HIV diagnoses in 2019.

In the US, the majority of HIV diagnoses (66%) in 2019 for persons ages >13 years were among MSM. When considering age and race, Black/African American and Hispanic/Latino MSM, ages 25-34 accounted for the largest percentage of HIV diagnoses indicating a continued need for HIV prevention services within these priority populations. Transgender communities are also at increased risk for acquiring HIV. Health departments and scientists report high HIV diagnoses in transgender communities, particularly among racial/ethnic minorities. While transgender populations represented 2% of new HIV diagnoses in 2018, Black/African-American (48%) and Hispanic/Latino (32%) transgender persons collectively comprised 80% of those new HIV diagnoses.[6] In addition, a recent CDC study found that these transgender populations represented the majority of persons diagnosed with HIV after receiving an HIV test in the study sample.[7]

b. Statutory Authorities

This program is authorized under Sections 301 and 318(a) of the Public Health Service Act; 42 USC Sections 241 and 247c(a), as amended.

c. Healthy People 2030

This NOFO addresses the "Healthy People 2030" focus area of HIV. Sexually Transmitted Infections - Healthy People 2030 | health.gov

d. Other National Public Health Priorities and Strategies

This NOFO aligns with the EHE Initiative and CDC DHP Strategic Plan to (1) reduce the number of people newly diagnosed with HIV; (2) increase access to care and optimize health outcomes for people with HIV; and (3) reduce HIV-related and associated health disparities.

- The HIV National Strategic Plan – A Roadmap to End the Epidemic for the United States, 2021-2025 (HIV Plan) – (HIV National Strategic Plan (2021-2025) | HIV.gov)
- Ending the HIV Epidemic in the United States – (www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview)
- Sexually Transmitted Infections National Strategic Plan for the United States (2021–2025): Groundbreaking, first ever five-year plan that aims to reverse the recent dramatic rise in STIs in the United States – (https://www.hhs.gov/programs/topic-sites/sexually-transmitted-infections/plan-overview/index.html)
- Viral Hepatitis National Strategic Plan: A Roadmap to Elimination 2021-2025: Provides a framework to eliminate viral hepatitis as a public health threat in the United States by 2030 – (https://www.hhs.gov/hepatitis/viral-hepatitis-national-strategic-plan/national-viral-hepatitis-action-plan-overview/index.html)
- Secretary's Minority AIDS Initiative (MAI) – (www.hiv.gov/federal-response/smaif/overview)

- HIV/AIDS Care Continuum – (www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum)
- Division of HIV AIDS Prevention Strategic Plan, 2017-2020 – (https://www.cdc.gov/hiv/pdf/dhap/cdc-hiv-dhap-external-strategic-plan.pdf)
- Division of Adolescent and School Health Strategic Plan, 2020-2025 – (https://www.cdc.gov/healthyyouth/about/pdf/strategic_plan/2025/dash-strategic-plan508.pdf)
- National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Strategic Plan through 2020 – (www.cdc.gov/nchhstp/strategicpriorities/default.htm)

All NOFO activities must be consistent with current and future CDC-supported programmatic guidance, scientific advances, and recommendations.

e. Relevant Work

This NOFO builds upon previous and current HIV prevention programs for community-based organizations, including:

- CDC-RFA-PS17-1704, "Comprehensive HIV Prevention Projects for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color" (www.cdc.gov/hiv/funding/announcements/ps17-1704/index.html)
- CDC-RFA-PS21-2102, "Comprehensive High-Impact HIV Prevention Programs for Community-Based Organizations" (www.cdc.gov/hiv/funding/announcements/ps21-2102/index.html)

NOFO activities will support current and future CDC HIV prevention programs and initiatives.

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

CDC-RFA-PS22-2203 Logic Model: Comprehensive High-Impact HIV Prevention Programs for Young Men of Color Who Have Sex with Men (YMSM) and Young Transgender (YTG) Persons of Color			
Strategies and Activities	**Short-term Outcomes**	**Intermediate Outcomes**	**Long-term Outcomes**
Prioritized HIV Testing • Conduct HIV testing among priority populations • Provide optional services (e.g.,	**Prioritized HIV Testing** **• Increased HIV testing among priority populations** **• Increased HIV diagnoses among priority**	**Prioritized HIV Testing** • Increased knowledge of HIV status among	Reduced HIV incidence among priority populations

Personalized Cognitive Counseling) **Status Neutral[8] Comprehensive High Impact HIV Prevention (HIP)** <u>*Prevention & Essential Services*</u> • Screen, provide, or refer clients to prevention and essential support services • Refer to or provide integrated STI and viral hepatitis screenings • Refer to or provide HIP behavioral interventions (Optional) • Offer condoms to ALL clients <u>*Prevention Services for Persons regardless of HIV Status*</u> • Screen, provide, or refer clients to antiretrovirals (ARVs) for HIV treatment or prevention (PrEP/nPEP) • Link clients to high quality medical services for HIV treatment or prevention • Link or re-engage clients out of HIV treatment or prevention care • Refer clients with HIV or qualifying STI to Partner	**population clients unaware of their HIV status** **Status Neutral Comprehensive HIP** **• Increased access to prevention and essential support services** **• Increased receipt of integrated screenings** **• Increased access to condoms** **• Increased screenings, referrals, and linkage to PrEP and HIV treatment services** **• Increased linkage to HIV care among persons with newly diagnosed HIV ≤30 day** **• Increased re-engagement to HIV care among persons with previously diagnosed HIV, not in care ≤30 days** **• Increased access to Partner Services among persons with newly diagnosed HIV or qualifying STI** **• Increased access to appropriate medication adherence services** **Collaborations, Promotion, and Recruitment** • Increased access to safe spaces among priority populations	priority populations **Status Neutral Comprehensive HIP** • Increased engagement in prevention and essential services • Increased use of condoms • Increased PrEP use • Increased viral suppression among persons with HIV **Collaboration, Promotion, and Recruitment** • Increased use of safe spaces among priority populations to address SDH-related barriers	Reduced death rate among priority populations with diagnosed HIV infection Reduced HIV-related disparities in incidence, morbidity, and viral suppression among priority populations Improved health outcomes for ALL persons regardless of HIV status

Services • Provide/refer clients to appropriate medication adherence services • Offer or refer clients to comprehensive SSP (if indicated) **Collaborations, Promotion, and Recruitment** • Establish service agreements with medical care, prevention and essential support service providers • Conduct program promotion and outreach • Designate a safe space for priority populations • Address social determinants of health			

i. Purpose

This NOFO addresses the national HIV epidemic by implementing CDC's comprehensive high-impact HIV prevention approach that reduce new HIV infections, increase access to HIV care and prevention services, and promote health equity among YMSM of color, YTG persons of color, and their partners. This will be achieved by enhancing CBO's capacity to increase HIV testing and integrated STI/viral hepatitis screenings, linkage to HIV prevention and care services, and providing/referring clients to essential support services, regardless of HIV status, and increase program monitoring and accountability.

ii. Outcomes

The program is expected to demonstrate measurable progress among its priority populations (i.e., YMSM of color, YTG persons of color) toward addressing the short-term outcomes depicted in the NOFO logic model. Potential indicators that quantify these outcomes are described in the section entitled CDC Evaluation and Performance Measurement Strategy.

Expected short-term outcomes include the following:

Prioritized HIV Testing

- **Increased HIV testing among priority populations**

- **Increased HIV diagnoses among persons in the priority populations who are unaware of their HIV status**

Status Neutral Comprehensive High-Impact HIV Prevention
Prevention and Essential Support Services

- **Increased access to prevention and essential support services by priority populations**
- **Increased receipt of integrated STI/VH screenings and services**
- **Increased access to condoms among priority populations**

Prevention Services for Persons regardless of HIV Status

- **Increased screenings, referrals and linkage to pre-exposure prophylaxis (PrEP) and HIV treatment services among priority populations**
- **Increased linkage to HIV care among persons with newly diagnosed HIV ≤30 days**
- **Increased re-engagement to HIV care among persons with previously diagnosed HIV, not in care ≤30 days**
- **Increased access to Partner Services among persons with newly diagnosed HIV or qualifying STI**
- **Increased access to appropriate medication adherence services**
- **Increased access to safe spaces among priority populations**

iii. Strategies and Activities

Applicants are required to provide a comprehensive plan for HIV prevention services for priority populations–young men of color who have sex with men (YMSM) or young transgender persons of color (YTG) and their partners, regardless of HIV status. The applicant organization's High-Impact HIV Prevention program plan for YMSM of color and YTG persons of color must consist of all the following program strategies:

- Prioritized HIV Testing
- Status Neutral Comprehensive High-Impact HIV Prevention for Priority Populations
    - Prevention Services for Persons Regardless of HIV Status
        - Prevention Services for Persons at Increased Risk for Acquiring HIV
        - Prevention and Medication Adherence Support Services for Persons with HIV
    - Status Neutral Prevention & Essential Services
- Program Collaboration, Promotion, and Recruitment
- Community Engagement Group (CEG)
- HIV Planning Group (HPG)

This program will support the national implementation of high-impact HIV prevention programs by CBOs under the two core funding categories described below.

Category A: HIV prevention services for Young Men of Color Who Have Sex with Men (YMSM of color) and their partners regardless of age, gender, and race/ethnicity.
Category B: HIV prevention services for Young Transgender Persons of Color (YTG of color) and their partners regardless of age, gender, and race/ethnicity.

NOTE: Throughout this NOFO, "young" and "youth" are specifically defined as individuals between the ages of 13 and 34 years.

Applicants may only apply for funding under one category. CDC will not consider any application applying for two categories.

*Applicants are required to provide status neutral HIV prevention services for priority populations and their partners.

Project Structure

There will be two phases of the project: a development phase lasting no longer than 6 months from the start of Year 1 (April 1, 2022 – September 30, 2022), followed by ongoing program implementation, monitoring, and evaluation.

- Development Phase (April 1, 2022 – September 30, 2022): Recipients will collaborate with CDC as well as community, local, and state partners to finalize required or recommended activities of their programs. During this time, recipients are expected to complete staff hiring processes and attend all required trainings that support the effective implementation of their programs. During the Development Phase:
    - Recipients must work with CDC/DHP to revise and finalize their detailed Year 1 work plan and five (5) year work plan based on the approved funding amount and program strategies and activities as described later in the Applicant Evaluation and Performance Measurement Plan section of the NOFO.
    - Recipients must work with CDC/DHP to revise and finalize their evaluation plan as described later in the Applicant Evaluation and Performance Measurement Plan (EPMP) section of the NOFO.
    - If recipient is fully staffed during the development phase and the entire 6 months is not needed for program development, full implementation of the approved program is expected during the development phase.
    - Recipients are expected to work with CDC/DHP to proactively develop a capacity building/technical assistance/training needs plan.
    - Recipients will be expected to attend a Recipient Orientation meeting in Atlanta, Georgia, during Year 1 and should allocate funds to support the travel of up to three staff persons to attend the 4- to 5-day meeting.
- Ongoing Implementation Phase: It is expected that each recipient will begin programmatic implementation no later than October 1, 2022 through March 31, 2027.
    - During Year 1 only (April 1, 2022 – March 31, 2022), recipients will be expected to achieve **at least 50%** of each NOFO performance measure described throughout the NOFO and approved by CDC.
    - Beginning in Year 2, and for all subsequent years (Years 3, 4, and 5), recipients are expected to **meet or exceed** all NOFO performance measures.
    - Recipients must also allocate sufficient funds to enable appropriate program staff to attend all required CDC meetings and trainings (virtually or in-person) that support the prevention approaches described in this NOFO, as communicated by CDC in advance of the meetings throughout the performance period.

- Recipients must develop proactive capacity building assistance/technical assistance (CBA/TA) plans annually in collaboration with CDC.

Applicants must address all strategies and activities delineated above, unless otherwise indicated.

Justification of Need

Since there is no singular HIV prevention approach that will work effectively to address the overarching goals of this program, applicants should assess and consider approaches that when combined will have the greatest public health impact. The combined activities should also have the greatest potential to address the social and structural determinants of health that are known to create the most significant barriers to HIV testing; linking, retaining and re-engaging clients into HIV medical care; and accessing prevention and essential support services in the organization's jurisdiction. Services should account for the synergies of syndemic conditions (e.g., STIs, viral hepatitis, injection drug/substance use) and should be delivered in a status neutral way to avoid promulgating institutionalized HIV status-related stigma. This framework acknowledges that prevention and care/treatment together contribute to reducing HIV-related morbidity, mortality, and health disparities among racial and ethnic minorities in the United States and the Commonwealth of Puerto Rico.

All applicants must incorporate the following general requirements into their proposed programs:

- Applicants should ensure the proposed program aligns with the local or state health department's Jurisdictional HIV Prevention Plan (e.g., Integrated HIV Prevention and Care Plan, EHE Plan, Getting to Zero Plan).
- Applicants must use the most current local and/or state HIV epidemiologic and surveillance data, Health Resources and Services Administration (HRSA) Ryan White program data, and/or HIV needs assessment data to provide the information requested in this section. CDC recommends that applicants use the local and/or state health department as their primary source of this data whenever possible.

More specifically, applicants must conduct the following:

- Define the specific service area(s) in which they plan to deliver their program. Local surveillance and epidemiologic data, when available, should be used to identify the proposed service area within the eligible jurisdiction that are disproportionately affected by HIV and where people with and at greatest risk for HIV reside and/or frequent.
- Develop an approach that includes the required components and additional components that will, when combined, have the greatest public health impact. These combined activities should have the greatest potential to address the social and structural determinants of health that are known to create the most significant barriers to HIV testing; linking, retaining, and re-engaging clients with care; and accessing prevention and essential support services.
- Develop a client-centered, status neutral, high-impact HIV prevention (HIP) program that includes a combination of strategies and services to continually engage priority populations who could benefit from the reduction of barriers to accessing HIV medical care and other prevention and essential support services. The program model should include strategies and services to engage priority populations regardless of HIV status. Visit the following websites for additional information on HIP strategies and services:

https://www.cdc.gov/hiv/effective-interventions/index.html and http://www.cdc.gov/hiv/policies/hip.html.

- Enhance existing and develop new strategies to identify and collaborate with organizations that currently provide similar and/or complementary services in the proposed service area(s); this may be done in consultation with the health department.
- Describe how these funds will augment existing HIV prevention services and provide an assurance that the funds being requested will not duplicate or supplant funds received from any other federal or non-federal entity.

COMPREHENSIVE HIGH-IMPACT HIV PREVENTION PROGRAM

Applicants are required to develop and implement a comprehensive high-impact HIV prevention program for the priority population clients who are at increased risk for acquiring HIV or living with HIV. The program should align with the goals and objectives of the HIV Plan which also complements the EHE initiative. In addition to the HIV Plan, the proposed program should be guided by the principles of an HIV status neutral approach and addressing social determinants of health and syndemics adversely affecting HIV outcomes in efforts to promote and achieve health equity among the priority populations. Proposed programs should include the implementation and delivery of strategies and activities that prevent new HIV transmission, link clients to HIV prevention and care services, and refer clients to and provide essential support services that aid in reducing HIV-related disparities and health inequities. Applicants may provide the outlined services in a **maximum of three (3)** service areas within the applicant's jurisdiction.

Status Neutral Approach[8]

The status neutral approach highlights HIV testing as a gateway to prevention services and acknowledges that people who benefit from HIV prevention services have similar needs and barriers regardless of the outcome of their HIV test. This approach promotes the same engagement of priority populations in the provision of HIV prevention and care services regardless of HIV status. A status neutral approach can increase efficiency and prevent the establishment of services that continue to promulgate the institutional stigma related to HIV and its intersection with other identities, such as gender, sexual orientation, and race/ethnicity identities. Applicant organizations should include a status neutral approach in their program activities and provision of services to priority populations.

Prioritized HIV Testing

HIV testing is an essential component of comprehensive high-impact prevention programs. Applicants should promote a status neutral approach, where HIV testing serves as an entry point to prevention services, regardless of HIV test result to improve HIV prevention and care outcomes. Applicant organizations are required to develop new or enhance existing HIV testing programs for which **at least 75%** of the tested persons are of the proposed priority population(s). Recipients will be required to conduct the following:

- Develop new or enhance existing HIV testing programs that prioritize priority population clients who are at greatest risk for acquiring HIV and who are unaware of their HIV status.
- Integrate HIV testing into the comprehensive high-impact HIV prevention program and the overall mission and operations of the organization's HIV prevention and care services. This should include the development of strategies to recruit members of the

priority populations at greatest risk for acquiring HIV and who are unaware of their HIV status; and reduce the priority populations' barriers to accessing HIV testing and address health inequities among the priority populations disproportionately affected by HIV.

- Implement prioritized HIV testing in non-healthcare settings to identify HIV using multiple strategies and the most current recommendations. Follow current CDC guidelines and recommendations for HIV testing. (https://www.cdc.gov/hiv/pdf/testing/CDC_HIV_Implementing_HIV_Testing_in_Nonclinical_Settings.pdf). Prioritized HIV testing efforts should also be conducted in accordance with state and local regulations.
- Use the latest HIV testing technology available, preferably 4th generation HIV testing technology, when feasible, throughout the program award.
- Establish annual HIV testing objectives for the priority population(s) using local jurisdictional data and/or agency historical data.
    - Organizations applying for funding under **Category A (YMSM of color)** must identify a minimum of eight (8) new HIV diagnoses annually.
    - Organizations applying for funding under **Category B (YTG persons of color)** must identify a minimum of six (6) new HIV diagnoses annually.

- Applicant organizations must identify a variety of settings where prioritized testing will be conducted and most effective in identifying members of the priority population(s) with undiagnosed HIV and those who are lost to HIV medical care. Examples include, but are not limited to:
    - Onsite testing within the organization
    - Venue-based testing (e.g., Retail Pharmacy, Substance Use Centers, Clubs/Bars, etc.)
    - Mobile/field testing
    - Self-Testing (Home-based) – If self-testing is used, organizations are required to provide specific protocols, in conjunction with the local or state health department, which includes recruitment processes, follow-up, and linkage procedures. https://www.cdc.gov/hiv/testing/self-testing.html
    - Large-scale HIV Testing Event(s) – Organizations may participate in a large-scale HIV testing event per budget period that is specifically promoted to YMSM of color or YTG persons of color and provides the organization access to their priority population. Community event(s) should be used to establish a mechanism to engage priority population(s), assist with program collaboration, promotion, and recruitment of priority population(s). The event(s) can occur in collaboration with existing organizations (e.g., local/state health departments, CBOs, etc.) that work with or provide services to the priority population(s). Examples of large-scale HIV testing events include, but are not limited to HIV/AIDS Awareness Days, PRIDE events, House and Ball events, and events sponsored by school-based health programs or other school-based providers.
    - Consider the use and implementation of Social Network Strategy (SNS) to recruit the priority population(s), if feasible. (https://www.cdc.gov/hiv/effective-interventions/diagnose/social-network-strategy?Sort=Title%3A%3Aasc&Intervention%20Name=Social%20Network%20Strategy)

- Serve the identified members of the proposed priority population supported by local epidemiologic and surveillance data and the appropriate health department's Jurisdictional HIV Prevention Plan (e.g., Integrated HIV Prevention and Care Plan, and/or EHE Plans, Getting to Zero Plan) (See Attachment B: Organizational Capacity and Proposed Priority Population Worksheet). **At least 75%** of individuals tested must be considered members of the applicant's priority population.

Integrated, Status Neutral Syndemic Screening Activities

Recipients should have or establish the capacity to implement various integrated screening activities (e.g., screening for syndemic conditions such as STIs, viral hepatitis, and/or TB), in conjunction with HIV testing for members of their priority population(s) regardless of HIV status. Recipients will be required to provide the following service integration activities:

- Support and promote collaboration between HIV, STI, viral hepatitis, and/or TB programs through the support and provision of integrated screening activities delivered in conjunction with HIV testing. Funds from this NOFO may be used for other screening tests, including those described below, only if these tests are provided in conjunction with HIV screening, are supported by epidemiologic data, and are in accordance with current CDC guidelines and recommendations. Visit https://www.cdc.gov/nchhstp/highqualitycare/guidelines.html and https://www.cdc.gov/tb/publications/guidelines/testing.htm for additional information.
- Use **up to 5%** of the total approved funding amount to implement and/or strengthen and enhance integrated screening activities within the agency.
- Collaborate with key staff of the participating facilities to plan, develop, and implement the integrated screening activities for STIs, viral hepatitis, and/or TB.
- Collaborate with the STD, hepatitis, and/or TB prevention programs in the jurisdiction to design, develop, and implement proposed screening and treatment services.
- Encourage priority population members who are tested for HIV to get a syphilis serology and screening for urethral and rectal gonorrhea and chlamydia. The applicant can use self-collection of specimens (urine and vaginal/rectal swabs).
- Ensure that clients receive their test results as soon as possible, especially those who test positive.
- Ensure that clients who test positive are linked to appropriate medical care and receive timely and appropriate evaluation and treatment.
- For clients who test positive for STIs, ensure that Partner Services are initiated as soon as possible after diagnosis, in accordance with CDC recommendations and state and local requirements. Ensure compliance with health department disease (e.g., HIV, STI, viral hepatitis, and/or TB) reporting regulations.
- For clients who are candidates for hepatitis A or B vaccination (or COVID-19 and other vaccinations, as appropriate), provide referrals to these services.
- Periodically review monitoring data to assess the value of continuing screening for other STIs, viral hepatitis, and TB.
- When appropriate and feasible, use all available mechanisms to bill for integrated screening services and obtain reimbursement from third-party payers (e.g., Medicaid, Medicare, private insurance).

If the recipient does not have the capacity to perform integrated screening activities in conjunction with HIV testing, the organization must refer clients for integrated screening and during the Development phase (**first six months**) of the program, the organization must:

- Establish a service agreement with a clinical care provider in the service area(s).
- Submit the service agreement with the application or during the project development phase.
- Ensure the service agreement clearly describes services offered by the clinical care provider and the agreed upon referral process between the recipients and the clinical provider. This agreement should include how the clinical care provider will confirm receipt of service obtained by the referred client.

ALL recipients are expected to refer clients to or provide clients with integrated screening for other STIs, viral hepatitis, and/or TB.
Funds from this NOFO may not be used for clinical services; treatment of HIV, STIs, viral hepatitis, and/or TB; vaccination against hepatitis A or hepatitis B; and vaccination against human papillomavirus (HPV).
Visit http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm?s_cid=rr5912a1_e and http://www.cdc.gov/tb/topic/testing/default.htm#who for additional information.

Federally Qualified Health Centers

Applicants that are Federally Qualified Health Centers (FQHCs), if located in a geographic area with high HIV disease burden and provide services to the priority population(s), may opt to implement routine HIV testing within their clinic setting, in accordance with the CDC recommendation (2006 HIV Testing in Healthcare Setting Guidance: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr551ra1.htm). The majority of the HIV testing must be conducted in an outreach setting; up to 25% of the HIV testing efforts can be conducted as routine, opt-out HIV testing. FQHCs are also required to conduct prioritized HIV testing in an outreach setting (as outlined above).

CDC recognizes that a shift in the community, changes in the prevalence within a jurisdiction, and/or changes in the HIV landscape may require adjustments to the annual performance measures given the priority population (e.g., Category A or Category B). Therefore, CDC may allow an organization the flexibility to adjust annual HIV testing objectives and/or strategies throughout the 5-year period of performance, upon discussion and approval with the CDC/DHP assigned Project Officer.

Optional HIV Testing Activity
Recipients may also implement the following complementary services with the HIV testing program in accordance with the NOFO requirements, as appropriate.
Personalized Cognitive Counseling (PCC)

- Recipients **may opt** to implement Personalized Cognitive Counseling (PCC), when appropriate with repeat testers, upon receipt of training from a CDC-approved provider. PCC is an intervention designed to reduce sexual risk behaviors among men who have sex with men (MSM) who are repeat testers for HIV. Repeat testers are described as individuals who have previously been tested

and have engaged in unsafe sexual behaviors since the receipt of their last HIV test result. Visit https://www.cdc.gov/hiv/effective-interventions/diagnose/personalized-cognitive-counseling/index.html?Sort=Priority%3A%3Aasc&Intervention%20Name=Personalized%20Cognitive%20Counseling&;Intervention%20Name=Personalized%20Cognitive%20Counseling for additional information.

Additional HIV Testing Information

In accordance with the guidelines established by the local and/or state health department and CDC data requirements, applicant organizations are required to:

- Develop strategies to collect and report the required CDC HIV testing variables to CDC. Additional information is in the Applicant Evaluation and Performance Measurement Section of the NOFO.
- Coordinate with the local or state health department regarding HIV testing plans, to include trainings and process for referring clients to Partner Services. Coordinate training(s) to support the confirmation of persons newly diagnosed with HIV, identified by the CBO for Partner Services. Confirmation of the coordination with the state or local health department must be provided via Attachment C: Health Department Prioritized HIV Testing and Partner Services Letter of Agreement.
- Work with the local or state health department to collaborate with various entities to support using advances in HIV testing and algorithms to improve the detection of early and acute HIV, when feasible and appropriate, considering the capacity of the recipient.
- Report information on HIV diagnoses to your respective health department (e.g., state, local health department's surveillance program).
- Work with health departments to explore opportunities for seeking reimbursement and to determine whether third-party reimbursement makes sense financially, and is appropriate and feasible. Organizations with the capacity to bill and obtain reimbursement are expected to use all available mechanisms to obtain reimbursement for HIV testing from third-party payers (e.g., Medicaid, Medicare, private insurance).

Applicant organizations must also conduct the following:

- Ensure that the proposed HIV testing activities meet all local, state, and federal requirements for HIV testing. If required by state or local regulations, the organization must arrange for physician oversight of the HIV testing program. (See Attachment C: Health Department Prioritized HIV Testing and Partner Services Letter of Agreement)
- If physician oversight is required, the applicant must submit a signed Physician Oversight Letter of Intent with the application for funding. (See Attachment D: Letter of Intent from a Physician for State Regulations and HIV Testing Activities)
- If conducting rapid HIV testing, submit a copy of the current Clinical Laboratory Improvement Amendments (CLIA) certificate with the application.

Prevention Services for Persons Regardless of HIV Status

Although services below are differentiated based on HIV status to allow for more clarity for the applicant, the implementation strategy must focus on weaving these services together using a status neutral approach. Applicants should evaluate a combination of approaches that include the required components and additional components that will, when combined, have the greatest

public health impact. Navigation support services align with the goals and objectives of the HIV Plan and the use of HIV navigators for linkage and re-engagement activities to HIV medical care and pre-exposure prophylaxis (PrEP) as an evidence-based strategy should be implemented as a component of the applicant's program.

Prevention Services for Persons at Increased Risk for Acquiring HIV

In support of achieving the national goals of preventing and reducing HIV transmission among priority population(s) and reducing HIV-related disparities, recipients will be required to conduct the following activities for clients at increased risk for acquiring HIV to increase access to PrEP and non-occupational post-exposure prophylaxis (nPEP) services, including screening, referrals, linkage to PrEP or nPEP provider, and prescribing PrEP and nPEP:

- Assess and refer persons with a non-reactive HIV test result, who are at increased risk for acquiring HIV, to PrEP and nPEP services, in accordance with CDC guidance (https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf).
- Support the awareness and uptake of PrEP and nPEP services among priority population(s)
- Provide and/or refer **at least 90%** of YMSM of color and YTG persons of color to PrEP services within 30 days for clinical evaluation
- Use or establish a referral network of PrEP and nPEP clinical service providers to support referrals and provision of PrEP and nPEP services
- Use existing resources in the jurisdiction to identify and/or develop a referral network for PrEP and nPEP provides. Examples may include, but not limited to, preplocator.org, PrEP provider directories, Ready-Set-PrEP, PrEP warmlines, TelePrEP or other existing resources in jurisdiction.
- Coordinate a navigation plan to ensure clients are appropriately referred and linked to PrEP and nPEP services
- Establish Service Agreement with a PrEP Provider (See Attachment E: Linkage to HIV Medical Care and PrEP Provider Plan)

In addition, applicants will be required to provide the following:

- At **least one** MOA/MOU with the application for PrEP service provider(s) proximal to the organization's service area(s) and have capacity and history of providing services to the priority population(s). MOA/MOU must be updated, valid, and submitted annually.
- Service agreement must describe the agreed upon referral and linkage process to PrEP and nPEP services and include the process for confirming that services were accessed as well as the specific role of the partner/collaborator.

Prevention Services for Persons with HIV

To achieve the national goal of improving HIV-related outcomes for PWH, recipients will be required to conduct the following activities for clients with HIV:

- Linkage to and Re-engagement in HIV Medical Care
- Partner Services Referrals
- Medication Adherence Support to Achieve Viral Suppression

- Establish Service Agreement with an HIV Medical Care Provider (See Attachment E: Linkage to HIV Medical Care and PrEP Provider Plan Template)

Linkage to HIV Medical Care

Recipients will be required to conduct the following linkage to HIV medical care activities:

- Link **at least 90%** of persons newly diagnosed with HIV to HIV medical care and ART initiation immediately, but **no later than 30 days** after diagnosis.
- Develop a navigation program that engages clients from the time of notification of diagnosis to the client's first HIV medical care appointment.
    - Employ **at least one trained HIV Navigator** (a minimum of 0.5 FTE) within the agency to help facilitate the coordination of the organization's linkage to HIV Medical Care plan activities. The hiring, training and development of navigators (e.g., community health workers, peer advocates, outreach workers) will help facilitate access to linkage, re-engagement, and retention services and referral to or provision of prevention and essential support services.
    - Develop or enhance systems for assisting persons with HIV with navigating services (i.e., obtaining necessary information, support, and skills to access complex medical systems) at all stages of care, treatment, prevention, and essential support services. If needed, organization may use telehealth as an option for Linkage to HIV Medical Care services.
    - Provide navigation services (e.g., accompanying persons to medical appointments, providing or referring to prevention and essential support services) that reduce barriers to medical care and address acceptance, responsibility, and behavior change.
- Submit a Linkage to HIV Medical Care Program Plan with the application. The Linkage to HIV Medical Care Program Plan must include detailed information about the linkage program to include staff responsible for linking clients to HIV medical care, the organization's linkage to care process (method and timeframe for linking clients to care within the allotted 30-day requirement), provider(s) associated with the linkage to care program, a process for securing multiple communication methods to contact clients, etc. (See Attachment E: Linkage to HIV Medical Care and PrEP Provider Plan Template)

Service Agreement with an HIV Medical Care and PrEP Provider(s)

Applicants must establish a service agreement with an HIV Medical Care and PrEP Provider(s) to maintain the continuity of status neutral service provision. Applicants may establish one service agreement where both PrEP and HIV medical care are provided, or applicants can establish two separate service agreements—one for a PrEP provider and one for an HIV medical provider. Applicants must provide the following information regarding HIV Medical Care and PrEP Provider(s):

- Applicant organizations are required to have a service agreement with an HIV Medical Care Provider (must submit **at least one** HIV medical care service agreement with the application)
- Applicant organizations are required to have a service agreement with a PrEP provider (must submit **at least one** PrEP provider service agreement with the application)

- HIV medical care provider and PrEP provider should be proximal to the organization's service area(s), culturally and linguistically competent and sensitive to the needs of the priority population(s), have the capacity and history of providing care and treatment to members of the priority population(s) diagnosed with HIV, and have the capacity and history of providing HIV prevention services for priority population(s) at increased risk for acquiring HIV.
- Service agreements must describe processes that will be used to link persons with newly diagnosed HIV to medical care within 30 days of HIV diagnosis.
- Service agreements must describe processes that will be used to link persons at increased risk for acquiring HIV to HIV prevention services (i.e., PrEP) within 30 days of clinical evaluation.
- HIV medical care and PrEP provider(s) may be internal and/or external to the organization.

Linkage to HIV Medical Care Activities

Recipients may opt to implement a CDC approved linkage to HIV Medical Care strategy listed below or use the CBO's existing linkage to HIV medical care program.
See https://www.cdc.gov/hiv/effective-interventions/treat/index.html for additional information regarding Linkage to Care strategies.

- Anti-Retroviral Treatment and Access to Services (ARTAS)
- HIV Navigation Services – STEPS to Care
- Stay Connected (Clinics Only)

Re-engagement in HIV Medical or Preventive Care Services

Recipients will be required to conduct the following activities related to re-engagement in HIV medical care:

- Re-engage **at least 90%** of persons previously diagnosed with HIV and who are not-in-care, into HIV medical care and on ART, immediately upon discovery that they are not receiving care, but **no later than 30 days after.**
- Re-engage clients previously prescribed PrEP who continue to qualify for this intervention but have stopped taking PrEP.
- Support local and/or state health departments with Data-to-Care efforts. Recipients should work with the jurisdiction's local and/or state health department to follow-up and/or link persons that are out-of-care using the health department Not-In-Care (NIC) list.

Partner Services Referrals

Partner Services are a broad array of services that should be offered to persons with HIV or other STIs and their sexual or needle-sharing partners. By identifying people with HIV and other STIs, confidentially notifying their partners of their possible exposure, and providing them with a range of medical, prevention, and psychosocial services, Partner Services can improve the health outcomes not only of individuals with HIV, but of communities as well. Recipients must comply with jurisdictional Partner Services requirements and policies.

Recipients will be required to conduct the following Partner Services activities:

- Refer **100%** of persons with newly diagnosed HIV or qualifying STI to Partner Services.
- Ensure that clients testing positive for HIV, are referred immediately, but not greater than 30 days after diagnosis, in accordance with CDC recommendations and state and local requirements.
- Ensure persons with previously diagnosed HIV are also referred to the health department immediately upon identification.

Medication Adherence Services for HIV Treatment or Prevention

Medication Adherence services to support direct observation, maintenance on ART, and overall reaching and maintaining viral suppression; it also involves providing medication adherence services for HIV prevention (PrEP/nPEP).

Recipients will be required to conduct the following medication adherence support activities:

- Implement medication adherence interventions to further strengthen their high-impact HIV prevention program.
- Provide or refer **at least 90%** clients to appropriate medication adherence services and interventions based upon the identified needs of the client.
- Provide or refer **at least 90%** of clients at increased risk for acquiring HIV to medication adherence services for HIV prevention (e.g., PrEP phone or social media app reminders)
- Provide or refer **at least 90%** of persons with HIV (newly and previously diagnosed) to medication adherence services for HIV treatment (e.g., social media app and phone call reminders, transportation to medical appointments)
- Submit a service agreement upon award, if the organization will be referring clients to medication adherence services.

Medication Adherence Support Services

Recipients may opt to implement a CDC approved linkage to medication adherence intervention strategy listed below or use the CBO's existing medication adherence support program.

See https://www.cdc.gov/hiv/effective-interventions/treat/index.html for additional information regarding Medication Adherence strategies.

- Partnership for Health
- Stay Connected

In anticipation of continuous advancements in the availability of medication adherence and strategies, recipients may opt to implement new CDC supported interventions and strategies as they become available, with prior written approval from CDC.

Status Neutral Prevention & Essential Support Services

Recipients are required to provide or refer clients to prevention and essential support services that align with the goals and objectives of the HIV Plan and CDC's High-Impact HIV prevention approach. A**t least 90%** of priority population members should receive a referral to or provision of prevention and essential support services, regardless of their HIV status. Provision of prevention and essential support services may include training and development of navigators (e.g., community health workers, PrEP or linkage to HIV care navigators, peer advocates, outreach workers, etc.) to facilitate increased access to services needed among priority population members. The goal is to reduce barriers to accessing HIV prevention and care services and other prevention and essential support services. Recipients will be required to:

- Develop or enhance systems for assisting clients with navigating services (obtaining necessary information, support, and skills to access complex medical systems) for all persons, regardless of HIV status.
- Refer clients to or provide prevention and essential support services, regardless of HIV status, based on the identified needs of the client.
- Develop and implement a process for referring clients to and providing prevention and essential support services.
- Establish collaborations supported by service agreements over the course of the 5-year period of performance. Applicants should submit **at least two** established MOA/MOU or service agreements (internal and/or external to organization) with a prevention and essential support services provider with the application. The agreement(s) should be reflective of the services most requested by the priority population(s). The MOA/MOU should be uploaded as a PDF in Other Attachments and named "PESS MOUs_MOAs".
- Use PS22-2203 funds to help clients navigate the following prevention and essential support services that may include, but are not limited to:
    - Health benefits navigation and enrollment (e.g., Insurance navigation and enrollment)
    - CDC-supported evidence-based risk reduction interventions
    - Behavioral health services (e.g., mental health counseling and services, substance use treatment services, SSPs)
    - Integrated screening for STIs, viral hepatitis, and/or TB in conjunction with HIV testing
    - Social services (e.g., transportation services (to and from HIV prevention and essential support services and medical care appointments), employment services, basic education continuation and completion services, food banks, food programs, including Supplemental Nutrition Assistance Program (SNAP), and comprehensive sexual health education, including HIV education (e.g., risk reduction programs, school-based healthcare providers)).
    - General primary care and contraception related services.
    - Educational services for hormone replacement therapy (HRT) and sex reassignment procedures. (Applicant organization should develop relationships with providers with experience providing HRT)
    - Harm reduction services inclusive of referrals and/or provision of syringe services programs (SSP) in accordance with local and state SSP policies.
    - Housing Assistance

Risk Reduction Behavioral Interventions (*optional*)

Applicant organizations may opt to implement health education and risk reduction behavioral interventions to support recruitment, outreach, and engagement in HIV prevention and services for priority population members at increased risk for acquiring HIV and for persons with HIV. See https://www.cdc.gov/hiv/effective-interventions/prevent/index.html for additional information on approved CDC-supported risk reduction behavioral interventions.

Risk Reduction Behavioral Interventions for Persons at Increased Risk for Acquiring HIV

- Optional activities to support recruitment, outreach, and engagement in HIV prevention services include: d-Up!, Safe in the City video, PROMISE, Sin Buscar Excusas, and TWIST

Risk Reduction Behavioral Interventions for Persons with HIV

- Optional activities to support recruitment, outreach, and engagement in HIV prevention and care services include: Partnership for Health, PROMISE, Stay Connected, Steps to Care, Taking Care of Me video, and TWIST

In anticipation of continuous advancements in the availability of risk reduction behavioral interventions and strategies, recipients may opt to implement new CDC supported interventions and strategies as they become available, with prior written approval from CDC.

Condom Distribution

Free and accessible condoms are an integral component of an HIV prevention program. Recipients will be required to conduct the following:

- Implement condom distribution as a structural intervention to increases access to and use of condoms of priority population members, regardless of HIV status.
- Offer condoms to **100%** of priority population members, regardless of HIV status.
- Ensure that effective condom distribution programs adhere to the following principles:
    - Provide condoms free of charge
    - Implement social marketing efforts to promote condom use by increasing awareness of condom benefits and normalizing condom use within priority population(s)
    - Conduct both promotion and distribution activities at the individual, organizational, and community levels. For additional information and guidance, please visit https://www.cdc.gov/hiv/effective-interventions/prevent/condom-distribution-programs/index.html.

Program Collaborations, Promotion, and Recruitment

Successful implementation of proposed programs will require recipients to establish formalized collaborations, conduct outreach and program promotion activities to facilitate recruitment and engagement of priority population members, and provide dedicated safe space(s) to engage priority populations in HIV prevention and care activities as well as address the most salient essential support service needs of priority population clients. The following information outlines activities and strategies that will assist with the successful implementation of comprehensive high-impact HIV prevention programs.

Formalized Collaborations

Successful program implementation of the required components of this NOFO will be influenced by the applicant organization's ability to increase coordination and collaboration among community, local, and state HIV prevention and care service providers. CBOs can achieve this by providing the required HIV prevention services of this NOFO either directly or through newly established or enhancing existing formalized collaborations. Recipients will be required to conduct the following activities regarding formalized collaborations:

- Collaborate with other organizations that have an established history of working with and recruiting members of the priority population(s) at greatest risk for HIV acquisition or transmission.
- Enhance existing and establish new formalized collaborative partnerships, supported by detail specific service agreements, with medical (e.g., Community Health Centers (CHCs), private providers) and essential support service providers to maximize reach, increase coordination and collaboration, and support the provision of comprehensive HIV prevention services (e.g., PrEP provider networks, retention in care, viral suppression).

Organizations may subcontract with a **maximum of two (2) organizations** to provide direct services as described in the Strategies and Activities section of this NOFO.

- Recipients must perform a substantial role in the delivery of services.
- The amount of funding allocated for subcontractors must align with the proposed services to be provided by the subcontractor(s).
- Subcontractor organization(s) must be located and provide services in the same state as the recipient.
- Subcontractor organization(s) must have a history of consistently serving the proposed priority population(s) for at least the last 24 months.
- Recipient is responsible for the monitoring and performance of the subcontractor(s).

Community Engagement Group (CEG)/Consumer Advisory Board (CAB)

Recipients must establish a new or enhance an existing Community Engagement Group (CEG) or Consumer Advisory Board (CAB) to assist with program planning, implementation, and evaluation efforts. The CEG/CAB must include YMSM of color or YTG persons of color depending upon the category for which funding is requested. Members of the priority population(s) must comprise **at least 75%** of the CEG/CAB. At a minimum, recipients will be required to conduct the following activities:

- Establish a Community Engagement Group (CEG) to assist with programmatic decision-making (e.g., program recruitment, planning, implementation, evaluation, and design or use of the safe space). The program must seek input from the CEG and community stakeholders to select the most appropriate program promotion and recruitment strategies to determine the appropriate use of incentives (monetary and non-monetary) in the program.
- Host CEG meetings at least twice per year in the form of focus groups, surveys, interviews, needs assessments, pop-up events, Town Hall gatherings, etc.
- Maintain participation on the CEG of at least 75% of the PS22-2203 program priority population(s). Remaining members must have experience working in HIV prevention and/or care and a history of working with the priority population(s).
- Use the CEG throughout the period of performance to ensure services are responsive to the needs of the priority population(s).

A strong pre-existing Consumer Advisory Board (CAB) within the agency may be used in lieu of the CEG.

HIV Planning Groups (HPGs)

Recipients are expected to conduct the following regarding HPGs:

- Participate in jurisdiction's HIV Planning process as defined by the local and/or state health department jurisdiction and align with the Jurisdictional HIV Prevention Plan (e.g., Integrated HIV Prevention and Care Plan, EHE Initiative Plan, Getting to Zero Plan) or other applicable documents provided by the local and/or state health department.

Recipients are responsible for delivering culturally appropriate and linguistically responsive program promotion, outreach, and recruitment activities among the priority population(s) as client recruitment is essential to the success of this comprehensive high-impact HIV prevention program. Recipients will be required to conduct the following program promotion, outreach, and recruitment activities:

- Use recruitment and retention strategies based on experienced entry into social networks, known to significantly structure or influence the social lives of the priority populations (e.g., House and Ball events, house parties, texting groups, social media networks, dating websites, mobile applications).
- Use the internet and other media-based approaches to promote awareness of the HIV prevention programs specifically within social networks of the priority population(s). Develop and use cutting-edge and innovative strategies, as well as traditional outreach strategies, the Internet, social media, and surveillance data (to support mapping of areas of highest morbidity) to establish a comprehensive program promotion, outreach, and recruitment plan.
- Deliver strategic, culturally and linguistically appropriate, community-based program marketing campaigns to increase public awareness of services available via the proposed program; destigmatize HIV and HIV medical care; empower disproportionately affected populations; promote HIV testing; promote linkage to, retention in, and re-engagement to HIV medical care; and promote navigation to and provision of prevention and essential support services, including PrEP and nPEP.
- Prioritize existing social marketing efforts that can be tailored to their jurisdiction's specific requirements from CDC's Let's Stop HIV Together portfolio of social marketing campaigns. Applicants should use campaigns such as Doing It and Start Talking, Stop HIV to address the required strategies and activities of this program (e.g., prioritized HIV testing). For more information on CDC's social marketing campaigns, please visit (http://www.cdc.gov/actagainstaids/) . See Attachment F: Social Media Program Guidance for HIV Prevention Community-Based Organizations for additional resources and information.
- Consider the development of the program promotion, outreach, and recruitment component to address participation by priority population members through multiple points of entry into the program.

Safe Spaces

Applicant organizations **must designate a dedicated physical space** (safe space) within the organization or located off-site in a location that is proximal and easily accessible to YMSM of color and YTG persons of color. This space will be used to engage, develop, and maintain ongoing relationships with clients, and address social and structural determinants of health affecting HIV outcomes most requested by the priority population(s). To supplement activities conducted within the physical safe space, recipients may also establish virtual safe space(s) to

engage priority populations in HIV prevention and care services and address SDH-related barriers impacting the provision of HIV prevention and care services among priority populations. Recipients will be required to conduct the following in safe spaces:

- Designate a dedicated physical space, as a culturally, linguistically, and age-appropriate safe space that is used to establish and maintain an ongoing relationship with the clients being served. The safe space should be accessible and located either within the organization or off-site within proximity of the recipient's primary location. The safe space may function as a primary point of recruitment and location for program activities for the priority population(s).
    - The safe space should be designed to empower the priority population(s) and provide HIV/STI risk-reduction skills.
    - The safe space must ensure the safety of all persons employed and those served by the recipient must be an integral element of the recipient's mission, values, and activities.
    - The safe space must be supported by policies and procedures on discrimination and harassment that support an inclusive, affirming, and non-judgmental HIV prevention program.
    - The safe space must also be supported by clear written guidelines about interactions between staff (regardless of their age) and persons served by the organization as well as guidelines about interactions between clients of different ages, if applicable.

- Identify and address **at least two** social determinants of health within the safe space that resonate with priority population members in efforts to reduce barriers to accessing HIV prevention and care services and other essential support services.
- At a minimum, applicants should conduct an assessment among priority populations to determine where to focus efforts. Assessment may include, but are not limited to the following:
    - Focus groups, key informant interviews, surveys, or historical program data that aids in identifying SDH to optimize HIV prevention and care services among priority population(s)

Activities to address social determinants of health affecting HIV prevention and care services for the priority population(s) may include, but is not limited to the following:

- Modifying discriminatory organizational policies and procedures
- Developing status neutral anti-HIV stigma, racism, homophobia/transphobia social media/marketing campaigns that focus on priority populations, providers, frontline staff, community-at-large, etc.
- Developing Standard of Care Guidelines or Standard Operating Procedures on engaging with priority population(s) in the provision of HIV prevention and care services
- Providing services or referrals to essential support services impacting HIV prevention and care for priority population(s)

Recipients will work in collaboration with CDC to identify and address SDH-related factors most salient among priority population(s). Additional guidance will be provided during the Developmental phase (1st 6-months of period of performance) and updated accordingly via

regular monitoring with assigned Project Officer.

Data-Driven Approaches

The use of HIV surveillance data and other program data to support mapping of areas of highest morbidity for data-driven planning is highly encouraged to maximize reach of the priority population(s). These data should be used to determine program implementation, outreach and recruitment strategies and activities (e.g., HIV testing locations, recruitment venues, extended or non-traditional hours, etc.). Recipients are required to collaborate with the health department to obtain data to inform the program outreach and recruitment plans.

- Applicants must use state and/or local HIV epidemiologic and surveillance data, Health Resources and Services Administration (HRSA) Ryan White program data, and/or HIV needs assessment data for program planning and implementation efforts. CDC recommends that applicants use the local and/or state health department as their primary source for these data.
- Applicants should consult with the jurisdiction's health department and refer to the Jurisdictional HIV Prevention Plan (e.g., Integrated HIV Prevention and Care Plan, EHE Plan, Getting to Zero Plan) for relevant data to assist with selecting the proposed priority population. The applicant's proposed priority population must be indicated as a priority population for the jurisdiction in which the applicant provides services.

To describe the social and environmental characteristics of the affected populations, data from research studies and other valid data sources may also be used if the health department data are not available or to complement data obtained from the health department.

1. Collaborations

a. With other CDC projects and CDC-funded organizations:

Recipients are required to collaboratively partner with CDC. Recipients must also establish, build, and/or maintain working partnerships with other CDC recipients (e.g., directly-funded CBOs) and state or local health departments to ensure communication, collaboration, and coordination for the national delivery of comprehensive high-impact HIV prevention programs that are consistent with CDC standards and guidance.

Service Agreement with HIV Medical Care and PrEP Provider(s)

The applicant organization must submit **at least one** established service agreement with an HIV medical care provider and PrEP provider (internal or external to the organization), regardless of the services being provided internally or externally. The applicant organization is encouraged to establish additional collaborations supported by service agreements over the course of the five (5)-year period of performance. The service agreement should be revised annually, as needed. When establishing the service agreements, the applicant organization should consider the following:

- Proximity of the provider to the applicant organization's service area(s).
- The provider's capacity and history providing culturally and linguistically competent care and treatment for YMSM of color and YTG persons of color regardless of HIV status
- Processes that will be used to link clients at increased risk for acquiring HIV to PrEP services within 30 days of clinical evaluation

- Processes that will be used to link newly diagnosed persons with HIV and re-engage or link previously diagnosed persons with HIV to HIV medical care within 30 days of diagnosis.
- Payment requirements for services rendered (e.g., Ryan White provider, type of health insurance accepted).

Additionally, the service agreement must include, but is not limited to the following:

- Name and address of the provider(s).
- Name, title, and contact information (i.e., primary work address, email, and phone number) for the primary point of contact for the HIV medical care provider and PrEP provider.
- Name and address of the applicant organization (must include the name, title, and primary contact information [i.e., primary work address, email, and phone number]).
- Detailed list of all services provided by the HIV medical care and PrEP provider organization(s).
- Detailed description of the agreed-upon processes that will be used to link persons with newly diagnosed HIV to medical care within 30 days of HIV diagnosis and persons with previously diagnosed HIV who are out of care, including:
    a. Scheduling of first medical appointment, and
    b. Process for confirming the individual's attendance at the first medical appointment, in accordance with federal, state, and local policies.

- Terms of the Agreement to include the expiration and/or annual renewal date.
- Add the following statement to the service agreement: "[INSERT HIV Medical Care or PrEP Provider Organization] has read and agreed to the processes, roles, and responsibilities outlined in [INSERT Applicant Organization's] Linkage to HIV Medical Care and PrEP Provider Program Plan."
- Service Agreements for HIV Medical Care provider(s) should have the filename "Appendix_HMC Service Agreement;" and they should be uploaded as a PDF onto www.grants.gov.
- Service Agreements for PrEP provider(s) should have the filename "Appendix_PrEP Provider Service Agreement" and they should be uploaded as a PDF onto www.grants.gov.
- Signatures from the Business Official for the applicant organization and the HIV medical care and PrEP provider(s).

Health Department and HIV Planning Group (HPG) Collaboration
Recipients must coordinate and collaborate with state and local health departments. Specifically, recipients are expected to collaborate with the health department in the following ways:

- Refer PWH or qualifying STI to Partner Services, provided in accordance with local and/or state regulations.
- Use or engage with an existing referral network of PrEP and nPEP clinical service providers to support referral of clients considered to be at increased risk for acquiring HIV to these providers (e.g., PrEPlocator.org, PrEP warmlines, TelePrEP, or existing resources in the jurisdiction).

- Participate in the state and/or local HIV Planning Group (HPG) process as defined by the local or state health department jurisdiction where the recipient is located.
- Support the integration of HIV prevention activities with STI, adolescent and school-based health, viral hepatitis, and TB screening and prevention services, whenever feasible and appropriate.
- Establish contact with other organizations serving the priority population(s) in the proposed service area(s) to facilitate dialogue and explore opportunities related to HIV/STI prevention and health and wellness approaches, including comprehensive sexual health.
- Develop their navigation and prevention and essential support services components to align with and complement existing efforts in their jurisdiction.
- Provide an update to the HPG on the final PS22-2203 approved program. The update may be provided at an HPG meeting or via written report. Coordination should be made with the HPG and/or health department contact to determine how the update shall be provided.

Additionally, recipients must work with their state and/or local health department where the organization is located to conduct the following:

- Identify specific areas where priority population members reside and/or frequent.
- Obtain a written agreement from the local or state health department that supports providing the CBO throughout the period of performance with the necessary data to identify and focus HIV prevention services in areas most affected. (See Attachment C: Health Department Letter of Support/Health Department Prioritized HIV Testing and Partner Services Letter of Agreement)

Other CDC-funded Programs

If multiple organizations are funded within a jurisdiction, funded organizations are encouraged to collaborate with other PS22-2203 funded organizations to facilitate information exchange, eliminate duplication of efforts, and to reduce oversaturation of HIV Prevention services in known venues frequented by the priority population(s).

Potential collaborations with other CDC-funded Programs

- PS18-1802: Integrated Human Immunodeficiency Virus (HIV) Surveillance and Prevention Programs for Health Departments
- PS18-1807: Promoting Adolescent Health Through School-Based HIV/STD Prevention
- PS19-1901: Strengthening STD Prevention and Control for Health Department
- PS19-1904: Capacity Building Assistance for High-Impact HIV Prevention
- PS19-1906: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States
- PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States
- PS21-2102: Comprehensive High-Impact HIV Prevention Programs for Community-Based Organizations
- PS21-2103: Integrated Viral Hepatitis Surveillance and Prevention Funding for Health Departments

b. With organizations not funded by CDC:

Recipients may establish, build, and/or maintain collaborative relationships that will support the implementation of the proposed program. Consideration should be given to developing strategic partnerships with the following types of organizations: federal agencies (e.g., the Health Resources and Services Administration, the Centers for Medicaid and Medicare Services) and their recipients; public health departments; American Indian/Alaska Native tribal governments and/or tribally designated organizations; local and state education agencies; colleges and universities; non-CDC funded CBOs; capacity building assistance organizations; faith-based organizations; for-profit organizations; clinics and hospitals; non-government organizations; state and local governments; community advocates; community members; and other stakeholders that may have a vested interest in promoting health through HIV prevention, care, and treatment. For additional information on other federally funded programs, visit https://www.cdc.gov/hiv/policies/

MOA/MOU for Prevention and Essential Support Services

Applicants will be required to:

- Submit **at least two** established MOA/MOU with a Prevention and Essential Support Service provider (internal or external to the organization), regardless of whether the services are being provided internally or externally. The MOA/MOU should be reflective of the services most requested by the priority population(s). Applicants must file the MOU/MOA, as appropriate, name the file "PESS MOUs_MOAs" and upload it as a pdf file at www.grants.gov.

Recipients are encouraged to establish additional collaborations supported by MOAs/MOUs over the course of the five (5)-year period of performance. When establishing prevention and essential support services MOAs/MOUs, the applicant should consider the following:

- Proximity of the provider to the applicant's service area.
- The provider's capacity and history to serve the priority population(s).
- Payment requirements for services rendered (e.g., Ryan White provider, type of health insurance accepted).
- Types of services available for persons with HIV and HIV-negative persons at increased risk of acquiring HIV to access.
- Accessibility and availability of telehealth by the provider if option is requested by the applicant.

Additionally, the MOAs/MOUs must include, but is not limited to, the following:

- Name and address of the provider(s).
- Name, title, and contact information (i.e., primary work address, email, and phone number) for the primary point of contact for the provider.
- Detailed description of the agreed-upon referral processes for prevention and essential support services between the applicant and the prevention and essential support service provider.
- Process for confirming that the individual accessed the service, in accordance with federal, state, and local policies.

- Signatures from the Business Official for the applicant and the prevention and essential support services provider.

2. Target Populations

Funding will be made available for activities under two categories:

Category A: HIV prevention services for Young Men of Color Who Have Sex with Men (YMSM of color) and their partners regardless of age, gender, and race/ethnicity.

Category B: HIV prevention services for Young Transgender Persons of Color (YTG persons of color) and their partners regardless of age, gender, and race/ethnicity.

- Applicants must select one of the two proposed priority population(s) from those populations identified within their local or state health department's most current Jurisdictional HIV Prevention Plan and/or Integrated HIV Prevention and Care Plan as being people living with or at greatest risk of HIV infection.
- Applicants must deliver services in the following 22 states listed below in addition to Washington, DC and Puerto Rico. These locations were selected based on the number of MSM of color aged 13-29 years living with diagnosed HIV at the end of 2019 (National HIV Surveillance System)[4]. These locations have greater than 100 reported HIV cases among this population. Implementation of services in the listed 22 states, Washington, DC, and Puerto Rico will provide the greatest effectiveness for this funding because it will reach those areas with the greatest need for the HIV prevention services prioritizing YMSM of color. Currently, there are limited national surveillance data available for transgender populations.

Alabama	Georgia	Maryland	New Jersey	Ohio	Tennessee
Arizona	Illinois	Michigan	New York	Pennsylvania	Texas
California	Indiana	Missouri	Nevada	Puerto Rico	Virginia
Florida	Louisiana	Mississippi	North Carolina	South Carolina	Washington, DC

- This plan should include social determinants data to identify communities that are disproportionately affected by HIV and plan activities to reduce or eliminate these disparities. Disparities by race, ethnicity, gender identity, sexual orientation, geography, socioeconomic status, disability status, primary language, health literacy, and other relevant dimensions (e.g., tribal communities) should be considered. (See Attachment B: Organizational Capacity and Proposed Priority Population Worksheet)
- Applicants are expected to include a link directly to their health department's Jurisdictional HIV Prevention Plan, HIV surveillance epidemiological data on priority population(s), Integrated HIV Prevention and Care Plan, and/or Ending the HIV Epidemic in the United States Plan.
- Attachment B: Organizational Capacity and Proposed Priority Population Worksheet must be submitted with the application.
- Applicants must address how they will include specific populations who can benefit from the program.

a. Health Disparities

All applicants must design their program specific to the priority population for the Category for which the applicant applies. Applicants must design their program specific to either Category A (YMSM of color) or Category B (YTG persons of color), but not both categories. All applicants must design their programs so that it is accessible and available to the priority population chosen in either Category A or B. Disparities by race, ethnicity, gender identity, sexual orientation, geography, socioeconomic status, disability status, primary language, health literacy, and other relevant dimensions (e.g., tribal communities) should be considered when developing the proposed program and identifying the priority population(s). Organizations that are funded under this NOFO will be required to provide services to the primary prioritized population(s) specified in their applications; however, no persons will be turned away from services, regardless of their race, ethnicity, or other demographic characteristics. In addition, the prioritized population described in the work plan and narrative must match the prioritized population identified in the *Attachment B: Organizational Capacity and Proposed Priority Population Worksheet.*

Health Equity

The program should support efforts to improve the health of populations disproportionately affected by HIV, viral hepatitis, sexually transmitted infections (STIs), and TB by maximizing the health impact of public health services, reducing disease incidence, and advancing health equity.

A health disparity occurs when a health outcome is seen to a greater or lesser extent between populations. Health disparities in HIV, viral hepatitis, STIs, and TB are inextricably linked to a complex blend of social determinants that influence which populations are most disproportionately affected by these infections and diseases.

Social determinants are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes (https://www.cdc.gov/socialdeterminants/index.htm). These include conditions for early childhood development; education, employment, and work; food security, health services, housing, income, and social exclusion. Health equity is a desirable goal that entails special efforts to improve the health of those who have experienced social or economic challenges. It requires:

- Continuous efforts focused on elimination of health disparities, including disparities in health and in the living and working conditions that influence health, and
- Continuous efforts to maintain a desired state of equity after health disparities are eliminated.

Programs should use data, including social determinants data, to identify communities within their jurisdictions that are disproportionately affected by HIV, viral hepatitis, STIs and TB and related diseases and conditions, and plan activities to help eliminate health disparities. In collaboration with partners and appropriate sectors of the community, programs should consider social determinants of health in the development, implementation, and evaluation of program specific efforts and use culturally and linguistically appropriate interventions and strategies that are tailored for the communities for which they are intended.

iv. Funding Strategy

Funding will be made available for activities under two categories:

- **Category A:** HIV prevention services for Young Men of Color Who Have Sex with Men (YMSM of color) and their partners regardless of age, gender, and race/ethnicity.
- **Category B:** HIV prevention services for Young Transgender Persons of Color (YTG persons of color) and their partners regardless of age, gender, and race/ethnicity.

Applicants are eligible to apply for funding under **one** of the above funding categories. CDC will not consider any application applying for two categories.

b. Evaluation and Performance Measurement

i. CDC Evaluation and Performance Measurement Strategy

Evaluation and performance measurement help demonstrate achievement of proposed program outcomes; build a stronger evidence base for specific program strategies; clarify applicability of the evidence base to different populations, settings, and contexts; and drive continuous program improvement. Proposed evaluation and performance measurement can also determine if program strategies are scalable and effective at reaching priority populations.

Applicants must provide an evaluation and performance measurement plan that is consistent with their PS22-2203 work plan and the CDC evaluation and performance measurement strategy. When developing their budget, applicants should not allocate more than 10% of their total budget to support evaluation staff, consultants and/or contractors. The applicant must describe how they will use the PS22-2203 funds allocated to support evaluation activities.

The CDC National HIV Prevention Program Monitoring and Evaluation (NHM&E) strategy for monitoring and evaluating programs and recipients performance will include several activities, spanning both process monitoring and evaluation and monitoring of outcomes, and will be consistent with the logic model and approach previously presented. Guidance on collecting, using, and submitting NHM&E and other performance targets will be provided by CDC on an ongoing basis throughout the period of performance.

Key evaluation questions to be answered, include but are not limited to the following. To what extent do CBOs:

1. Conduct HIV testing among persons at increased risk for acquiring HIV?
2. Identify persons with newly diagnosed HIV?
3. Link or re-engage persons with HIV to HIV medical care?
4. Refer or link clients at increased risk for acquiring HIV to PrEP services?
5. Refer persons with HIV or qualifying STI to Partner Services?
6. Refer persons with HIV and persons at increased risk of acquiring HIV to prevention and essential support services?
7. Screen for STI and viral hepatitis?
8. Distribute condoms to ALL persons regardless of HIV status?
9. Integrate prevent and care services?

Data collection initiated under this grant/cooperative agreement has been approved by the Office

of Management and Budget (OMB) under OMB No. 0920-0696, Exp. 10/31/2021, National HIV Prevention Monitoring and Evaluation, Expiration Date October 31, 2021. OMB approval will be renewed and updated to satisfy the data collection requirements for this NOFO. Any change to the existing data collection will be subject to review and approval by the Office of Management and Budget under the Paperwork Reduction Act.

Recipients will be responsible for NHM&E data collection and reporting that include, but are not limited to, standardized data reporting as described under the OMB ICR #0920-0696. Data collection and reporting requirements will be limited to data that will be analyzed and used for program monitoring and quality improvement. Recipients will submit to CDC the required NHM&E data on the implementation of the approved HIV prevention programs funded under this NOFO. These data will be used by CDC to calculate indicators and generate Rapid Feedback Reports (RFRs) regarding program accomplishments related to this NOFO, DHP's Strategic Plan, and the HIV Plan goals.

Required NHM&E data include, but are not limited to:
1. Test-level data: Test-level data are reported for each HIV test provided.
2. Individual-level data: Individual-level data are reported for individual clients who receive CDC-funded services (e.g., provision and referral of Prevention and Essential Support Services).

Recipients will collect and report both qualitative and quantitative data for required performance reporting. CDC will also work with recipients to report data on costs of the services supported by funding from this NOFO.

CDC will review evaluation findings and performance measures routinely and identify (1) areas in need of program improvement and additional capacity building assistance, and (2) programs demonstrating substantial success in specific program areas. Evaluation findings and performance targets will be used to demonstrate the value of this program and describe effective implementation of the NOFO.

Performance measurement findings will be shared with recipients at least twice a year through the dissemination of rapid feedback reports (RFRs). The RFR will summarize each recipient's performance as well as the performance of all other recipients funded under this NOFO. Evaluation results may be shared at national conferences, through publication in peer-reviewed journals, and via online reports. In addition, CDC may partner with recipients to conduct focused evaluation assessments and/or studies to describe and/or assess effectiveness of program strategies (e.g., safe space utilization).

Outcomes and Indicators
Prioritized HIV Testing

- *Short-term Outcome 1* – Increased HIV testing among priority populations
    - Indicator 1: Number and percentage of HIV tests conducted among priority populations
        - Recipients must conduct **at least 75%** of HIV testing among priority populations—YMSM of color and YTG persons of color and their partners

- *Short-term Outcome 2* – Increased HIV diagnoses among priority population clients unaware of their HIV status
    - Indicator 2: Number and percentage of persons with newly diagnosed HIV identified through PS22-2203 funds
        - Recipients of Category A must annually identify **a minimum of 8 new HIV diagnoses** among YMSM of color.
        - Recipients of Category B must annually identify a **minimum of 6 new HIV diagnoses** among YTG persons of color.

Status Neutral Comprehensive High-Impact HIV Prevention

- *Short-term Outcome 3* – Increased access to prevention and essential support services
    - Indicator 3: Percentage of persons referred to or provided prevention and essential support services
        - Recipients must refer **at least 90%** of priority population clients to or provide clients with one or more prevention and essential support services, regardless of HIV status.

- *Short-term Outcome 4* – Increased receipt of integrated screenings
    - Indicator 4: Percentage of PS22-2203 HIV tests conducted where client was provided screening for STIs (e.g., syphilis, gonorrhea, chlamydia), viral hepatitis, or TB in conjunction with PS22-2203 funded HIV testing

- *Short-term Outcome 5* – Increased access to condoms by priority populations
    - Indicator 5: Number of condoms offered to priority populations
        - Recipients must offer condoms to **100%** of priority population clients

- *Short-term Outcome 6* – Increased screenings, referrals, and linkage to PrEP
    - Indicator 6: Number and percentage of HIV-negative persons screened for, referred to, and linked to PrEP
        - Recipients must refer **at least 90%** of YMSM of color and YTG persons of color at increased risk for acquiring HIV to a PrEP provider or provide clients with these services directly.

- *Short-term Outcome 7* – Increased linkage to HIV care among persons with newly diagnosed HIV within 30 days
    - Indicator 7: Number and percentage of persons with newly diagnosed HIV linked to HIV medical care within 30 days
        - Recipients must link **at least 90%** of persons with newly diagnosed HIV into HIV medical care within 30 days of diagnosis.

- *Short-term Outcome 8* – Increased linkage to or re-engagement in HIV care among persons with previously diagnosed HIV, not in care, within 30 days
    - Indicator 8: Number and percentage of persons with previously diagnosed HIV, who are not in care, who are then linked to or re-engaged in HIV medical care within 30 days
        - Recipients must link or re-engage **at least 90%** of persons with previously diagnosed HIV, who are not in care to HIV medical care within 30 days.

- *Short-term Outcome 9* – Increased access to Partner Services among persons newly diagnosed with HIV or qualifying STI
    - Indicator 9: Percentage of persons newly diagnosed with HIV or qualifying STI referred to Partner Services
        - Recipients must refer **100%** of persons newly diagnosed with HIV or qualifying STI to Partner Services within 30 days, in accordance with state and local regulations

- *Short-term Outcome 10* – Increased access to appropriate medication adherence services
    - Indicator 10: Number and percentage of clients referred to or provided medication adherence services for HIV treatment or prevention
        - Recipients must refer **at least 90%** of clients to medication adherence services for HIV treatment or prevention or provide these services directly

ii. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How the applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, and other relevant data information (e.g., performance measures proposed by the applicant)
- Plans for updating the Data Management Plan (DMP) as new pertinent information becomes available. If applicable, throughout the lifecycle of the project. Updates to DMP should be provided in annual progress reports. The DMP should provide a description of the data that will be produced using these NOFO funds; access to data; data standards ensuring released data have documentation describing methods of collection, what the data represent, and data limitations; and archival and long-term data preservation plans. For more information about CDC's policy on the DMP, see https://www.cdc.gov/grants/additionalrequirements/ar-25.html.

Where the applicant chooses to, or is expected to, take on specific evaluation studies, the applicant should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan, including a DMP, if applicable, within the first 6 months of award, as described in the Reporting Section of this NOFO.

All recipients are expected to comply with the NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs (2011). All standards included in the NCHHSTP Data Security and Confidentiality Guidelines should be implemented by recipients, unless otherwise justified. A Certification of Compliance statement signed by an overall responsible party or parties (ORP) will be submitted annually to the CDC Project Officer at the same time the Annual Performance Report (APR) is submitted. For information on the data security and confidentiality guidelines and example certification statement, please refer to
http://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf

c. Organizational Capacity of Recipients to Implement the Approach

All applicants must demonstrate their existing or forthcoming capacity to successfully execute all proposed strategies and activities to meet the program requirements of the selected funding category. Applicants must have demonstrable expertise, experience, and/or capacity to develop, implement, and evaluate the required program strategies and activities. Applicants are required to provide the following informaiton on organizational capacity:

- Demonstrate that they have the requisite experience and credibility in working with the proposed priority population within the designated community consistently for at least the last 24 months. Applicant organizations should demonstrate that the organization (e.g., community-based organization, community health centers, hospitals with non-government and/or college/university affiliation) is rooted in the community specific to the funding category. Specific elements considered as part of the assessment include, but are not limited to, length of service, outcomes of the services, the applicant's overall relationship with the community.
- Provide a description of their mission; organizational structure; overall organizational budget and funding sources; staff size and expertise; the nature and scope of their work and capabilities; long-term sustainability plan; and other information that would help CDC assess the organization's infrastructure (including physical infrastructure) and capacity to implement the proposed program.
- Demonstrate that they have substantial experience providing HIV prevention and/or care services to the proposed priority population (i.e., YMSM of color or YTG persons of color) that are culturally, linguistically, and educationally appropriate.
- Demonstrate experience working with state, tribal, local, and/or territorial health departments, community health centers, and other community providers who serve the selected priority population(s) and propose plans to enhance existing and establish new formalized collaborative partnerships.
- Demonstrate that staff members have experience providing services to the priority population(s) and/or describesplans to hire staff that have experience working with the priority population(s). This includes experience and expertise related to the implementation of the required strategies and activities, recent examples of HIV prevention program development and implementation, specifically for the priority population(s), and demonstrated outcomes or benefits related to the HIV prevention services provided.
    - If applicable, the applicant will be expected to provide a description of their current CDC funded HIV prevention projects. When feasible, applicants must hire

direct service staff who are reflective of the priority population(s) and who have 12 months minimum experience working with the priority population(s).

Workforce Capacity
Applicants must provide details on their workforce capacity and competence, expertise and experience serving and/or working with the priority population(s) selected as it relates to all category-specific program strategies and activities.

Applicants should ensure sustainability efforts, to include Capacity Building Education/Workforce Development and/or Training programs for staff. The staff development plan should focus on personal and workforce development to enhance the skill set of the existing staff within the organization or help develop the skills and abilities of the youth in the mentorship program. This may be achieved by supporting staff to attend/participate in the following, but not limited to CDC/Capacity Building Assistance - Workforce Capacity Program/e-learning program, HIV Testing in Non-Clinical Settings Training, Behavioral Risk Reduction Intervention Training, and Grant Writing Workshop.

Appropriate Staffing
Applicants must provide evidence of adequate program management/staffing plans, performance measurement, evaluation, financial reporting, management of travel requirements, and workforce development and training. Applicants must have a plan to ensure the program has competent staff (e.g., accessing capacity building assistance to support workforce development), inclusive of subcontractors and consultants if applicable, throughout the duration of the five (5) year period of performance. The plan should be designed to promote and sustain peer leadership from within the priority population(s). Staff must have the breadth of subject matter expertise and experience required to conduct all proposed work.

Applicants should describe how they will assess staff competencies and develop a plan to address gaps through organizational and individual training and development opportunities. Additionally, a curriculum vitae or resume must be submitted for each existing key staff person who will be affiliated with this program - Executive Director, Principal Investigator, Program Manager, and Business Official. Applicants are also required to provide an agency-wide organizational chart and an organizational chart for the proposed program, name the file "Org Charts." Resumes/CVs should be uploaded as a PDF and named "ResumesCVs."

Work Plan Template
Applicants who wish to use a template for their work plan may find a sample work plan template on the PS22-2203 website (https://wwwdev.cdc.gov/hiv/funding/announcements/ps22-2203/index.html).

d. Work Plan
Applicants are required to provide a work plan that provides both a high-level overview of the entire five (5)-year period of performance and a detailed description of the first year of the award. The work plan should incorporate all NOFO-related program strategies and activities. Applicants should propose specific, measurable, achievable, realistic, and time-based (SMART) process and/or outcome objectives for each activity aligned with the related NOFO performance objectives. Also included should be the training, capacity building, and technical assistance (TA)

needs to support the implementation of the proposed program. Included in the work plan should be a concise description on how the recipients plan to implement and monitor each program activity.

Note: Post-award, proposed work plan activities may be adjusted in collaboration with CDC to better address the overarching goals and/or changing jurisdictional dynamics of the project.

The applicant should address the following outlined in their work plan:

- Five (5)-Year Overview of Program (include narrative)
    - Intended outcomes for the entire five (5)-year period of performance
- Year 1 Detailed Work Plan
    - Program strategies and activities
    - SMART objectives aligned with performance targets (including quantitative baselines and targets, based on the proposed program, that lead to an increase, decrease, or maintenance over time)
    - The following program measures are required and should be included in the work plan:
        - Number and percentage of HIV tests conducted (At least 75% of HIV test among priority populations)
        - Number and percentage of persons with newly diagnosed HIV identified through PS22-2203 funded testing
        - Percentage of persons referred to or provided prevention and essential support services (A minimum of 90% of priority population clients should be referred to or provided prevention and essential support services)
        - Percentage of PS22-2203 HIV tests conducted where client was provided screening for STIs (e.g., syphilis, gonorrhea, chlamydia), viral hepatitis, or TB in conjunction with PS22-2203 funded HIV testing
        - Number of condoms offered to priority populations
        - Number and percentage of HIV-negative clients at increased risk of acquiring HIV screened, referred, and linked to PrEP
        - Number and percentage of persons with newly diagnosed HIV identified through PS22-2203 funded testing linked to HIV medical care within 30 days (A minimum of 90% of persons with newly diagnosed HIV should be linked to HIV medical care within 30 days of diagnosis)
        - Number and percentage of persons with previously diagnosed HIV, not-in-care, linked to or re-engaged in HIV medical care within 30 days (A minimum of 90% of persons with previously diagnosed HIV, not-in-care, should be linked to or re-engaged in HIV medical care within 30 days)
        - Percentage of persons with newly diagnosed HIV or qualifying STI referred to Partner Services (100% of persons with newly diagnosed HIV should be referred to Partner Services, in accordance with state and local regulations)

- Number and percentage of clients referred to or provided medication adherence services for HIV treatment of prevention (A minimum of 90% of clients should be referred to or provided medication adherence services)

- Activities aligned with program objectives
- Timeline for implementation (including staffing of the proposed program, CBA/TA and training, etc.)

Work Plan Template

A work plan template is not required; however, for applicants who wish to use a template for their work plan, a sample work plan template is located on the PS22-2203 website (https://wwwdev.cdc.gov/hiv/funding/announcements/ps22-2203/index.html).

e. CDC Monitoring and Accountability Approach

Monitoring activities include routine and ongoing communication between CDC and recipients, site visits, and recipient reporting (including work plans, performance, and financial reporting). Consistent with applicable grants regulations and policies, CDC expects the following to be included in post-award monitoring for grants and cooperative agreements:

- Tracking recipient progress in achieving the desired outcomes.
- Ensuring the adequacy of recipient systems that underlie and generate data reports.
- Creating an environment that fosters integrity in program performance and results.

Monitoring may also include the following activities deemed necessary to monitor the award:

- Ensuring that work plans are feasible based on the budget and consistent with the intent of the award.
- Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes.
- Working with recipients on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets.
- Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.

Monitoring and reporting activities that assist grants management staff (e.g., grants management officers and specialists, and project officers) in the identification, notification, and management of high-risk recipients.

Recipients performing at a less than sufficient level to achieve program objectives within stated timeframes will be placed on a time-phased Improvement Plan (IP) developed by the CDC Project Officer in collaboration with the recipient. The IP is a comprehensive tool used to assist recipients to improve program performance through identifying factors contributing to less than sufficient performance and developing specific action steps to address areas in need of improvement.

In addition to those listed, other activities deemed necessary to monitor the award may be applied.

f. CDC Program Support to Recipients

In a cooperative agreement, CDC staff will be substantially involved in the program activities, above and beyond routine grant monitoring. CDC activities for this program are as follows:

- Collaborate to ensure coordination and implementation of strategies to arrange for availability of HIV prevention providers in non-healthcare and healthcare organizations.
- Work with recipients to identify and address CBA/TA needs that are essential to the success of the project.
    - Within the first three (3) months of funding, recipients must work with the assigned CDC Project Officer to establish a Capacity Building Assistance (CBA) Tracking System (CTS) user account to facilitate receipt of capacity building assistance.
    - Within the first six (6) months of funding, CDC will work with the recipients to identify plans for participation in all appropriate CDC approved trainings.
        - Applicants will have access to training and technical assistance that will strengthen staff capacity relevant to all required strategies and activities of the program.
        - Recipients will be required to participate in CDC approved trainings on NHM&E requirements, data collection and submission, HIV testing, evidence-based interventions, etc.
    - Within the first six (6) months of funding, CDC will work with recipients to finalize data collection, use, and submission requirements.
- Facilitate coordination, collaboration, and, where feasible, service integration among federal agencies, other CDC funded programs, health departments, local and state planning groups, other CDC directly-funded CBOs, national capacity building assistance providers, medical care providers and other recipients of the Ryan White HIV/AIDS Treatment Extension Act of 2009, and other partners working with people living with and at greatest risk of acquiring HIV toward common goals of risk reduction, disease detection, and a continuum of HIV prevention, care, and treatment.
- Monitor recipient program performance (by Program Office) via use of multiple approaches, such as site visits, emails, conference calls, and standardized review of performance reports and other data reports, to support program development, implementation, evaluation, and improvement.
- Provide guidance and coordination to funded organizations to improve the quality and effectiveness of work plans, evaluation strategies, products and services, and collaborative activities with other organizations.
- Collaborate to compile and publish accomplishments, best practices, performance criteria, and lessons learned during the period of performance.
- Collaborate, as appropriate, in assessing progress toward meeting strategic and operational goals/objectives and in establishing measurement and accountability systems for documenting outcomes, such as increased performance improvements and best or promising practices.

- Collaborate on strategies to ensure the provision of appropriate and effective HIV prevention services to target populations, as deemed appropriate and as requested.
- Provide requirements and expectations for standardized and other data reporting and support monitoring and evaluation (M&E) activities with CDC and contractual TA, including web-based training on NHM&E, materials such as data collection tools, and online TA via the NHM&E Service Center.
- Convene, plan, and facilitate recipient meeting(s) during the period of performance.

B. Award Information

1. Funding Instrument Type:

CA (Cooperative Agreement)

CDC's substantial involvement in this program appears in the CDC Program Support to Recipients Section.

2. Award Mechanism:

U65

3. Fiscal Year:

2022

4. Approximate Total Fiscal Year Funding:

$11,000,000

5. Total Period of Performance Funding:

$55,000,000

This amount is subject to the availability of funds.

- Category A - $41,250,000
- Category B - $13,750,000

Estimated Total Funding:

$55,000,000

6. Total Period of Performance Length:

5

year(s)

7. Expected Number of Awards:

30

8. Approximate Average Award:

$350,000

Per Budget Period

9. Award Ceiling:

$0
Per Budget Period

This amount is subject to the availability of funds.

10. Award Floor:
$0
Per Budget Period

11. Estimated Award Date:
April 01, 2022

12. Budget Period Length:
12 month(s)

Throughout the project period, CDC will continue the award based on the availability of funds, the evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the federal government. The total number of years for which federal support has been approved (project period) will be shown in the "Notice of Award." This information does not constitute a commitment by the federal government to fund the entire period. The total period of performance comprises the initial competitive segment and any subsequent non-competitive continuation award(s).

13. Direct Assistance
Direct Assistance (DA) is not available through this NOFO.

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

C. Eligibility Information

1. Eligible Applicants

Eligibility Category:
25 (Others (see text field entitled "Additional Information on Eligibility" for clarification))

99 (Unrestricted (i.e., open to any type of entity above), subject to any clarification in text field entitled "Additional Information on Eligibility")

2. Additional Information on Eligibility

Applicants are eligible to apply for funding under **one** category (**Category A or B**). This NOFO is seeking applications from organizations that were founded for the purpose of serving the selected priority population(s) and are rooted or embedded within the communities they serve.

- Applicants may provide HIV prevention services in a **maximum of three (3) service areas** within the applicant's jurisdiction. Applicants can provide HIV prevention services in areas that cross over into bordering state health department jurisdictions (e.g., District of Columbia, Maryland, and Virginia).

- The applicant must have a history of providing HIV prevention services in the applicant's jurisdiction, discussed provision of services with their state or local health department in which they report HIV diagnoses, and received written consent from state or local health department. (See Attachment C: Health Department Letter of Support/Health Department Prioritized HIV Testing and Partner Services Letter of Agreement).

Additionally, applicants must submit the following documents listed as attachments. Applicants will be considered non-responsive and will be deemed ineligible if the documents are not submitted with the application.

- Health Department Agreement for HIV Testing/Partner Services Letter (See Attachment C: Health Department Letter of Support and Prioritized HIV Testing and Partner Services Letter of Agreement). The form should be saved as a PDF, named "Attachment C_HIV Testing Documents," and uploaded onto www.grants.gov.
- Service Agreement(s) with HIV Medical Care Provider(s). The form should be saved as a PDF, named "Appendix_HMC Service Agreement" and uploaded onto www.grants.gov.
- Service Agreement(s) with PrEP provider(s). The form should be saved as a PDF, named “Appendix_PrEP Provider Service Agreement,” and uploaded onto www.grants.gov.
- Applicant must demonstrate engagement and provision of HIV prevention or care services to the selected priority population(s). Examples include Progress Reports, Notice of Award or Media publications, or letter from an applicant’s funding source, other than CDC, documenting the applicant’s service to the priority population. The evidence of prevention or care service should be uploaded as a PDF and named "Appendix_Evidence of Service".

3. Justification for Less than Maximum Competition

N/A

4. Cost Sharing or Matching

Cost Sharing / Matching Requirement:

No

Cost sharing or matching funds are not required for this program. Although no statutory matching requirement for this NOFO exists, leveraging other resources and related ongoing efforts to promote sustainability is strongly encouraged.

5. Maintenance of Effort

Maintenance of effort is not required for this program.

D. Application and Submission Information

1. Required Registrations

An organization must be registered at the three following locations before it can submit an application for funding at www.grants.gov.

a. Data Universal Numbering System:

All applicant organizations must obtain a Data Universal Numbering System (DUNS) number. A DUNS number is a unique nine-digit identification number provided by Dun & Bradstreet (D&B). It will be used as the Universal Identifier when applying for federal awards or cooperative agreements.
The applicant organization may request a DUNS number by telephone at 1-866-705-5711 (toll free) or internet at http:// fedgov.dnb. com/ webform/ displayHomePage.do. The DUNS number will be provided at no charge.
If funds are awarded to an applicant organization that includes sub-recipients, those sub-recipients must provide their DUNS numbers before accepting any funds.

b. System for Award Management (SAM):
The SAM is the primary registrant database for the federal government and the repository into which an entity must submit information required to conduct business as a recipient. All applicant organizations must register with SAM, and will be assigned a SAM number. All information relevant to the SAM number must be current at all times during which the applicant has an application under consideration for funding by CDC. If an award is made, the SAM information must be maintained until a final financial report is submitted or the final payment is received, whichever is later. The SAM registration process can require 10 or more business days, and registration must be renewed annually. Additional information about registration procedures may be found at SAM.gov and the SAM.gov Knowledge Base.

c. Grants.gov:
The first step in submitting an application online is registering your organization at www.grants.gov, the official HHS E-grant Web site. Registration information is located at the "Applicant Registration" option at www.grants.gov.
All applicant organizations must register at www.grants.gov. The one-time registration process usually takes not more than five days to complete. Applicants should start the registration process as early as possible.

Step	System	Requirements	Duration	Follow Up
1	Data Universal Number System (DUNS)	1. Click on http:// fedgov.dnb.com/ webform 2. Select Begin DUNS search/request process 3. Select your country or territory and follow the instructions to obtain your DUNS 9-digit # 4. Request appropriate staff member(s) to obtain DUNS number, verify & update information under DUNS number	1-2 Business Days	To confirm that you have been issued a new DUNS number check online at (http:// fedgov.dnb.com/ webform) or call 1-866-705-5711

2	System for Award Management (SAM) formerly Central Contractor Registration (CCR)	1. Retrieve organizations DUNS number 2. Go to SAM.gov and designate an E-Biz POC (note CCR username will not work in SAM and you will need to have an active SAM account before you can register on grants.gov)	3-5 Business Days but up to 2 weeks and must be renewed once a year	For SAM Customer Service Contact https://fsd.gov/ fsd-gov/ home.do Calls: 866-606-8220
3	Grants.gov	1. Set up an individual account in Grants.gov using organization new DUNS number to become an authorized organization representative (AOR) 2. Once the account is set up the E-BIZ POC will be notified via email 3. Log into grants.gov using the password the E-BIZ POC received and create new password 4. This authorizes the AOR to submit applications on behalf of the organization	Same day but can take 8 weeks to be fully registered and approved in the system (note, applicants MUST obtain a DUNS number and SAM account before applying on grants.gov)	Register early! Log into grants.gov and check AOR status until it shows you have been approved

2. Request Application Package

Applicants may access the application package at www.grants.gov.

3. Application Package

Applicants must download the SF-424, Application for Federal Assistance, package associated with this notice of funding opportunity at www.grants.gov.

4. Submission Dates and Times

If the application is not submitted by the deadline published in the NOFO, it will not be processed. Office of Grants Services (OGS) personnel will notify the applicant that their application did not meet the deadline. The applicant must receive pre-approval to submit a paper application (see Other Submission Requirements section for additional details). If the applicant is authorized to submit a paper application, it must be received by the deadline provided by OGS.

a. Letter of Intent Deadline (must be emailed or postmarked by)

Due Date for Letter Of Intent 10/04/2021

The LOI date will generate once the Synopsis is published if Days or a Date are entered.

b. Application Deadline

Due Date for Applications 11/19/2021

11/19/2021

11:59 pm U.S. Eastern Standard Time, at www.grants.gov. If Grants.gov is inoperable and cannot receive applications, and circumstances preclude advance notification of an extension, then applications must be submitted by the first business day on which grants.gov operations resume.

Due Date for Information Conference Call

To obtain a schedule of the pre-application and technical assistance activities or additional information related to this notice of funding opportunity, please visit (https://www.cdc.gov/hiv/funding/announcements/ps22-2203/index.html).

5. Pre-Award Assessments

Risk Assessment Questionnaire Requirement

CDC is required to conduct pre-award risk assessments to determine the risk an applicant poses to meeting federal programmatic and administrative requirements by taking into account issues such as financial instability, insufficient management systems, non-compliance with award conditions, the charging of unallowable costs, and inexperience. The risk assessment will include an evaluation of the applicant's CDC Risk Questionnaire, located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, as well as a review of the applicant's history in all available systems; including OMB-designated repositories of government-wide eligibility and financial integrity systems (see 45 CFR 75.205(a)), and other sources of historical information. These systems include, but are not limited to: FAPIIS (https://www.fapiis.gov/), including past performance on federal contracts as per Duncan Hunter National Defense Authorization Act of 2009; Do Not Pay list; and System for Award Management (SAM) exclusions.

CDC requires all applicants to complete the Risk Questionnaire, OMB Control Number 0920-1132 annually. This questionnaire, which is located at https://www.cdc.gov/grants/documents/PPMR-G-CDC-Risk-Questionnaire.pdf, along with supporting documentation must be submitted with your application by the closing date of the Notice of Funding Opportunity Announcement. If your organization has completed CDC's Risk Questionnaire within the past 12 months of the closing date of this NOFO, then you must submit a copy of that questionnaire, or submit a letter signed by the authorized organization representative to include the original submission date, organization's EIN and DUNS.

When uploading supporting documentation for the Risk Questionnaire into this application package, clearly label the documents for easy identification of the type of documentation. For example, a copy of Procurement policy submitted in response to the questionnaire may be labeled using the following format: Risk Questionnaire Supporting Documents _ Procurement Policy.

Duplication of Efforts

Applicants are responsible for reporting if this application will result in programmatic, budgetary, or commitment overlap with another application or award (i.e. grant, cooperative agreement, or contract) submitted to another funding source in the same fiscal year. Programmatic overlap occurs when (1) substantially the same project is proposed in more than one application or is submitted to two or more funding sources for review and funding

consideration or (2) a specific objective and the project design for accomplishing the objective are the same or closely related in two or more applications or awards, regardless of the funding source. Budgetary overlap occurs when duplicate or equivalent budgetary items (e.g., equipment, salaries) are requested in an application but already are provided by another source. Commitment overlap occurs when an individual's time commitment exceeds 100 percent, whether or not salary support is requested in the application. Overlap, whether programmatic, budgetary, or commitment of an individual's effort greater than 100 percent, is not permitted. Any overlap will be resolved by the CDC with the applicant and the PD/PI prior to award.

Report Submission: The applicant must upload the report in Grants.gov under "Other Attachment Forms." The document should be labeled: "Report on Programmatic, Budgetary, and Commitment Overlap."

6. Content and Form of Application Submission

Applicants are required to include all of the following documents with their application package at www.grants.gov.

7. Letter of Intent

The purpose of an LOI is to allow CDC program staff to estimate the number of and plan for the review of submitted applications.

Completed LOI must be sent via email to CBOFOA@cdc.gov
Erica K. Dunbar
CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Address: 1600 Clifton Road NE-MS US8-3 Atlanta, GA 30329
Email address: CBOFOA@cdc.gov
Visit the PS22-2203 website: https://www.cdc.gov/hiv/funding/announcements/ps22-2203/index.html, and click on the Letter of Intent to Apply for Funding link to complete the form. Please note the Letter of Intent is requested but not required.

8. Table of Contents

(There is no page limit. The table of contents is not included in the project narrative page limit.): The applicant must provide, as a separate attachment, the "Table of Contents" for the entire submission package.

Provide a detailed table of contents for the entire submission package that includes all of the documents in the application and headings in the "Project Narrative" section. Name the file "Table of Contents" and upload it as a PDF file under "Other Attachment Forms" at www.grants.gov.

9. Project Abstract Summary

A project abstract is included on the mandatory documents list and must be submitted at www.grants.gov. The project abstract must be a self-contained, brief summary of the proposed project including the purpose and outcomes. This summary must not include any proprietary or confidential information. Applicants must enter the summary in the "Project Abstract Summary" text box at www.grants.gov.

10. Project Narrative

(Unless specified in the "H. Other Information" section, maximum of 20 pages, single spaced, 12 point font, 1-inch margins, number all pages. This includes the work plan. Content beyond the specified page number will not be reviewed.)

Applicants must submit a Project Narrative with the application forms. Applicants must name this file "Project Narrative" and upload it at www.grants.gov. The Project Narrative must include **all** of the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. The Project Narrative must be succinct, self-explanatory, and in the order outlined in this section. It must address outcomes and activities to be conducted over the entire period of performance as identified in the CDC Project Description section. Applicants should use the federal plain language guidelines and Clear Communication Index to respond to this Notice of Funding Opportunity. Note that recipients should also use these tools when creating public communication materials supported by this NOFO. Failure to follow the guidance and format may negatively impact scoring of the application.

a. Background

Applicants must provide a description of relevant background information that includes the context of the problem (See CDC Background).

b. Approach

i. Purpose

Applicants must describe in 2-3 sentences specifically how their application will address the public health problem as described in the CDC Background section.

ii. Outcomes

Applicants must clearly identify the outcomes they expect to achieve by the end of the project period, as identified in the logic model in the Approach section of the CDC Project Description. Outcomes are the results that the program intends to achieve and usually indicate the intended direction of change (e.g., increase, decrease).

iii. Strategies and Activities

Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the period of performance outcomes. Applicants must select existing evidence-based strategies that meet their needs, or describe in the Applicant Evaluation and Performance Measurement Plan how these strategies will be evaluated over the course of the project period. See the Strategies and Activities section of the CDC Project Description.

1. Collaborations

Applicants must describe how they will collaborate with programs and organizations either internal or external to CDC. Applicants must address the Collaboration requirements as described in the CDC Project Description.

2. Target Populations and Health Disparities

Applicants must describe the specific target population(s) in their jurisdiction and explain how such a target will achieve the goals of the award and/or alleviate health disparities. The applicants must also address how they will include specific populations that can benefit from the program that is described in the Approach section. Applicants must address the Target Populations and Health Disparities requirements as described in the CDC Project Description.

c. Applicant Evaluation and Performance Measurement Plan

Applicants must provide an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. At a minimum, the plan must describe:

- How applicant will collect the performance measures, respond to the evaluation questions, and use evaluation findings for continuous program quality improvement. The Paperwork Reduction Act of 1995 (PRA): Applicants are advised that any activities involving information collections (e.g., surveys, questionnaires, applications, audits, data requests, reporting, recordkeeping and disclosure requirements) from 10 or more individuals or non-Federal entities, including State and local governmental agencies, and funded or sponsored by the Federal Government are subject to review and approval by the Office of Management and Budget. For further information about CDC's requirements under PRA see http://www.hhs.gov/ ocio/policy/collection/.
- How key program partners will participate in the evaluation and performance measurement planning processes.
- Available data sources, feasibility of collecting appropriate evaluation and performance data, data management plan (DMP), and other relevant data information (e.g., performance measures proposed by the applicant).

Where the applicant chooses to, or is expected to, take on specific evaluation studies, they should be directed to:

- Describe the type of evaluations (i.e., process, outcome, or both).
- Describe key evaluation questions to be addressed by these evaluations.
- Describe other information (e.g., measures, data sources).

Recipients will be required to submit a more detailed Evaluation and Performance Measurement plan (including the DMP elements) within the first 6 months of award, as described in the Reporting Section of this NOFO.

d. Organizational Capacity of Applicants to Implement the Approach

Applicants must address the organizational capacity requirements as described in the CDC Project Description.

If applicable, a curriculum vitae or resume must be submitted for each existing key staff person who will be affiliated with this program - Executive Director, Principal Investigator, Program Manager, and Business Official. Applicants are also required to provide an agency-wide organizational chart and an organizational chart for the proposed program, name the file "Org Charts." Resumes/CVs should be uploaded as a PDF and named "ResumesCVs."

11. Work Plan

(Included in the Project Narrative's page limit)

Applicants must prepare a work plan consistent with the CDC Project Description Work Plan section. The work plan integrates and delineates more specifically how the recipient plans to carry out achieving the period of performance outcomes, strategies and activities, evaluation and performance measurement.

12. Budget Narrative

Applicants must submit an itemized budget narrative. When developing the budget narrative, applicants must consider whether the proposed budget is reasonable and consistent with the purpose, outcomes, and program strategy outlined in the project narrative. The budget must include:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel
- Other categories
- Contractual costs
- Total Direct costs
- Total Indirect costs

Indirect costs could include the cost of collecting, managing, sharing and preserving data.

Indirect costs on grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000. Negotiated indirect costs may be paid to the American University, Beirut, and the World Health Organization.

If applicable and consistent with the cited statutory authority for this announcement, applicant entities may use funds for activities as they relate to the intent of this NOFO to meet national

standards or seek health department accreditation through the Public Health Accreditation Board (see: http://www.phaboard.org). Applicant entities to whom this provision applies include state, local, territorial governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau), or their bona fide agents, political subdivisions of states (in consultation with states), federally recognized or state-recognized American Indian or Alaska Native tribal governments, and American Indian or Alaska Native tribally designated organizations. Activities include those that enable a public health organization to deliver public health services such as activities that ensure a capable and qualified workforce, up-to-date information systems, and the capability to assess and respond to public health needs. Use of these funds must focus on achieving a minimum of one national standard that supports the intent of the NOFO. Proposed activities must be included in the budget narrative and must indicate which standards will be addressed.

Vital records data, including births and deaths, are used to inform public health program and policy decisions. If applicable and consistent with the cited statutory authority for this NOFO, applicant entities are encouraged to collaborate with and support their jurisdiction's vital records office (VRO) to improve vital records data timeliness, quality and access, and to advance public health goals. Recipients may, for example, use funds to support efforts to build VRO capacity through partnerships; provide technical and/or financial assistance to improve vital records timeliness, quality or access; or support vital records improvement efforts, as approved by CDC.

Applicants must name this file "Budget Narrative" and upload it as a PDF file at www.grants.gov. If requesting indirect costs in the budget, a copy of the indirect cost-rate agreement is required. If the indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those Recipients under such a plan. Applicants must name this file "Indirect Cost Rate" and upload it at www.grants.gov.

The itemized budget narrative should follow the format of the NOFO and be organized by program strategy: Prioritized HIV Testing; Status Neutral Comprehensive High-Impact HIV Prevention for Priority Populations; and Program Collaborations, Promotion, and Recruitment. At a minimum, the budget should include the following strategies and activities, where 75% of funds should be allocated to address Comprehensive High-Impact HIV prevention and care strategies (1&2) and 25% of funds allocated to address Program Collaborations, Promotion, and Recruitment (3):

1. Prioritized HIV Testing
2. Status Neutral Comprehensive High-Impact HIV Prevention for Priority Populations
    a. Prevention Services for Persons regardless of HIV status
    b. Status Neutral Prevention & Essential Services
3. Program Collaboration, Promotion, and Recruitment

Applicant organizations that propose to implement integrated screening activities must submit an itemized budget to support these activities, utilizing up to **5%** of total approved funding amount to support integrated screening as part of the overall Comprehensive High-Impact Prevention program budget.

Budget narrative should include plans to support travel for up to three staff persons to attend the Recipient Orientation meeting in Atlanta, Georgia, during Year 1.

13. Funds Tracking

Proper fiscal oversight is critical to maintaining public trust in the stewardship of federal funds. Effective October 1, 2013, a new HHS policy on subaccounts requires the CDC to set up payment subaccounts within the Payment Management System (PMS) for all new grant awards. Funds awarded in support of approved activities and drawdown instructions will be identified on the Notice of Award in a newly established PMS subaccount (P subaccount). Recipients will be required to draw down funds from award-specific accounts in the PMS. Ultimately, the subaccounts will provide recipients and CDC a more detailed and precise understanding of financial transactions. The successful applicant will be required to track funds by P-accounts/sub accounts for each project/cooperative agreement awarded. Applicants are encouraged to demonstrate a record of fiscal responsibility and the ability to provide sufficient and effective oversight. Financial management systems must meet the requirements as described 45 CFR 75 which include, but are not limited to, the following:

- Records that identify adequately the source and application of funds for federally-funded activities.
- Effective control over, and accountability for, all funds, property, and other assets.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement payment requirements.
- Written procedures for determining cost allowability.
- Written procedures for financial reporting and monitoring.

14. Pilot Program for Enhancement of Employee Whistleblower Protections

Pilot Program for Enhancement of Employee Whistleblower Protections: All applicants will be subject to a term and condition that applies the terms of 48 Code of Federal Regulations (CFR) section 3.908 to the award and requires that recipients inform their employees in writing (in the predominant native language of the workforce) of employee whistleblower rights and protections under 41 U.S.C. 4712.

15. Copyright Interests Provisions

This provision is intended to ensure that the public has access to the results and accomplishments of public health activities funded by CDC. Pursuant to applicable grant regulations and CDC's Public Access Policy, Recipient agrees to submit into the National Institutes of Health (NIH) Manuscript Submission (NIHMS) system an electronic version of the final, peer-reviewed manuscript of any such work developed under this award upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication. Also at the time of submission, Recipient and/or the Recipient's submitting author must specify the date the final manuscript will be publicly accessible through PubMed Central (PMC). Recipient and/or Recipient's submitting author must also post the manuscript through PMC within twelve (12) months of the publisher's official date of final publication; however the author is strongly

encouraged to make the subject manuscript available as soon as possible. The recipient must obtain prior approval from the CDC for any exception to this provision.

The author's final, peer-reviewed manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article. Recipient and its submitting authors working under this award are responsible for ensuring that any publishing or copyright agreements concerning submitted articles reserve adequate right to fully comply with this provision and the license reserved by CDC. The manuscript will be hosted in both PMC and the CDC Stacks institutional repository system. In progress reports for this award, recipient must identify publications subject to the CDC Public Access Policy by using the applicable NIHMS identification number for up to three (3) months after the publication date and the PubMed Central identification number (PMCID) thereafter.

16. Funding Restrictions

Restrictions that must be considered while planning the programs and writing the budget are:

- Recipients may not use funds for research.
- Recipients may not use funds for clinical care except as allowed by law.
- Recipients may use funds only for reasonable program purposes, including personnel, travel, supplies, and services.
- Generally, recipients may not use funds to purchase furniture or equipment. Any such proposed spending must be clearly identified in the budget.
- Reimbursement of pre-award costs generally is not allowed, unless the CDC provides written approval to the recipient.
- Other than for normal and recognized executive-legislative relationships, no funds may be used for:
    - publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
    - the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
- See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients.
- The direct and primary recipient in a cooperative agreement program must perform a substantial role in carrying out project outcomes and not merely serve as a conduit for an award to another party or provider who is ineligible.

Additional Funding Restrictions:

- Recipients may not use funds for construction.
- Recipients may not use funds to support direct implementation of school-based HIV prevention programs.
- Recipients may not use funds to purchase or supply medications.
- Recipients may not use funds to purchase sterile needles or syringes for drug injection.
- Recipients may not use funds for clinical services, such as the provision of PrEP and nPEP; treatment of HIV, STDs, viral hepatitis, and/or TB; vaccination against hepatitis A or hepatitis B; and vaccination against human papillomavirus (HPV).

17. Data Management Plan

As identified in the Evaluation and Performance Measurement section, applications involving data collection or generation must include a Data Management Plan (DMP) as part of their evaluation and performance measurement plan unless CDC has stated that CDC will take on the responsibility of creating the DMP. The DMP describes plans for assurance of the quality of the public health data through the data's lifecycle and plans to deposit the data in a repository to preserve and to make the data accessible in a timely manner. See web link for additional information:
https://www.cdc.gov/grants/additionalrequirements/ar-25.html

18. Other Submission Requirements

a. Electronic Submission:

Applications must be submitted electronically by using the forms and instructions posted for this notice of funding opportunity at www.grants.gov. Applicants can complete the application package using Workspace, which allows forms to be filled out online or offline. All application attachments must be submitted using a PDF file format. Instructions and training for using Workspace can be found at www.grants.gov under the "Workspace Overview" option.

b. Tracking Number: Applications submitted through www.grants.gov are time/date stamped electronically and assigned a tracking number. The applicant's Authorized Organization Representative (AOR) will be sent an e-mail notice of receipt when www.grants.gov receives the application. The tracking number documents that the application has been submitted and initiates the required electronic validation process before the application is made available to CDC.

c. Validation Process: Application submission is not concluded until the validation process is completed successfully. After the application package is submitted, the applicant will receive a "submission receipt" e-mail generated by www.grants.gov. A second e-mail message to applicants will then be generated by www.grants.gov that will either validate or reject the submitted application package. This validation process may take as long as two business days. Applicants are strongly encouraged to check the status of their application to ensure that submission of their package has been completed and no submission errors have occurred. Applicants also are strongly encouraged to allocate ample time for filing to guarantee that their application can be submitted and validated by the deadline published in the NOFO. Non-validated applications will not be accepted after the published application deadline date.

If you do not receive a "validation" e-mail within two business days of application submission, please contact www.grants.gov. For instructions on how to track your application, refer to the e-mail message generated at the time of application submission or the Grants.gov Online User Guide.

https:// www.grants.gov/help/html/help/index.htm? callingApp=custom#t= Get_Started%2FGet_Started. htm

d. Technical Difficulties: If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The www.grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at 1-800-518-4726 or by e-mail at support@grants.gov. Application submissions sent by e-mail or fax, or on CDs or thumb drives will not be accepted. Please note that www.grants.gov is managed by HHS.

e. Paper Submission: If technical difficulties are encountered at www.grants.gov, applicants should call the www.grants.gov Contact Center at 1-800-518-4726 or e-mail them at support@grants.gov for assistance. After consulting with the Contact Center, if the technical difficulties remain unresolved and electronic submission is not possible, applicants may e-mail CDC GMO/GMS, before the deadline, and request permission to submit a paper application. Such requests are handled on a case-by-case basis.

An applicant's request for permission to submit a paper application must:

1. Include the www.grants.gov case number assigned to the inquiry
2. Describe the difficulties that prevent electronic submission and the efforts taken with the www.grants.gov Contact Center to submit electronically; and
3. Be received via e-mail to the GMS/GMO listed below at least three calendar days before the application deadline. Paper applications submitted without prior approval will not be considered.

   If a paper application is authorized, OGS will advise the applicant of specific instructions for submitting the application (e.g., original and two hard copies of the application by U.S. mail or express delivery service).

E. Review and Selection Process

1. Review and Selection Process: Applications will be reviewed in three phases

a. Phase 1 Review

All applications will be initially reviewed for eligibility and completeness by CDC Office of Grants Services. Complete applications will be reviewed for responsiveness by the Grants Management Officials and Program Officials. Non-responsive applications will not advance to Phase II review. Applicants will be notified that their applications did not meet eligibility and/or published submission requirements.

b. Phase II Review

A review panel will evaluate complete, eligible applications in accordance with the criteria below.

i. Approach
ii. Evaluation and Performance Measurement
iii. Applicant's Organizational Capacity to Implement the Approach

Not more than thirty days after the Phase II review is completed, applicants will be notified electronically if their application does not meet eligibility or published submission requirements

i. Approach **Maximum Points:** 45

The review panel will evaluate eligible applications based on the applicant's experience, capacity, and ability to implement the published program requirements for the selected priority population(s) documented in the application. This review criteria will be applied to both Category A and Category B applications. The review panel will evaluate the extent to which the applicant:

- Presents outcomes that are consistent with the period of performance outcomes described in the NOFO project description and logic model **(5 points)**
- Presents a five (5)-year work plan overview and a detailed Year 1 work plan that is aligned with each of the required strategies and associated activities, outcomes, and performance measures in the approach and is consistent with the content and format proposed by CDC. **(5 points)**
- Describes a plan for implementing a comprehensive high-impact prevention program for the priority population clients who are at increased risk for acquiring HIV or living with HIV **(15 points)**. The proposed plan must include:
    - Description of how their program aligns with the goals and objectives of the HIV National Strategic Plan (HIV Plan) which also complements the EHE initiative
    - Description of their proposed strategies for conducting prioritized HIV testing among at least 75% of the proposed priority population(s) and their proposed strategies for conducting all of the required HIV testing activities (e.g., outreach, mobile testing, self-testing, HIV testing events, etc).
    - Description of the plans for implementing complementary services with the HIV testing program in accordance with NOFO requirements
    - Description of their proposed strategies for delivering status neutral comprehensive high-impact HIV prevention, based on guidance provided in the NOFO

- Describes plans for implementing the following activities as required by the NOFO, including **(5 points)**:

    - Linkage to HIV Medical Care and PrEP Services
    - Service agreements with HIV medical care and PrEP Providers
    - Re-engagement in HIV medical or preventative care services
    - Partner services referrals
    - Medication adherence services for HIV treatment or prevention
    - Status neutral prevention and essential support services
    - Risk reduction behavioral interventions (optional)
    - Condom distribution

- Proposes strategies for establishing formalized program collaborations, promotion, and recruitment efforts, community engagement group (CEG), and designated Safe Space activities. **(5 points)**
    - Applicant organizations must describe a plan to identify and address at least two social determinants of health that resonate with priority population members in efforts to reduce barriers to accessing HIV prevention and care services and other essential support services. **(5 points)**
- Proposes strategies for implementation of or referral to various integrated screening activities (e.g., screening for syndemic conditions such as STDs, viral hepatitis, and/or TB, in conjunction with HIV testing for members of their priority population(s)) regardless of HIV status **(5 points)**

ii. Evaluation and Performance Measurement **Maximum Points:** 10

The extent to which the applicant proposes an evaluation and performance measurement plan that is consistent with their work plan and the CDC evaluation and performance measurement strategy.

- Proposes an evaluation and performance measurement plan that demonstrates how the recipient will fulfill the requirements described in the CDC Evaluation and Performance Measurement and Project Description sections of this NOFO. **(2 points)**
- Proposes an evaluation and performance measurement plan that is consistent with their work plan and the CDC evaluation and performance measurement strategy. **(2 points)**
- Proposes an evaluation and performance measurement plan will answer key evaluation questions. **(2 points)**
- Proposes methods to collect and report both qualitative and quantitative data for required performance. **(2 points)**
- Proposes a plan that includes the use of data-driven approaches including the use of HIV surveillance data and other program data to support mapping of areas of highest morbidity for data-driven planning is highly encouraged to maximize reach of the priority population(s). **(2 points)**

iii. Applicant's Organizational Capacity to Implement the Approach **Maximum Points:** 45

The review panel will evaluate the extent to which the applicant:

- Provides services in jurisdictions that had at least 100 reported HIV cases among racial/ethnic minority MSM aged 13-29 years living with diagnosed HIV at the end of 2019 (2019 HIV Surveillance Report). Applicants implementing services in locations that have at least 100 reported HIV cases among this population will provide the greatest public health impact for this funding as it will reach areas with greatest need for HIV prevention services prioritizing YMSM of color and YTG persons of color. Please note, due to limited national surveillance data available for transgender populations, this criteria will be used for both Categories A and B. Applicants may provide services in a **maximum of three (3) service areas** within the applicant's jurisdiction. Applicants can provide HIV prevention services in areas that cross over into bordering state health department jurisdictions (e.g., District of Columbia, Maryland, and Virginia). The

applicant must have a history of providing HIV prevention services in their jurisdiction/proposed service area(s), discussed provision of services with their state or local health department in which they report HIV diagnoses, and received written consent from state or local health department. (See Attachment C: Health Department Letter of Support/Health Department Prioritized HIV Testing and Partner Services Letter of Agreement). Jurisdictions having at least 100 HIV cases among YMSM of color aged 13-29 living with HIV at the end of 2019 include the following: **(15 points)**

Alabama	Georgia	Maryland	New Jersey	Ohio	Tennessee
Arizona	Illinois	Michigan	New York	Pennsylvania	Texas
California	Indiana	Missouri	Nevada	Puerto Rico	Virginia
Florida	Louisiana	Mississippi	North Carolina	South Carolina	Washington, DC

- Demonstrates that they have the requisite experience and credibility in working with the proposed priority population within the designated community consistently for at least the last 24 months. Applicant organizations should demonstrate that the organization (e.g., community-based organization, community health centers, hospitals with non-government and/or college/university affiliation) is rooted in the community specific to the funding category. Specific elements considered as part of the assessment include, but are not limited to, length of service, outcomes of the services, the applicant's overall relationship with the community. (**10 points)**
- Provides a description of their mission; organizational structure; overall organizational budget and funding sources; staff size and expertise; the nature and scope of their work and capabilities; long-term sustainability plan; and other information that would help CDC assess the organization's infrastructure (including physical infrastructure) and capacity to implement the proposed program. **(5 points)**
- Demonstrates that they have substantial experience providing HIV prevention and/or care services to the proposed priority population (i.e., YMSM or YTG persons of color) that are culturally, linguistically, and educationally appropriate, **(10 points)**
- Demonstrates experience working with state, tribal, local, and/or territorial health departments, community health centers, and other community providers who serve the selected priority population and proposes plans to enhance existing and establish new formalized collaborative partnerships. **(3 points).**
- Demonstrates that staff members have experience providing services to the priority population and/or describes plans to hire staff that have experience working with the priority population. When feasible, applicants must hire direct service staff who are reflective of the priority population(s) and who have 12 months minimum experience working with the priority population. **(2 points).**

Budget **Maximum Points:** 0

Reviewed, but not scored.

Although the budget is not scored, the applicant should consider the following in development of their budget.

Ensure the itemized PS22-2203 budget and justification is reasonable and consistent with the stated objectives and planned program activities.

c. Phase III Review

Applicants will be ranked based on scores from the Objective Review Panel. Not all applicants applying for funding will receive a Pre-Decisional Site Visit (PDSV). Applicants will be selected for a PDSV based on the following:

- Ranked scores from the Objective Review process
- Geographic location: There will be preference for applicants providing services within jurisdictions that had at least 100 reported HIV cases among racial/ethnic minority MSM age 13-29 years living with diagnosed HIV at the end of 2019
- Priority Popuation(s): The proposed priority population(s) to be served ensures an equitable balance in terms of prioritized racial or ethnic minority groups and/or populations

The intent of the PDSV is to assess the applicant's capacity to implement the proposed program, this includes assessing the physical location, staffing, viable board of directors, access to priority population(s), potential partnerships and collaborators, etc.

The PDSV will address the following and applicants will be evaluated on this content during the PDSV.

- Organization Infrastructure – Assess the applicant's expertise, experience, and capacity to develop, implement, and evaluate the required PS22-2203 program strategies and activities. In addition, this section will assess the applicant organization's ability to sustain the proposed program effectively and efficiently, to include local collaboration and partnerships.
- Programmatic Infrastructure – Assess the applicant's experience with and ability to identify and address the needs of the proposed priority population(s). This section will also assess the applicant organization's ability to implement the proposed program activities and strategies effectively and efficiently.
- Proposed Comprehensive High-Impact HIV Prevention Program – Assess the applicant's implementation of CDC's protocols and procedures in all proposed program components.

During PDSVs, CDC staff will meet with appropriate project management and staff, which may include representatives of governing bodies, executive director, program manager, etc. The PDSV (1) facilitates a technical review of the application and discussion of the proposed program; (2) further assesses an applicant's capacity to implement the proposed program; and (3) identifies unique programmatic conditions that may require further training, technical assistance, or other CDC resources. CDC will contact the health department during the PDSV process to verify data submitted by the applicant (e.g., priority population data).

For HIV Prevention Program proposals, applicants can receive a maximum PDSV score of 350 points. If the HIV Prevention Program proposal fails to score at least 250 points during

the PDSV, the applicant will not be considered for funding. For additional information, visit the PS22-2203 NOFO website. https://www.cdc.gov/hiv/funding/announcements/ps22-2203/index.html

Final funding determinations will be based on application scores from the Objective Review, scores from the PDSV, and CDC's funding preferences.
The following factors also may affect the funding decision:

- Preference to ensure equitable balance in terms of prioritized racial or ethnic minority groups and/or population. (The number of funded applicants serving each racial or ethnic minority group may be adjusted based on the burden of HIV disease in that group as measured by HIV reporting.)
- Preference for the balance of funded applicants based on (1) burden of HIV within jurisdictions and (2) disproportionately affected geographic areas, as measured by CDC (geographical diversity).

Review of risk posed by applicants.
Prior to making a Federal award, CDC is required by 31 U.S.C. 3321 and 41 U.S.C. 2313 to review information available through any OMB-designated repositories of government-wide eligibility qualification or financial integrity information as appropriate. See also suspension and debarment requirements at 2 CFR parts 180 and 376.

In accordance 41 U.S.C. 2313, CDC is required to review the non-public segment of the OMB-designated integrity and performance system accessible through SAM (currently the Federal Recipient Performance and Integrity Information System (FAPIIS)) prior to making a Federal award where the Federal share is expected to exceed the simplified acquisition threshold, defined in 41 U.S.C. 134, over the period of performance. At a minimum, the information in the system for a prior Federal award recipient must demonstrate a satisfactory record of executing programs or activities under Federal grants, cooperative agreements, or procurement awards; and integrity and business ethics. CDC may make a Federal award to a recipient who does not fully meet these standards, if it is determined that the information is not relevant to the current Federal award under consideration or there are specific conditions that can appropriately mitigate the effects of the non-Federal entity's risk in accordance with 45 CFR §75.207.

CDC's framework for evaluating the risks posed by an applicant may incorporate results of the evaluation of the applicant's eligibility or the quality of its application. If it is determined that a Federal award will be made, special conditions that correspond to the degree of risk assessed may be applied to the Federal award. The evaluation criteria is described in this Notice of Funding Opportunity.

In evaluating risks posed by applicants, CDC will use a risk-based approach and may consider any items such as the following:

(1) Financial stability;

(2) Quality of management systems and ability to meet the management standards prescribed in this part;

(3) History of performance. The applicant's record in managing Federal awards, if it is a prior recipient of Federal awards, including timeliness of compliance with applicable reporting

requirements, conformance to the terms and conditions of previous Federal awards, and if applicable, the extent to which any previously awarded amounts will be expended prior to future awards;

(4) Reports and findings from audits performed under subpart F 45 CFR 75 or the reports and findings of any other available audits; and

(5) The applicant's ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.

CDC must comply with the guidelines on government-wide suspension and debarment in 2 CFR part 180, and require non-Federal entities to comply with these provisions. These provisions restrict Federal awards, subawards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal programs or activities.

2. Announcement and Anticipated Award Dates

Notice of Award will be received on or before April 1, 2022.

F. Award Administration Information

1. Award Notices

Recipients will receive an electronic copy of the Notice of Award (NOA) from CDC OGS. The NOA shall be the only binding, authorizing document between the recipient and CDC. The NOA will be signed by an authorized GMO and emailed to the Recipient Business Officer listed in application and the Program Director.

Any applicant awarded funds in response to this Notice of Funding Opportunity will be subject to the DUNS, SAM Registration, and Federal Funding Accountability And Transparency Act Of 2006 (FFATA) requirements.

Unsuccessful applicants will receive notification of these results by e-mail with delivery receipt or by U.S. mail.

2. Administrative and National Policy Requirements

Recipients must comply with the administrative and public policy requirements outlined in 45 CFR Part 75 and the HHS Grants Policy Statement, as appropriate.

Brief descriptions of relevant provisions are available at http://www.cdc.gov/grants/additionalrequirements/index.html#ui-id-17.

The HHS Grants Policy Statement is available at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.

- AR-4: HIV/AIDS Confidentiality Provisions
- AR-5: HIV Program Review Panel Requirements
- AR-6: Patient Care
- AR-8: Public Health System Reporting Requirements
- AR-9: Paperwork Reduction Act Requirements
- AR-10: Smoke-Free Workplace Requirements
- AR-11: Healthy People 2030

- AR-12: Lobbying Restrictions
- AR-13: Prohibition on Use of CDC Funds for Certain Gun Control Activities
- AR-14: Accounting System Requirements
- AR-15: Proof of Non-profit Status
- AR-16: Security Clearance Requirement
- AR-21: Small, Minority, And Women-owned Business
- AR 23: Compliance with 45 CFR Part 87 (faith-based organizations)
- AR-24: Health Insurance Portability and Accountability Act Requirements
- AR-25: Data Management and Access
- AR-26: National Historic Preservation Act of 1966
- AR-27: Conference Disclaimer and Use of Logos
- AR-29: Compliance with EO13513, "Federal Leadership on Reducing Text Messaging while Driving," October 1, 2009

The full text of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75, can be found at: https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75

Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS must administer their programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy).This includes taking reasonable steps to provide meaningful access to persons with limited English proficiency and providing programs that are accessible to and usable by persons with disabilities. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html and https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html.

• Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov.

• For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and taking appropriate steps to provide effective communication, see http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html.

• HHS funded health and education programs must be administered in an environment free of sexual harassment, see https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.

• For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-

discrimination laws, see https://www.hhs.gov/conscience/conscience-protections/index.html and https://www.hhs.gov/conscience/religious-freedom/index.html.

3. Reporting

Reporting provides continuous program monitoring and identifies successes and challenges that recipients encounter throughout the project period. Also, reporting is a requirement for recipients who want to apply for yearly continuation of funding. Reporting helps CDC and recipients because it:

- Helps target support to recipients;
- Provides CDC with periodic data to monitor recipient progress toward meeting the Notice of Funding Opportunity outcomes and overall performance;
- Allows CDC to track performance measures and evaluation findings for continuous quality and program improvement throughout the period of performance and to determine applicability of evidence-based approaches to different populations, settings, and contexts; and
- Enables CDC to assess the overall effectiveness and influence of the NOFO.

The table below summarizes required and optional reports. All required reports must be sent electronically to GMS listed in the "Agency Contacts" section of the NOFO copying the CDC Project Officer.

Report	***When?***	***Required?***
Recipient Evaluation and Performance Measurement Plan, including Data Management Plan (DMP)	*6 months into award*	*Yes*
Annual Performance Report (APR)	*No later than 120 days before end of budget period. Serves as yearly continuation application.*	*Yes*
End of Year Performance Report (EOY)	*No later than 90 days after end of performance period. Serves as annual report documenting program implementation successes, challenges, and CBA/TA needs*	*Yes*
Data on Performance Measures	*CDC program determines. Only if program wants more frequent performance measure reporting than annually in APR.*	*Yes*
Federal Financial Reporting Forms	*90 days after the end of the budget period.*	*Yes*
Final Performance and Financial Report	*90 days after end of project period.*	*Yes*
Payment Management System (PMS) Reporting	*Quarterly reports due January 30; April 30; July 30; and October 30.*	*Yes*

a. Recipient Evaluation and Performance Measurement Plan (required)
With support from CDC, recipients must elaborate on their initial applicant evaluation and performance measurement plan. This plan must be no more than 20 pages; recipients must submit the plan 6 months into the award. HHS/CDC will review and approve the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC, or other guidance otherwise applicable to this Agreement.

Recipient Evaluation and Performance Measurement Plan (required): This plan should provide additional detail on the following:

Performance Measurement

• Performance measures and targets
• The frequency that performance data are to be collected.
• How performance data will be reported.
• How quality of performance data will be assured.
• How performance measurement will yield findings to demonstrate progress towards achieving NOFO goals (e.g., reaching target populations or achieving expected outcomes).
• Dissemination channels and audiences.
• Other information requested as determined by the CDC program.

Evaluation

• The types of evaluations to be conducted (e.g. process or outcome evaluations).
• The frequency that evaluations will be conducted.
• How evaluation reports will be published on a publically available website.
• How evaluation findings will be used to ensure continuous quality and program improvement.
• How evaluation will yield findings to demonstrate the value of the NOFO (e.g., effect on improving public health outcomes, effectiveness of NOFO, cost-effectiveness or cost-benefit).
• Dissemination channels and audiences.

HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the activities and use of HHS/CDC funding under this Agreement.

b. Annual Performance Report (APR) (required)
The recipient must submit the APR via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period. This report must not exceed 45 pages excluding administrative reporting. Attachments are not allowed, but web links are allowed.

This report must include the following:

- **Performance Measures:** Recipients must report on performance measures for each budget period and update measures, if needed.
- **Evaluation Results:** Recipients must report evaluation results for the work completed to date (including findings from process or outcome evaluations).
- **Work Plan:** Recipients must update work plan each budget period to reflect any changes in period of performance outcomes, activities, timeline, etc.
- **Successes**
    - Recipients must report progress on completing activities and progress towards achieving the period of performance outcomes described in the logic model and work plan.
    - Recipients must describe any additional successes (e.g. identified through evaluation results or lessons learned) achieved in the past year.
    - Recipients must describe success stories.
- **Challenges**
    - Recipients must describe any challenges that hindered or might hinder their ability to complete the work plan activities and achieve the period of performance outcomes.
    - Recipients must describe any additional challenges (e.g., identified through evaluation results or lessons learned) encountered in the past year.
- **CDC Program Support to Recipients**
    - Recipients must describe how CDC could help them overcome challenges to complete activities in the work plan and achieving period of performance outcomes.
- **Administrative Reporting** (No page limit)
    - SF-424A Budget Information-Non-Construction Programs.
    - Budget Narrative – Must use the format outlined in "Content and Form of Application Submission, Budget Narrative" section.
    - Indirect Cost Rate Agreement.

For year 2 and beyond of the award, recipients may request that as much as 75% of their estimated unobligated funds be carried over into the next budget period.
The carryover request must:

- Express a bona fide need for permission to use an unobligated balance;
- Include a signed, dated, and accurate Federal Financial Report (FFR) for the budget period from which funds will be transferred (as much as 75% of unobligated balances); and
- Include a list of proposed activities, an itemized budget, and a narrative justification for those activities.

The recipients must submit the Annual Performance Report via www.Grantsolutions.gov no later than 120 days prior to the end of the budget period.

c. Performance Measure Reporting (optional)

CDC programs may require more frequent reporting of performance measures than annually in the APR. If this is the case, CDC programs must specify reporting frequency, data fields, and format for recipients at the beginning of the award period.

In addition to the Annual Performance Report, recipients are required to submit data at the end of each budget year. Recipients will be required to complete an End of Year (EOY) Performance Report that captures the quantitative data from the last six months of the previous budget period and qualitative data for the entire 12-month budget period. The EOY Performance Report is due 90 days after the end of the budget period.

d. Federal Financial Reporting (FFR) (required)

The annual FFR form (SF-425) is required and must be submitted 90 days after the end of the budget period through the Payment Management System (PMS). The report must include only those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds, and may not reflect any unliquidated obligations. There must be no discrepancies between the final FFR expenditure data and the Payment Management System's (PMS) cash transaction data. Failure to submit the required information by the due date may adversely affect the future funding of the project. If the information cannot be provided by the due date, recipients are required to submit a letter of explanation to OGS and include the date by which the Grants Officer will receive information.

e. Final Performance and Financial Report (required)

The Final Performance Report is due 90 days after the end of the period of performance. The Final FFR is due 90 days after the end of the period of performance and must be submitted through the Payment Management System (PMS). CDC programs must indicate that this report should not exceed 40 pages. This report covers the entire period of performance and can include information previously reported in APRs. At a minimum, this report must include the following:

- Performance Measures – Recipients must report final performance data for all process and outcome performance measures.
- Evaluation Results – Recipients must report final evaluation results for the period of performance for any evaluations conducted.
- Impact/Results/Success Stories – Recipients must use their performance measure results and their evaluation findings to describe the effects or results of the work completed over the project period, and can include some success stories.
- A final Data Management Plan that includes the location of the data collected during the funded period, for example, repository name and link data set(s)
- Additional forms as described in the Notice of Award (e.g., Equipment Inventory Report, Final Invention Statement).

Recipients will be required to complete a Program Close-out Report that captures the quantitative data from the last six months of the previous budget period and qualitative data for

the enter period of performance. The Program Close-out Report is due 90 days after the end of the period of performance.

4. Federal Funding Accountability and Transparency Act of 2006 (FFATA)

Federal Funding Accountability and Transparency Act of 2006 (FFATA), P.L. 109–282, as amended by section 6202 of P.L. 110–252 requires full disclosure of all entities and organizations receiving Federal funds including awards, contracts, loans, other assistance, and payments through a single publicly accessible Web site, http://www.USASpending.gov.

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by applicants: 1) information on executive compensation when not already reported through the SAM, and 2) similar information on all sub-awards/subcontracts/consortiums over $25,000.

For the full text of the requirements under the FFATA and HHS guidelines, go to:

- https://www.gpo.gov/fdsys/pkg/PLAW-109publ282/pdf/PLAW-109publ282.pdf,
- https://www. fsrs.gov/documents /ffata_legislation_ 110_252.pdf
- http://www.hhs.gov/grants/grants/grants-policies-regulations/index.html#FFATA.

5. Reporting of Foreign Taxes (International/Foreign projects only)

A. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred for non-host governmental entities operating where no applicable tax exemption exists. This waiver does not apply to countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health. Successful applicants will receive information on VAT requirements via their Notice of Award.

B. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) (“United States foreign assistance funds”). Outlined below are the specifics of this requirement:

1) Annual Report: The recipient must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the recipient did not pay any taxes during the reporting period.]

2) Quarterly Report: The recipient must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October

15 and January 15.

3) Terms: For purposes of this clause:
“Commodity” means any material, article, supplies, goods, or equipment;
“Foreign government” includes any foreign government entity;
“Foreign taxes” means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

4) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.

5) Contents of Reports: The reports must contain:

a. recipient name;
b. contact name with phone, fax, and e-mail;
c. agreement number(s) if reporting by agreement(s);
d. reporting period;
e. amount of foreign taxes assessed by each foreign government;
f. amount of any foreign taxes reimbursed by each foreign government;
g. amount of foreign taxes unreimbursed by each foreign government.

6) Subagreements. The recipient must include this reporting requirement in all applicable subgrants and other subagreements.

6. Termination

CDC may impose other enforcement actions in accordance with 45 CFR 75.371- Remedies for Noncompliance, as appropriate.

The Federal award may be terminated in whole or in part as follows:

(1) By the HHS awarding agency or pass-through entity, if the non-Federal entity fails to comply with the terms and conditions of the award;

(2) By the HHS awarding agency or pass-through entity for cause;

(3) By the HHS awarding agency or pass-through entity with the consent of the non-Federal entity, in which case the two parties must agree upon the termination conditions, including the effective date and, in the case of partial termination, the portion to be terminated; or

(4) By the non-Federal entity upon sending to the HHS awarding agency or pass-through entity written notification setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if the HHS awarding agency or pass-through entity determines in the case of partial termination that the reduced or modified portion of the Federal award or subaward will not accomplish the purposes for which the Federal award was made, the HHS awarding agency or pass-through entity may terminate the Federal award in its entirety.

G. Agency Contacts

CDC encourages inquiries concerning this notice of funding opportunity.

Program Office Contact

For programmatic technical assistance, contact:

First Name:
Erica K., Senior Advisor, Health Department and CBO Initiatives
Last Name:
Dunbar
Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention

Address:
1600 Clifton Rd, NE-MS US8-3 Atlanta, GA 30329

Telephone:

Email:
cbofoa@cdc.gov

Grants Staff Contact

For **financial, awards management, or budget assistance,** contact:

First Name:
Edna
Last Name:
Green
Grants Management Specialist
Department of Health and Human Services
Office of Grants Services

Address:
2939 Flowers Road, M/S TV-2

Telephone:
770-488-2858
Email:
EGreen@cdc.gov
For assistance with **submission difficulties related to** www.grants.gov, contact the Contact Center by phone at 1-800-518-4726.

Hours of Operation: 24 hours a day, 7 days a week, except on federal holidays.

CDC Telecommunications for persons with hearing loss is available at: TTY 1-888-232-6348

H. Other Information

Following is a list of acceptable attachments **applicants** can upload as PDF files as part of their application at www.grants.gov. Applicants may not attach documents other than those listed; if other documents are attached, applications will not be reviewed.

- Project Abstract
- Project Narrative
- Budget Narrative
- Report on Programmatic, Budgetary and Commitment Overlap
- Table of Contents for Entire Submission

For international NOFOs:

- SF424
- SF424A
- Funding Preference Deliverables

Optional attachments, as determined by CDC programs:
Resumes / CVs

Letters of Support

Organization Charts

Non-profit organization IRS status forms, if applicable

Indirect Cost Rate, if applicable

Memorandum of Agreement (MOA)

Memorandum of Understanding (MOU)

In addition, the applicant must develop their work plan within the project narrative and ensure that all components are addressed. The Project Narrative, inclusive of the work plan, cannot exceed 20 pages.
The following documents do not count toward the 20-page limit for the Project Narrative and Work Plan and must be included with the application submission. All the following mentioned documents should be uploaded as a PDF file under "Other Attachment Forms" at www.grants.gov.

- Service Agreements for HIV Medical Care provider(s), name the file "Appendix_HMC Service Agreement"
- Service Agreements for PrEP provider, name the file "Appendix_PrEP Provider Service Agreement"
- One of the following to support Evidence of Service, Location, and History Serving the Proposed Target Population, name the file "Appendix_Evidence of Service"
    - A copy of a progress report from a funder
    - Letter from an applicant's funding source, other than CDC, documenting the applicant's service to the priority population(s) (must reflect consistent service for at least the last 24 months)

- Resumes/CVs for key PS22-2203 positions (Executive Director, Principal Investigator, Program Manager, and Business Official), name the file “ResumesCVs”
- Organizational Charts (Agency-wide and PS22-2203 prevention program, name the file Org Charts”
- Letter of Intent from a Physician for State Regulations and HIV Testing Activities, if required, name the file "LOI"
- CLIA waiver, if applicable, name the file "CLIA waiver"
- Self-Testing (HIV Testing) Protocol, if applicable, name the file "Self-Testing"
- Linkage to HIV Medical Care and PrEP Program Plan, name the file “Linkage to HIV Care and PrEP Plan”
- One (1) Letter of Support from civic, non-profit business, and/or faith-based organization, name the file "LOS"
- Indirect Cost Rate, if applicable, name the file "Indirect Cost"
- Two Memorandums of Agreement/Understanding(s) for Prevention and Essential Support Service Providers, name the file “PESS MOAs_MOUs”
- Capacity and Proposed Priority Population Worksheet*, “Priority Population Data Table"
- CDC Assurances and Certifications (see Section 5. CDC Assurances and Certifications)
- Risk Assessment Questionnaire Requirement (see Section 5. CDC Assurances and Certifications)
- Duplication of Effort Report, if applicable (see Section 5. CDC Assurances and Certifications)

*Templates and/or samples of these documents are located at https://www.cdc.gov/hiv/funding/announcements/ps22-2203/index.html

PS22-2203 List of Attachments

All attachments are located at https://www.cdc.gov/hiv/funding/announcements/ps22-2203/index.html

- Attachment A: Letter of Intent to Apply for Funding
- Attachment B: Organizational Capacity and Proposed Priority Population Worksheet
- Attachment C: Health Department Letter of Support and Prioritized HIV Testing and Partner Services Letter of Agreement
- Attachment D: Letter of Intent from a Physician for State Regulations and HIV Testing Activities
- Attachment E: Linkage to HIV Medical Care and PrEP Provider Plan Template
- Attachment F: Social Media Program Guidance for HIV Prevention Community-Based Organizations
- Attachment G: Work Plan Guidance Document
- Attachment H: CDC Form 0.1113 Assurance of Compliance (must be downloaded from www.grants.gov)
- Attachment I: Sample Table of Contents

***PS22-2203 application package and Attachment H: CDC Assurance of Compliance must be downloaded from www.grants.gov.

References

1. U.S. Department of Health and Human Services. 2021. HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021–2025. Washington, DC.
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I. Glossary

Activities: The actual events or actions that take place as a part of the program.

Administrative and National Policy Requirements, Additional Requirements (ARs): Administrative requirements found in 45 CFR Part 75 and other requirements mandated by statute or CDC policy. All ARs are listed in the Template for CDC programs. CDC programs must indicate which ARs are relevant to the NOFO; recipients must comply with the ARs listed in the NOFO. To view brief descriptions of relevant provisions, see http:// www.cdc.gov/ grants/ additional requirements/ index.html. Note that 2 CFR 200 supersedes the administrative requirements (A-110 & A-102), cost principles (A-21, A-87 & A-122) and audit requirements (A-50, A-89 & A-133).

Approved but Unfunded: Approved but unfunded refers to applications recommended for approval during the objective review process; however, they were not recommended for funding by the program office and/or the grants management office.

Assistance Listings: A government-wide compendium published by the General Services Administration (available on-line in searchable format as well as in printable format as a .pdf file) that describes domestic assistance programs administered by the Federal Government.

Assistance Listings Number: A unique number assigned to each program and NOFO throughout its lifecycle that enables data and funding tracking and transparency

Award: Financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements (e.g., cooperative agreements) in the form of money, or property in lieu of money, by the federal government to an eligible applicant.

Budget Period or Budget Year: The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.

Carryover: Unobligated federal funds remaining at the end of any budget period that, with the approval of the GMO or under an automatic authority, may be carried over to another budget period to cover allowable costs of that budget period either as an offset or additional authorization. Obligated but liquidated funds are not considered carryover.

Competing Continuation Award: A financial assistance mechanism that adds funds to a grant and adds one or more budget periods to the previously established period of performance (i.e., extends the "life" of the award).

Continuous Quality Improvement: A system that seeks to improve the provision of services with an emphasis on future results.

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

Cost Sharing or Matching: Refers to program costs not borne by the Federal Government but by the recipients. It may include the value of allowable third-party, in-kind contributions, as well as expenditures by the recipient.

Direct Assistance: A financial assistance mechanism, which must be specifically authorized by statute, whereby goods or services are provided to recipients in lieu of cash. DA generally involves the assignment of federal personnel or the provision of equipment or supplies, such as vaccines. DA is primarily used to support payroll and travel expenses of CDC employees assigned to state, tribal, local, and territorial (STLT) health agencies that are recipients of grants and cooperative agreements. Most legislative authorities that provide financial assistance to STLT health agencies allow for the use of DA. http:// www.cdc.gov /grants /additionalrequirements /index.html.

DUNS: The Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number is a nine-digit number assigned by Dun and Bradstreet Information Services. When applying for Federal awards or cooperative agreements, all applicant organizations must obtain a DUNS number as the Universal Identifier. DUNS number assignment is free. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the Internet, obtaining a DUNS number may take one to two days at no charge. If an organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at http://fedgov.dnb.com/ webform/displayHomePage.do.

Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

Federal Funding Accountability and Transparency Act of 2006 (FFATA): Requires that information about federal awards, including awards, contracts, loans, and other assistance and payments, be available to the public on a single website at www.USAspending.gov.

Fiscal Year: The year for which budget dollars are allocated annually. The federal fiscal year starts October 1 and ends September 30.

Grant: A legal instrument used by the federal government to transfer anything of value to a recipient for public support or stimulation authorized by statute. Financial assistance may be money or property. The definition does not include a federal procurement subject to the Federal Acquisition Regulation; technical assistance (which provides services instead of money); or assistance in the form of revenue sharing, loans, loan guarantees, interest subsidies, insurance, or direct payments of any kind to a person or persons. The main difference between a grant and a cooperative agreement is that in a grant there is no anticipated substantial programmatic involvement by the federal government under the award.

Grants.gov: A "storefront" web portal for electronic data collection (forms and reports) for federal grant-making agencies at www.grants.gov.

Grants Management Officer (GMO): The individual designated to serve as the HHS official responsible for the business management aspects of a particular grant(s) or cooperative agreement(s). The GMO serves as the counterpart to the business officer of the recipient organization. In this capacity, the GMO is responsible for all business management matters associated with the review, negotiation, award, and administration of grants and interprets grants administration policies and provisions. The GMO works closely with the program or project officer who is responsible for the scientific, technical, and programmatic aspects of the grant.

Grants Management Specialist (GMS): A federal staff member who oversees the business and other non-programmatic aspects of one or more grants and/or cooperative agreements. These activities include, but are not limited to, evaluating grant applications for administrative content and compliance with regulations and guidelines, negotiating grants, providing consultation and technical assistance to recipients, post-award administration and closing out grants.

Health Disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

Health Inequities: Systematic, unfair, and avoidable differences in health outcomes and their determinants between segments of the population, such as by socioeconomic status (SES), demographics, or geography.

Healthy People 2030: National health objectives aimed at improving the health of all Americans by encouraging collaboration across sectors, guiding people toward making informed health decisions, and measuring the effects of prevention activities.

Inclusion: Both the meaningful involvement of a community's members in all stages of the program process and the maximum involvement of the target population that the intervention will benefit. Inclusion ensures that the views, perspectives, and needs of affected communities, care providers, and key partners are considered.

Indirect Costs: Costs that are incurred for common or joint objectives and not readily and specifically identifiable with a particular sponsored project, program, or activity; nevertheless, these costs are necessary to the operations of the organization. For example, the costs of operating and maintaining facilities, depreciation, and administrative salaries generally are considered indirect costs.

Letter of Intent (LOI): A preliminary, non-binding indication of an organization's intent to submit an application.

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and which is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of, or opposition to, proposed or pending legislative proposals.

Logic Model: A visual representation showing the sequence of related events connecting the activities of a program with the programs' desired outcomes and results.

Maintenance of Effort: A requirement contained in authorizing legislation, or applicable regulations that a recipient must agree to contribute and maintain a specified level of financial effort from its own resources or other non-government sources to be eligible to receive federal grant funds. This requirement is typically given in terms of meeting a previous base-year dollar amount.

Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA): Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

Nonprofit Organization: Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher

educations, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

Notice of Award (NoA): The official document, signed (or the electronic equivalent of signature) by a Grants Management Officer that: (1) notifies the recipient of the award of a grant; (2) contains or references all the terms and conditions of the grant and Federal funding limits and obligations; and (3) provides the documentary basis for recording the obligation of Federal funds in the HHS accounting system.

Objective Review: A process that involves the thorough and consistent examination of applications based on an unbiased evaluation of scientific or technical merit or other relevant aspects of the proposal. The review is intended to provide advice to the persons responsible for making award decisions.

Outcome: The results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, reduced morbidity and mortality.

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A "program" may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

Period of performance –formerly known as the project period - : The time during which the recipient may incur obligations to carry out the work authorized under the Federal award. The start and end dates of the period of performance must be included in the Federal award.

Period of Performance Outcome: An outcome that will occur by the end of the NOFO's funding period

Plain Writing Act of 2010: The Plain Writing Act of 2010 requires that federal agencies use clear communication that the public can understand and use. NOFOs must be written in clear, consistent language so that any reader can understand expectations and intended outcomes of the funded program. CDC programs should use NOFO plain writing tips when writing NOFOs.

Program Strategies: Strategies are groupings of related activities, usually expressed as general headers (e.g., Partnerships, Assessment, Policy) or as brief statements (e.g., Form partnerships, Conduct assessments, Formulate policies).

Program Official: Person responsible for developing the NOFO; can be either a project officer, program manager, branch chief, division leader, policy official, center leader, or similar staff member.

Public Health Accreditation Board (PHAB): A nonprofit organization that works to promote and protect the health of the public by advancing the quality and performance of public health departments in the U.S. through national public health department accreditation http://www.phaboard.org.

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Statute: An act of the legislature; a particular law enacted and established by the will of the legislative department of government, expressed with the requisite formalities. In foreign or civil law any particular municipal law or usage, though resting for its authority on judicial decisions, or the practice of nations.

Statutory Authority: Authority provided by legal statute that establishes a federal financial assistance program or award.

System for Award Management (SAM): The primary vendor database for the U.S. federal government. SAM validates applicant information and electronically shares secure and encrypted data with federal agencies' finance offices to facilitate paperless payments through Electronic Funds Transfer (EFT). SAM stores organizational information, allowing www.grants.gov to verify identity and pre-fill organizational information on grant applications.

Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

Work Plan: The summary of period of performance outcomes, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

NOFO-specific Glossary and Acronyms

Application: A formal request to CDC for HIV prevention funding. The application contains a written narrative and budget reflecting the priorities described in the program announcement and the jurisdiction's comprehensive HIV prevention plan.

Behavioral Interventions: The use of behavioral approaches designed to moderate intra- and interpersonal factors to prevent acquisition and transmission of HIV.

Biomedical Interventions: The use of medical, clinical, and public health approaches designed to moderate biological and physiological factors to prevent HIV, reduce susceptibility to HIV, and/or decrease HIV infectiousness.
Capacity Building: Activities that strengthen the core competencies of an organization and contribute to its ability to develop and implement an effective HIV prevention intervention and sustain the infrastructure and resource base necessary to support and maintain the intervention.
Capacity Building Assistance (CBA): Activities that strengthen and maintain the organizational infrastructure and resources necessary to support HIV prevention services. Capacity building enhances the abilities of key personnel to plan and implement intervention activities. It may also focus on community development to support the delivery of effective HIV prevention services.
Capacity Building Assistance Consumers: Community-based organizations, health departments, HIV planning groups, and other community stakeholders serving high-risk and/or racial ethnic minority populations are the prioritized audience for HIV prevention CBA services.
CBA Providers: National and regional organizations funded by the CDC to provide expert programmatic, scientific, and technical support to health departments, community-based organizations, and communities in the design, implementation, and evaluation of HIV prevention interventions and programs.
Centers for Disease Control and Prevention (CDC): The lead federal agency for protecting the health and safety of people, providing credible information to enhance health decisions, and promoting health through strong partnerships. Based in Atlanta, Georgia, this agency of the U.S. Department of Health and Human Services serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.
Clinical Laboratory Improvement Amendment Program (CLIA): U.S. federal regulatory standards for the accuracy, reliability, and timelines of all clinical laboratory testing performed on humans, except as a part of research. CLIA requires that any facility examining human specimens for diagnosis, prevention, and treatment of a disease or for assessment of health must register with the federal Centers for Medicare and Medicaid Services (CMS) and obtain CLIA certification.
CLIA Certificate of Waiver: One of four types of certificates issued under CLIA, it is issued when tests have been approved by the FDA and are simple to use, require very little training to perform, and are highly accurate. Non-clinical testing sites that plan to offer waived rapid HIV tests must either apply for their own CLIA certificate of waiver or establish an agreement to work under the CLIA certificate of an existing laboratory.
Collaboration: Working with another person, organization, or group for mutual benefit by exchanging information, sharing resources, or enhancing the other's capacity, often to achieve a common goal or purpose.
Comprehensive HIV Prevention Plan: A plan that identifies priority population(s) and describes what interventions will best meet the needs of each priority population. The primary task of the community planning process is developing a comprehensive HIV prevention plan through a participatory, science-based planning process. The contents of the plan are described in the HIV Prevention Planning Guidance, and key information necessary

to develop the comprehensive HIV prevention plan is found in the epidemiologic profile and the community services assessment.
Condom Distribution: The means by which condoms are transferred, disseminated, or delivered from a community resource (e.g., health department, community-based organization, or health care organization).
Confidentiality: Ensuring that information is accessible only to those authorized to have access.
Confirmatory Testing: Additional testing performed to verify the results of an earlier (screening) test. For HIV diagnosis, a Western blot or, less commonly, an immunofluorescence assay (IFA) are typically used, though additional more sensitive tests may also be considered.
Coordination: Aligning processes, services, or systems to achieve increased efficiencies, benefits, or improved outcomes. Examples of coordination may include sharing information, such as progress reports, with state and local health departments or structuring prevention delivery systems to reduce duplication of effort.
Counseling and Testing: A process through which an individual receives information about HIV transmission and prevention, HIV tests, and the meaning of tests results; is provided HIV prevention counseling to reduce their risk for transmitting or acquiring HIV; and is provided testing to detect the presence of HIV antibodies.
Culturally Appropriate: Conforming to a culture's acceptable expressions and standards of behavior and thought. Interventions and educational materials are more likely to be culturally appropriate when representatives of the intended target audience are involved in planning, developing, and pilot testing them.
Effective: Demonstrating the desired effect when widely used in practice or under real-world conditions that are considerably less rigorous and controlled, rather than in environments that test efficacy but are still designed to ensure that the desired effect can be attributed to the intervention in question.
Epidemic: The occurrence of cases of an illness, specific health-related behavior, or other health-related events in a community or region in excess of normal expectancy.
Ethnicity: The cultural characteristics that connect a particular group or groups of people to each other, such as people of Hispanic or Latino origin.
Evidence-based Interventions: Behavioral, social, and structural interventions relevant to HIV risk reduction that have been tested using a methodologically rigorous design and have been shown to be effective in a research setting. These evidence or science-based interventions have been evaluated using behavioral or health outcomes; have been compared to a control/comparison group(s) (or pre-post data without a comparison group if a policy study); had no apparent bias when assigning persons to interventions or control groups or were adjusted for any apparent assignment bias; and produced significantly greater positive results when compared to the control/comparison group(s), while not producing adverse consequences.
Faith-based Organization: A faith-based organization is a non-governmental agency owned by religiously affiliated entities such as (1) individual churches, mosques, synagogues, temples,
or other places of worship or (2) a network or coalition of churches, mosques, synagogues, temples, or other places of worship.
Health Equity: A desirable goal that entails special efforts to improve the health of those

who have experienced social or economic disadvantage. It requires continuous efforts focused on elimination of health disparities, including disparities in the living and working conditions that influence health, and continuous efforts to maintain a desired state of equity after particular health disparities are eliminated.

HIV Planning Group (HPG): A group of local health officials, representatives from HIV-affected communities, and technical experts who share responsibility for developing a comprehensive HIV prevention plan for their community. The intent of the process is to increase meaningful community involvement in prevention planning, improve the scientific basis of program decisions, and target resources to those communities at highest risk for HIV transmission and acquisition.

HIV Medical Care/Evaluation/Treatment: Medical services that address HIV, including evaluation of immune system function and screening, treatment, and prevention of opportunistic infection.

HIV Prevention Counseling: An interactive process between client and counselor aimed at reducing sexual and drug use behaviors related to HIV acquisition or transmission.

HIV Screening: HIV testing strategy of all persons in a defined population.

HIV Testing Strategy: The approach an agency or a person uses when conducting HIV testing in order to decide who will be tested. Testing strategies include HIV screening that is population-based and prioritized testing of subpopulations of persons at higher risk.

Incentive: A type of reward (e.g., voucher for transportation, food, money, or other small reward) given as compensation for a person's time and participation in a particular activity.

Incidence: The number of new cases in a defined population within a certain time period (often a year). It is important to understand the difference between HIV incidence, which refers to new HIV infections, and new HIV diagnosis. New HIV diagnosis is a person who is newly diagnosed as HIV-infected, usually through HIV testing. These persons may have been infected recently or at some time in the past.

Intervention: A specific activity (or set of related activities) intended to reduce the risk of HIV transmission or acquisition. Interventions may be either biomedical or behavioral and have distinct process and outcome objectives and protocols outlining the steps for implementation.

Lead Organization with Contractual Partners: For the purposes of PS22-2203, the lead organization is defined as the organization that is the direct and primary applicant in a cooperative agreement program, but intends to formally collaborate through a contractual agreement with one or two additional organizations that will share in the proposed program activities. The lead organization must perform a substantial role (no less than 51%) in carrying out project objectives and not merely serve as a conduit for an award to another party or provider that is ineligible.

Linkage: Actively assisting clients with accessing needed services through a time-limited professional relationship. The active assistance typically lasts a few days to a few weeks and includes a follow-up component to assess whether linkage has occurred. Linkage services can include assessment, supportive counseling, education, advocacy, and accompanying clients to testing. Outreach is often conducted by peers or paraprofessional educators.

Partner Services (PS): A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can be offered HIV testing and learn their status or, if already infected, prevent transmission to others. PS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment,

and other prevention services.
Persons who inject drugs (PWID): Someone who uses a needle to inject drugs into his or her body.
Pre-decisional Site Visit (PDSV): A PDSV is the second step of the review process. It involves a site visit to the highest ranked agencies that are being considered for funding.
Prevalence: The total number of cases of a disease in a given population at a particular point in time. HIV/AIDS prevalence refers to persons living with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk that an individual will have a disease at a point in time.
Prevention Services: Any service or intervention directly aimed at reducing risk for transmitting or acquiring HIV (e.g., prevention counseling, behavioral interventions, risk reduction counseling, substance use and mental health services, and other services focused on social determinants of health). The goal is to provide a comprehensive health service to clients to reduce their risk of transmitting or acquiring HIV.
Previously Diagnosed HIV: HIV infection in a person who meets either of the following criteria: (1) self-reports having previously tested positive for HIV; or (2) has been previously reported to the health department's surveillance registry as being infected with HIV.
Primary Medical Care (for persons at increased risk of acquiring HIV): Routine outpatient care that a patient receives at first contact with a health care provider.
Priority Populations: The primary groups of people or organizations that a program, strategy, or intervention is designed to affect.
Qualitative Data: Non-numeric data, including information from sources such as narrative behavior studies, focus group interviews, open-ended interviews, direct observations, ethnographic studies, and documents. Findings from these sources are usually described in terms of underlying meanings, common themes, and patterns of relationships, rather than numeric or statistical analysis. Qualitative data often complement and help explain quantitative data.
Quantitative Data: Numeric information, such as numbers, rates, and percentages, representing counts or measurements suitable for statistical analysis.
Race: A client's self-reported classification of the biological heritage with which they most closely identify. Standard OMB race codes are applied.
Recruitment: The process by which persons are identified and invited to become participants in an intervention or other HIV prevention service, such as counseling, testing, and referral (CTR).
Referral: Directing clients to a service in person or through telephone, written, or other form of communication. Generally, a one-time event. Referral may be made formally from one clinical
provider to another, within a case management system by professional case managers, informally through support staff, or as part of an outreach services program.
Risk Behaviors: Behaviors that can directly expose persons to HIV or transmit HIV, if the virus is present (e.g., sex without a condom, sharing unclean needles). Risk behaviors are actual behaviors by which HIV can be transmitted, and a single instance of the behavior can result in transmission.
Risk Factors: Factors based on observations of behaviors and contexts in which HIV is likely to be transmitted (e.g., lifetime number of sex partners, crack use, environmental

factors like membership in a demographic group highly impacted by HIV, using expired-date condoms, Internet use). Influencing factors of behavioral risk refer to associations with risk (risk correlates and risk contexts), not behavioral determinants.
Risk Reduction Activities: Organized efforts to reach people at increased risk of acquiring or spreading HIV. Activities range from individual HIV prevention counseling to broad, community-based interventions.
Risk Reduction Education: Providing brief HIV facts on how HIV is transmitted, explanation of the HIV test procedure, information about the window period, and the meaning of the potential test results.
Ryan White Treatment Modernization Act: The name given to the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act when it was reauthorized in 2006. This is the primary federal legislation that addresses the needs of persons in the United States living with HIV/AIDS and their families. The original CARE Act was enacted in 1990.
Seroprevalence: The number of people in a population who test positive for HIV, based on serology (blood serum) specimens. Seroprevalence is often presented as a percent of the total specimens tested or as a rate per 1,000 persons tested.
Social Determinants: The economic and social conditions that influence the health of persons, communities, and jurisdictions and include conditions for early childhood development; education, employment, and work; food security; health services; housing; income; and social exclusion.
Social Network: A map of the relationships between persons, indicating the ways in which they are connected through various social familiarities, ranging from casual acquaintance to close familial bonds.
Social Networking: A recruitment strategy in which a chain of referrals is based on high-risk persons using their personal influence to enlist their peers they believe to be high-risk.
Substance Use Treatment Services: Services for the treatment and prevention of drug or alcohol use.
Surveillance: The ongoing and systematic collection, analysis, and interpretation of data about occurrences of a disease or health condition.
Syringe Services Program (SSP): Community-based prevention programs that can provide a range of services, including linkage to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for infectious diseases.
Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.
Transgender Female to Male (FTM): An individual whose physical or birth sex is female but whose gender expression and/or gender identity is male.
Transgender Male to Female (MTF): An individual whose physical or birth sex is male but whose gender expression and/or gender identity is female.
Transmission Risk: A behavior that places the priority population at potential risk for HIV or transmission.