AMENDMENT 1 – July 20, 2011

#1 – new deadline – pgs. 2, 95
#2 – correction – pg. 10
#3 – clarification – pg. 18, 20, 73, 108
#5 – new criteria – pgs. 43, 56
#6 – clarification – pg. 53
#7 – deletion of review scoring – pg. 110
#8 – updated Attachment X: Funding Tables – pgs. 134-135, 51
#9 – revised information about the number of awards for category C – pgs. 50 & 122

Table of Contents

PART 1. OVERVIEW INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Federal Agency Name: Federal Centers for Disease Control and Prevention (CDC)

Funding Opportunity Title: Comprehensive HIV Prevention Programs for Health Departments

Announcement Type: New – Type 1

Agency Funding Opportunity Number: CDC-RFA-PS12-1201

Catalog of Federal Domestic Assistance Number: 93.940, HIV Prevention Activities For Health Departments

Key Dates:

(Sign-up to receive notification of any changes at the "Send Me Change Notification Emails" link on the CDC-RFA-PS12-1201 synopsis page at www.grants.gov).

Application Deadlines:

Categories A, B, and C: **September 14, 2011**, 5:00pm, U.S. Eastern Standard Time

Category C, Cycle 2: June 1, 2013, 5:00pm, U.S. Eastern Standard Time

Category C, Cycle 3: June 1, 2014, 5:00pm, U.S. Eastern Standard Time

Letters of Intent (LOI) Deadline Date:

Submission of a LOI is **only** applicable to Category C: Demonstration Project funding.

Category C, Cycle 1: **July 21, 2011**, 5:00pm, U.S. Eastern Standard Time

Category C, Cycle 2: April 15, 2013, 5:00pm, U.S. Eastern Standard Time

Category C, Cycle 3: April 15, 2014, 5:00pm, U.S. Eastern Standard Time

Overview: This five-year funding opportunity announcement (FOA) for health departments reflects new methods for implementing high impact, comprehensive human immunodeficiency virus (HIV) prevention programs in order to achieve maximal results in addressing the HIV/AIDS epidemic throughout the United States and reducing new HIV infections. The comprehensive prevention program for health departments includes three categories: 1) core required program components and activities to be implemented by all jurisdictions, as well as recommended components for consideration by jurisdictions, but not required; 2) expanded HIV testing program activities; and 3) demonstration projects for implementing and evaluating innovative, high impact HIV prevention interventions and/or strategies. This FOA is a consolidation of CDC-RFA-PS10-1001: HIV Prevention Projects for Health Departments; CDC-RFA-PS10-1002: HIV Prevention Projects for the Pacific Islands and; CDC-RFA-PS10-10138: Expanded Human Immunodeficiency Virus (HIV) Testing for Disproportionately Affected Populations. It is intended to enhance HIV

prevention implementation, streamline the application process, pre-award and post-award administrative and reporting processes, and to reduce administrative burden.

The FOA is aligned with the National HIV/AIDS Strategy (NHAS). In accordance with the NHAS requirement that, by the end of 2010, CDC "develop policy recommendations for revising funding formulas and policy guidance in order to ensure that Federal HIV prevention funding allocations go to jurisdictions with the greatest need," CDC created a funding algorithm based on the number of adults and adolescents living with a diagnosis of HIV through 2008. Application of this new funding formula has resulted in funding realignment that is based on the magnitude of the HIV epidemic within each jurisdiction – with some jurisdictions receiving increases, and others receiving less funding than in previous years. Through careful examination of options to increase impact in areas with greatest need, the number of cities eligible for direct funding has also been expanded.

Executive Summary: The Centers for Disease Control and Prevention announces the availability of Fiscal Year (FY) 2012 funds for a cooperative agreement program for health departments. The purpose of this funding opportunity announcement is to implement comprehensive human immunodeficiency virus (HIV) prevention programs to reduce morbidity, mortality, and related health disparities. In accordance with the National HIV/AIDS Strategy (http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf), this FOA focuses on addressing the national HIV epidemic by reducing new infections, increasing access to care, improving health outcomes for people living with HIV, and promoting health equity. The aforementioned will be achieved by enhancing public health departments' capacities to increase HIV testing, link HIV positive persons to medical care and other essential services, and increase program monitoring and accountability. Standard performance measures for HIV prevention programs that are consistent with the focus of the National HIV/AIDS Strategy on improving performance and accountability will be included in this FOA.

The Funding Opportunity Announcement for Comprehensive HIV Prevention Programs for Health Departments includes three categories:

Category A: HIV Prevention Programs for Health Departments *(core funding)*

Category B: Expanded HIV Testing for Disproportionately Affected Populations *(limited eligibility and optional)*

Category C: Demonstration Projects to Implement and Evaluate Innovative, High Impact HIV Prevention Interventions and Strategies *(competitive and optional)*

This funding opportunity announcement is limited to health departments or their Bona Fide Agents. Community-based organizations (CBOs), for-profit entities, public non-profit, private non-profit, faith-based, and tribal organizations and colleges and universities are **not** eligible to apply for funding under this FOA.

All applicants must apply for Category A. Applicants may also apply for Category B (if eligible) and/or Category C. Applicants eligible for Category A and Category C of this FOA are limited to state, local and territorial health departments or their Bona Fide Agents. This includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, and Republic of Palau. Also eligible are the local (county or city) health departments serving the ten specific Metropolitan Statistical Areas (MSAs) or specified Metropolitan Divisions (MDs) that have the highest unadjusted number of persons living with a diagnosis of HIV infection as of year-end 2008. The ten eligible cities (MSAs/MDs) are Atlanta, Baltimore, Chicago, Fort Lauderdale, Houston, Los Angeles, Miami, New York, Philadelphia, and San Francisco.

Applicants eligible for Category B of this FOA are limited to state, local and territorial health departments or their Bona Fide Agents with at least 3,000 Black/African American and Hispanic/Latino adults and adolescents (unadjusted number) living with a diagnosis of HIV infection as of year-end 2008. A list of eligible jurisdictions is located under Section III: Eligibility Information for Category B.

Measurable outcomes of the program will be in alignment with one or more of the following performance goals for the National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention (NCHHSTP):

- Decrease the annual HIV incidence rate in communities where HIV is most heavily concentrated.
- Decrease the rate of HIV transmission by HIV-infected persons.
- Decrease risky sexual and drug-using behaviors among persons at high-risk for acquiring HIV.
- Increase the proportion of HIV-infected people in the United States who know they are infected.
- Increase the proportion of HIV-infected persons who are linked to prevention and care services.

Health Equity

The FOA supports efforts to improve the health of populations disproportionately affected by HIV/AIDS by maximizing the health impact of public health services, reducing disease prevalence, and promoting health equity consistent with the NHAS. Health disparities in HIV are inextricably linked to a complex blend of social determinants that influence populations most severely affected by this disease. Health equity is a desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage. See *Attachment I: Glossary of Terms* for definitions of health disparity, social determinants of health, and health equity.

Applicants should use epidemiologic and social determinants data to identify communities disproportionately affected by HIV and related diseases and conditions within their jurisdictions. Likewise, applicants should use data describing the social determinants of diseases in their coverage areas to accurately focus activities for reducing health disparities and to identify strategies to promote health equity. In collaboration with partners and appropriate sectors of the community, applicants should consider social determinants of health in the development, implementation, and evaluation of program

specific efforts and use culturally appropriate interventions that are tailored for the communities for which they are intended.

Social determinants of health affect disparities in HIV/AIDS, viral hepatitis, STD and TB. Studies have shown that HIV-infected persons with low literacy levels had less general knowledge of their disease and disease management and were more likely to be non-adherent to treatment than those with higher literacy (1, 2). Black men who have sex with men (MSM) at lower income levels are more likely to engage in sexual behaviors that put them at greater risk for acquiring STDs, compared to black MSM with higher income levels (3, 4). It has been found that heterosexual men and women in 23 major U.S. cities living below the poverty line were twice as likely to have HIV infection (2.4%) as those living above the poverty line (1.2%), and other social determinants of health, including homelessness, unemployment, and low education level, were independently associated with HIV infection (5). In addition, income was shown to be an important predictor of a lack of health insurance among persons with HIV and consequently may be a reason why they are less likely to receive treatment (6). Environmental factors such as housing conditions, social networks, and social support are also key drivers for infection with HIV, viral hepatitis, STDs, and TB. For example, a study among housed and homeless persons with HIV infection found that homeless persons had poorer health status, were less adherent to medication regimens, were more likely to be uninsured, and were more likely to have been hospitalized (7, 8).

Details of the health equity strategy and approach are outlined in the NCHHSTP Social Determinants of Health White Paper (http://www.cdc.gov/socialdeterminants/docs/SDH-White-Paper-2010.pdf).

Program Collaboration and Service Integration

This FOA supports the NCHHSTP program imperative calling for program collaboration and service integration (PCSI). PCSI promotes improved integrated HIV, viral hepatitis, STD, and TB prevention and treatment services at the client level through enhanced collaboration at the health department jurisdictional level, as well as organizational

program level, thereby offering opportunities to: (1) increase efficiency, reduce redundancy, and eliminate missed opportunities; (2) increase flexibility and better adapt to overlapping epidemics and risk behaviors; and (3) improve operations through the use of shared data, enabling service providers to adapt to, and keep pace with, changes in disease epidemiology and new technologies.

Populations disproportionately affected by HIV are also affected by other infections including TB, hepatitis C virus (HCV), hepatitis B virus (HBV), and STDs. This announcement encourages integration of diagnostic and prevention services for these diseases and other infections because of CDC's greater understanding of the extent to which:

- STDs increase the risk for acquisition and transmission of HIV.
- Control of TB, viral hepatitis, and STDs is needed to protect the health of HIV-infected persons.
- HIV, viral hepatitis, and STDs share common risks and modes of transmission.
- Risks for acquiring these diseases are associated with similar behaviors and environmental conditions and have reciprocal or interdependent effects.
- Clinical course and outcomes of these diseases are influenced by co-infection (e.g., TB is a leading cause of mortality for people with HIV, and TB accelerates HIV disease progression).
- Populations disproportionately affected by HIV are also disproportionately affected by infections with TB, HCV, HBV, and STDs.

Details of this strategy and approach are outlined in the NCHHSTP PCSI White Paper (http://www.cdc.gov/nchhstp/programintegration/docs/207181-C_NCHHSTP_PCSI%20WhitePaper-508c.pdf).

Advancing a Public Health Approach to Improve Sexual Health

The FOA supports efforts to improve program impact for prevention of HIV, STD, and viral hepatitis by enhancing traditional disease-specific control efforts with a holistic health promotion framework that more comprehensively addresses broader issues of

health and wellness, including sexual health. Sexual health is considered to be a state of physical, emotional, mental, and social well-being in relation to sexuality. Although it is inextricably bound to both physical and mental health, it is not limited to the absence of disease and dysfunction and is an important component of health across the lifespan. It includes the ability to understand and weigh the risks, responsibilities, outcomes, and impacts of sexual actions, and requires a positive and respectful approach to sexuality and sexual relationships and a respect for sexual rights.

HIV, STD, and viral hepatitis are highly stigmatized conditions, associated with sensitive behaviors, and are often concentrated among socially marginalized populations. Consequently, use of a broader sexual health-focused framework has the potential for reducing the fear, discrimination, and stigma associated with these conditions, thus enabling better reach of prevention programs to the general public, populations at risk, and health care providers. A more holistic and comprehensive health-focused framework may also help facilitate more open and honest societal dialogue around sensitive issues that are critically important to comprehensively address human sexuality, relationships, and sexual behavior. This approach is consistent with NHAS, which calls for more comprehensive and holistic approaches to reduce HIV incidence in the United States and provides an opportunity for working together to advance a public health approach to sexual health that includes HIV prevention.

This announcement is only for non-research activities supported by CDC. If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC website at the following Internet address: http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf

PART 2. FULL TEXT

I. FUNDING OPPORTUNITY DESCRIPTION

Statutory Authority

This program is authorized under Sections 301 and 318 of the Public Health Service Act (42 U.S.C. Section 241 and 247c), as amended.

Background

Thirty years into the Human Immunodeficiency Virus (HIV) epidemic, over 575,000 Americans have lost their lives to Acquired Immunodeficiency Syndrome (AIDS). HIV infection remains a major public health issue in the United States. More than 50,000 new HIV infections occur annually in the country. Approximately 1.2 million adults and adolescents are living with HIV in the United States and one in five (21%) persons living with HIV are not aware of their status (*9*). The epidemic continues to have a disproportionate impact on racial and ethnic minority populations – particularly African Americans and Hispanics – and on men who have sex with men (MSM) and injection drug users (IDU) regardless of race or ethnicity. In 2009, an estimated 52% of all HIV diagnoses occurred among African Americans and 17% in Hispanics. The rates of HIV infection per 100,000 population in 2009 were 66.6 among African American and 22.8 among Hispanics, compared to 7.2 among whites. The estimated rate of HIV infection per 100,000 population among African American females (47.8) was 19.9 times the rate among white females (2.4); the rate among Hispanic females (11.9) was 4.9 times the rate among white females. Males accounted for 76% of all diagnoses of HIV infection among adults and adolescents. Fifty-seven (57%) percent of diagnosed HIV infections among adult and adolescent males was attributed to male to male sexual contact. Among adult/adolescent males in whom HIV transmission was by heterosexual contact, African Americans constituted 69% and Hispanic/Latinos 17%. Among adult/adolescent females in whom HIV transmission was by heterosexual contact, African Americans constituted 68% and Hispanic/Latinos males 13%. (HIV Surveillance Report, Volume 21: Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas, 2009 www.cdc.gov/hiv/surveillance/resources/reports/2009report/index.htm).

Gay, bisexual, and other men who have sex with men (MSM) represent approximately 2% of the United States population, yet remain the population most severely affected by HIV and are the only risk group in which new HIV infections have been increasing steadily since the early 1990s. **At the end of 2008, most (75%) persons living with HIV were male, and 65.7% of the males were MSM.** Since the beginning of the United States epidemic, MSM have consistently represented the largest percentage of persons diagnosed with AIDS and persons with an AIDS diagnosis who have died.

Purpose

The purpose of this FOA is to support implementation of high impact, comprehensive HIV prevention programs to achieve maximum impact on reducing new HIV infections. In accordance with the NHAS, this FOA focuses on addressing the national HIV epidemic, reducing new infections, increasing access to care, improving health outcomes for people living with HIV, and promoting health equity. The aforementioned will be achieved by enhancing public health departments' capacities to increase HIV testing, refer and link HIV positive persons to medical care and other essential services, and increase program monitoring and accountability.

The goal of this FOA is to reduce HIV transmission by building capacity of health departments to:

- Focus HIV prevention efforts in communities and local areas where HIV is most heavily concentrated to achieve the greatest impact in decreasing the risks of acquiring HIV.
- Increase HIV testing.
- Increase access to care and improve health outcomes for people living with HIV by linking them to continuous and coordinated quality care and much needed medical, prevention and social services.
- Increase awareness and educate communities about the threat of HIV and how to prevent it.

- Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches, including delivery of integrated and coordinated biomedical, behavioral, and structural HIV prevention interventions.
- Reduce HIV-related disparities and promote health equity.

This program addresses the "Healthy People 2020" focus areas of HIV prevention.

Program Implementation

FOA CDC-RFA-PS12-1201: Comprehensive HIV Prevention Programs for Health Departments includes three categories:

- Category A: HIV Prevention Programs for Health Departments
- Category B: Expanded HIV Testing for Disproportionately Affected Populations (referred to as Expanded Testing Program)
- Category C: Demonstration Projects for Innovative, High Impact HIV Prevention Interventions and Strategies

Applicants must apply for Category A. Applicants may also apply for Category B (if eligible) and/or Category C.

An overview of required and optional recipient activities is provided for each category.

Recipient Activities

Category A: HIV Prevention Programs for Health Departments *(Required)*

In conducting activities to achieve the purpose of this FOA, the recipient will be responsible for the required components and activities under Category A. CDC will be responsible for conducting the activities under the CDC activities section.

The purpose of Category A is to support and enhance the ability of health departments to design, implement, and evaluate comprehensive HIV prevention programs that are effective, scalable, and intended to yield maximum impact on reducing new HIV infections. Category A is required for all applicants applying for funding. Applicants are expected to allocate programmatic and financial resources to local areas based on the burden of disease. Approximately 75% of Category A funding resources (including personnel costs) must be allocated to the required core components and activities. Applicants must implement all four of the core components; however, the distribution of resources and implementation of the elements under each core component should be based on scalability and balance of resources, epidemiologic data, local need, and at-risk and priority populations, including racial and ethnic groups. Applicants must also implement the three required activities to support the core components.

National-level Objectives and Performance Standards:

The following are the national-level objectives and performance standards that will be used for HIV testing and linkage to care activities funded under Category A.

Among all funded jurisdictions, CDC expects that approximately two million HIV tests will be provided annually, when the program is fully implemented.

CDC expects each funded jurisdiction to achieve the following performance standards, when the program is fully implemented:

- For targeted HIV testing in non-healthcare settings or venues, achieve at least a 1.0% rate of newly identified HIV-positive tests annually.
- At least 85% of persons who test positive for HIV receive their test results.
- At least 80% of persons who receive their HIV positive test results are linked to medical care and attend their first appointment.
- At least 75% of persons who receive their HIV positive test results are referred and linked to Partner Services.

Required Core Components

Required core components and activities to be included under CDC-RFA-PS12-1201, *Category A: HIV Prevention Projects for Health Departments* and implemented during the project period include: 1) HIV testing; 2) comprehensive prevention with positives; 3) condom distribution; and 4) policy initiatives.

1. **HIV Testing**
    a. Implement and/or coordinate opt-out HIV testing of patients ages 13-64 in healthcare settings (Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, 2006. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm?s_cid).
    b. Implement and/or coordinate HIV testing in non-healthcare settings to identify undiagnosed HIV infection using multiple strategies and the most current recommendations for HIV counseling, testing and referral.
    c. Support HIV testing activities in venues that reach persons with undiagnosed HIV infections.
    d. Ensure the provision of test results, particularly to clients testing positive.
    e. Promote routine, early HIV screening for all pregnant women, according to current CDC recommendations.
    f. Encourage and support health department and non-health department providers to increase the number of persons diagnosed with HIV through strengthening current HIV testing efforts or creating new services.
    g. Facilitate voluntary testing for other STDs (e.g., syphilis, gonorrhea, chlamydial infection), HBV, HCV, and TB, in conjunction with HIV testing, including referral and linkage to appropriate services, where feasible and appropriate and in accordance with current CDC guidelines and recommendations. *(This activity may be implemented in collaboration with STD, hepatitis, and/or TB programs).*
    h. Ensure that testing laboratories provide tests of adequate quality, report findings promptly, and participate in a laboratory performance evaluation program for testing. *(This activity may be done in conjunction with surveillance and/or laboratory services).*
    i. Incorporate new testing technologies, where feasible and appropriate.

For HIV Testing Definitions used throughout this FOA, see Attachment II: Recommended HIV Testing Definitions and Examples.

HIV testing should be a high priority within the jurisdiction's HIV prevention activities. For the implementation of HIV testing activities, CDC encourages applicants to partner and/or coordinate with providers such as community-based organizations, local health departments, tribal governments and organizations, community health centers, federally-qualified health centers, lesbian, gay, bisexual, and transgender (LGBT) health centers, STD clinics, hospitals, specialty clinics, etc.

The grantee will be expected to collect and submit client and test-level data for HIV testing, in accordance with CDC National HIV Monitoring and Evaluation (NHM&E) requirements. Required HIV testing data should be submitted through a CDC-approved reporting system. CDC will provide guidance on these requirements throughout the project period.

2. **Comprehensive Prevention with Positives**
   a. Provide linkage to HIV care, treatment, and prevention services for those persons testing HIV positive or currently living with HIV/AIDS.
   b. Promote retention or re-engagement in care for HIV-positive persons.
   c. Offer referral and linkage to other medical and social services such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and other services as needed for HIV-positive persons.
   d. Provide ongoing Partner Services (Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection, 2008. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm) for HIV-positive persons and their partners:

(1) Collaborate and coordinate with STD programs, and HIV and/or STD surveillance programs to utilize data to maximize the number of persons identified as candidates for Partner Services.

(2) Partner with non-health department providers, including CBOs and private medical treatment providers, to identify more opportunities to provide Partner Services.

e. Assure that HIV-positive pregnant women receive the necessary interventions and treatment for the prevention of perinatal transmission (according to the Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States, 2010. http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf). *For examples of additional demonstrated effective perinatal HIV prevention interventions that may be implemented, see Attachment III: Examples of Perinatal HIV Prevention Activities.*

f. Conduct sentinel event case review and community action to address local systems issues that lead to missed perinatal HIV prevention opportunities by utilizing the Fetal and Infant Mortality Review (FIMR)-HIV Prevention Methodology, including CDC's web-based data system (see www.fimrhiv.org), where appropriate and based on local need and the availability of resources. *Technical assistance (TA) and data support may be provided by CDC and the FIMR/HIV National Resource Center.*

g. Support behavioral and clinical risk screening followed by risk reduction interventions for HIV-positive persons and HIV-discordant couples at risk of transmitting HIV.

h. Support implementation of behavioral, structural, and/or biomedical interventions (including interventions focused on treatment adherence) for HIV infected persons.

i. Support and/or coordinate integrated hepatitis, TB, and STD screening (STD Treatment Guidelines, 2010), and Partner Services for HIV infected persons, according to existing guidelines.

j. Support reporting of CD4 and viral load results to health departments and use of these data for estimating linkage and retention in care, community viral load, quality of care, and providing feedback of results to providers and patients, as deemed appropriate.

k. Promote the provision of antiretroviral therapy (ART) in accordance with current treatment guidelines. *CDC funds may not be used to purchase antiretroviral therapy.*

Linkage to and retention in HIV care, Partner Services, and prevention services for those persons testing HIV positive or currently living with HIV/AIDS should be a high priority within the jurisdiction's HIV prevention activities. CDC encourages applicants to coordinate with partners such as Ryan White funded agencies, STD programs, surveillance programs, laboratory units, other health agencies, tribal organizations, community health centers, federally-qualified health centers, LGBT health centers, STD and TB clinics, hospitals, specialty clinics, etc. to implement comprehensive prevention with positives activities.

3. **Condom Distribution**

   a. Conduct condom distribution to target HIV-positive persons and persons at highest risk of acquiring HIV infection.

For targeted condom distribution activities, CDC encourages applicants to partner and/or coordinate with entities such as community-based organizations, local health departments, tribal organizations, community health centers, federally-qualified health centers, LGBT health centers, STD clinics, hospitals, specialty clinics, bars, clubs, local business partners, etc.

4. **Policy Initiatives**

a. Support efforts to align structures, policies, and regulations in the jurisdiction with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts. Policy efforts should aim to improve efficiency of HIV prevention efforts where applicable, and are subject to lobbying restrictions under federal law (see Administrative and National Policy Requirements, AR-12, Lobbying Restrictions, below).

(1) Examples of policy efforts to align existing structures, policies, and regulations to create an environment for optimal HIV prevention, care, and treatment could include, but are not limited to: addressing availability of condoms, sterile syringes, drug treatment, and pre- and post-exposure prophylaxis (PEP) and other prevention strategies and interventions; addressing barriers to CDCs 2006 HIV testing recommendations or to CD4 and viral load reporting; identifying and leveraging new opportunities for collecting and using data to improve patient prevention, care, and treatment; assessing and updating policies and regulations to facilitate the use and sharing of identifiable surveillance data across health department programs for public health action; addressing regulations related to pharmacy sale of sterile syringes; developing strategies to better align prevention and care planning efforts, especially for underserved population; and removing barriers to the use of high quality sexual health education curricula in schools.

Required Activities:

In addition to the required core components, applicants applying for funding under Category A must conduct: 1) jurisdictional HIV prevention planning; 2) capacity building and technical assistance, to include training; and 3) program planning, monitoring and evaluation, and quality assurance, to include data collection, management, and reporting as described below. These required activities must be included within the approximately 75% of funding resources allocated to the required core components and activities.

1. **Jurisdictional HIV Prevention Planning**

All fifty states, ten "cities" (MSAs/MDs) (Atlanta, Baltimore, Chicago, Fort Lauderdale, Houston, Los Angeles, Miami, New York, Philadelphia, and San Francisco), the District of Columbia, Puerto Rico, the Virgin Islands, and the United States Affiliated Pacific Island jurisdictions are required to have in place a prevention planning process to include the development of a jurisdictional HIV prevention plan and the establishment of an HIV prevention planning group (formerly HIV Community Planning Group). Community planning has evolved into HIV prevention planning, which aims to contribute to HIV prevention through developing both targeted and broad-based collaboration among stakeholders. **Prevention planning will entail broadening the group of partners and stakeholders engaged in prevention planning, improving the scientific basis of program decisions, and targeting resources to those communities at highest risk for HIV transmission and acquisition.** *See Attachment I for definitions. Refer to the most recent HIV Prevention Planning Guidance for more details about the prevention planning group process.*

a. Develop a jurisdictional HIV prevention plan to include the collaboration and coordination of HIV prevention, care, and treatment. **The jurisdictional HIV prevention plan will need to be developed and submitted to CDC within six months after the start of the project period and should be updated on an as-needed basis to reflect local needs.** The jurisdictional HIV prevention plan should align with the goals of NHAS. For jurisdictions with directly-funded state and city health departments, the city jurisdictional plan should complement the state jurisdictional plan and effectively depict and address the HIV epidemic within the jurisdiction. When developing the jurisdictional HIV prevention plan, applicants should utilize the Epi Profile and other available data sources to identify those populations with the greatest burden of the epidemic and those populations at greatest risk for HIV transmission and acquisition. Additionally, applicants should ensure that existing prevention resources are allocated and disseminated locally to the areas with the greatest HIV burden. The jurisdictional HIV prevention plan should include:

(1) A description of existing resources for HIV prevention services, care and treatment and key features on how the prevention services, interventions, and/or strategies are currently being used or delivered in the jurisdiction
(2) Need (e.g., resources, infrastructure, and service delivery)
(3) Gaps to be addressed and rationale for selection
(4) Prevention activities and strategies to be implemented within the jurisdiction
(5) Scalability of activities *(see Attachment I for definition of scalable)*
(6) Responsible agency/group to carry out the activity (i.e., Prevention Unit, Ryan White-funded agencies, and Housing Opportunities for People Living with AIDS (HOPWA))
(7) Relevant timelines

If a plan has already been developed within the previous two years that addresses the goals and objectives of this FOA (e.g., Enhanced Comprehensive HIV Prevention Plan (ECHPP), NHAS state plan), applicants may use and/or update the existing plan. The plan should include the actions listed above.

b. Facilitate a collaborative HIV prevention planning process that contributes to the reduction of HIV infection in the jurisdiction.
(1) Identify and obtain key stakeholders input to ensure broad-based community participation in the planning process. Foster a planning process that encourages parity, inclusion, and representation (often referred to as PIR) among planning members. The health department and prevention planning group should work collaboratively to develop strategies that will increase coordination of HIV programs across state, local, and tribal governments; businesses; faith communities; community/primary health care centers; other medical providers; educational institutions; people living with HIV/AIDS (PLWHA); care planning groups; and other key stakeholders within the jurisdiction. *Please note that these examples are not meant to be an all-inclusive list of partners.*

c. Ensure that the HIV Prevention Planning Group participates in the development of the following activities:

(1) **Engagement Process** - Strategies for increasing coordination across HIV programs (i.e., prevention, care, and treatment) across the state, jurisdiction, and tribal and local governments to reduce rates of new HIV infection. Steps for engagement should include: determining the goals of the plan and who to engage; developing engagement and retention strategies for previous partners; developing engagement strategies for new partnering agencies; prioritizing engagement activities; creating an implementation plan; monitoring progress; and maintaining the partner relationships.

(2) Letter of concurrence, concurrence with reservations, or non-concurrence – Letter signed by representatives of the Prevention Planning Group concurring that the jurisdictional HIV prevention plan sent forward by the health department allocates resources to the areas and populations with the greatest HIV disease burden. The letter should also include the process used by the Prevention Planning Group to review the jurisdictional HIV prevention plan. The letter of concurrence, concurrence with reservations, or non-concurrence should initially be submitted six months after funding with the jurisdictional HIV prevention plan and annually for the following (subsequent) years. See the template provided in *Attachment IV: Sample of Letter of Concurrence*.

2. **Capacity Building and Technical Assistance**

a. As part of the Comprehensive Program Plan (described under the Program Planning, Monitoring and Evaluation, and Quality Assurance required activity), include a description of capacity-building needs based on the most recent needs assessment conducted in the last two years within the jurisdiction.

(1) If a needs assessment does not exist or is outdated, the applicant will have to conduct or update the capacity-building needs assessment of the health department, HIV prevention service providers, and other prevention agencies/partners, including CBOs capacity to provide HIV prevention services.

b. Provide or collaborate with partners within or external to the health department (e.g., capacity building assistance providers, AIDS Education and Training

Centers, STD/HIV Prevention Training Centers) to offer capacity building assistance to HIV prevention service providers and other prevention agencies and partners.

c. Ensure that all health department staff are appropriately trained for their respective job responsibilities under this program.

d. Provide or coordinate training and technical assistance (e.g., interventions, organizational infrastructure, HIV testing efforts, policies for data security and confidentiality, data sharing across programs and data reporting to surveillance) for providers and staff of participating healthcare facilities and CBOs or other service organizations. Refer to http://www.cdc.gov/hiv/topics/cba/index.htm for examples of topic areas in which training or technical assistance may be needed.

e. Document and track provision of training and technical assistance to health department staff, staff of participating healthcare facilities and CBOs or other service organizations.

f. Facilitate exchange of information and peer-to-peer consultation and technical assistance among sites (e.g., convening jurisdiction-level workshops, development of collaborations, referral networks).

3. **Program Planning, Monitoring and Evaluation, and Quality Assurance**

a. Monitor the HIV/AIDS epidemic within the jurisdiction for program planning, resource allocation and monitoring and evaluation purposes.

(1) Utilize the most current epidemiological and surveillance data and other available data sources to assist in program planning and evaluation. Identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For eligible cities, applicants can report areas or zip codes within the MSA with at least 30% of the HIV epidemic within the jurisdiction. To ensure that resources are reaching the areas of greatest need, funded jurisdictions will be required to report annually to CDC on the amount of funding allocated to the areas with 30% or greater of the HIV epidemic and how the funds were used.

(2) Coordinate with state and local surveillance programs to collect data needed for HIV incidence and surveillance efforts.

(3) In areas participating in CDC's National HIV Behavioral Surveillance (NHBS), collaborate with local NHBS staff to assess exposure to, utilization of, and effect of HIV prevention programs.

(4) Submit to CDC, a current copy of the jurisdictional HIV/AIDS Epidemiological Profile (referred to as Epi Profile) with the application. *Epi Profiles should be developed as a function of HIV surveillance. If necessary, develop and/or update the jurisdictional Epi Profile throughout the project period in conjunction with the surveillance program and in accordance with the most recent guidelines.*

b. Develop and submit to CDC a detailed comprehensive program, monitoring and evaluation (M&E), and quality assurance (QA) plan, referred to as the Comprehensive Program Plan. CDC will work with health department programs to establish targets and performance measures for HIV program activities. The jurisdictional HIV prevention plan should be used as a reference for the development of the Comprehensive Program Plan. *The final version of this comprehensive program plan must be submitted to CDC within six months after start of the project period.* The comprehensive program plan should include the following:

(1) Program Description

(a) Annual and five year program goals and specific, measurable, achievable, relevant and time-phased (SMART) objectives for each required core component and activity, to include program performance targets. If applicable, include program goals and annual objectives for the recommended components.

(b) Activities that will be conducted to meet the objectives.

(c) Capacity building needs.

(d) Timeline for implementation of the activities.

(2) M&E Description

(a) Questions about program performance to be answered through program monitoring and evaluation.

(b) Qualitative and quantitative measures that will be used and data that will be needed to answer the M&E questions. M&E questions will be developed in conjunction with CDC and will incorporate targets needed for national and local monitoring.

(c) Mechanisms for data collection, entry, management, submission, analysis, utilization, and dissemination for all core and recommended activities. The description should indicate how information will be used to support program planning, resource allocation, and evaluation.

(d) Local monitoring and evaluation planning that include activities for:

- Healthcare settings: The M&E plan must include processes for monitoring the yield of newly diagnosed HIV infections in individual healthcare facilities. It must also include plans for addressing situations in which the yield is below 0.1%, including selecting alternative sites.
- Non-healthcare settings (CBOs or other service organizations): The M&E plan must include monitoring the rate of positive HIV tests and the yield of newly diagnosed HIV infections to assess the effectiveness of targeting. It must also include plans for working with CBOs, testing providers or other service organizations that are achieving low yield (e.g., a seropositivity rate of less than 1%), including improving targeting or selecting new sites.
- Service integration: If applicable, implement a process for monitoring and evaluating service integration activities.

(e) Procedures for maintaining data security and confidentiality, consistent with CDC guidelines. The agency is required to comply with the applicable provisions of the Privacy Act and to undertake other safeguards for individuals and establishments against invasion of privacy. To provide these safeguards in performance of the cooperative agreement, the applicant must agree to sign the following documents as applicable indicating that all information will be adequately protected according to

H.19 308(d) Contract Clause for Safeguards for Individuals and Establishments against Invasions of Privacy (*See Attachments V – VI*):

- Assurance of Confidentiality (AOC) – Covers the full period of funding,
- Memorandum of Understanding (MOU) – CPEMS System Administrator,
- MOU – Non-CPEMS System Administrator.

(f) Comply with all federal (i.e., HHS, and/or CDC) information systems and information processing security policies and regulations in performance of the security requirements and deliverables and be bound by the Assurance of Confidentiality. This includes developing local policies and procedures that clearly describe the physical security of the facility/facilities that will be used during the project; the procedures for protection, controlling, and handling of data during performance of the project including any development and testing activities; any required limitations on employees concerning the reproduction, transmission, or disclosure of data and project information; the physical storage procedures to protect data; the procedures for the destruction of source documents and other contract-related waste material; and personnel security procedures.

(g) Develop and maintain rules of behavior for data systems under the agency's responsibility. State/local data system rules of behavior needs to be responsive to CDC policies and the applicant must agree to sign and submit annually the following documents to CDC:

- Rules of Behavior (ROB) – CPEMS System Administrator,
- ROB – Non-CPEMS System Administrator,
- ROB – CPEMS Users,
- ROB – Non-CPEMS Users *(See Attachments VII-VIII)*

(h) Ensure that all agency personnel having access to identifiable and confidential information receive appropriate training, read the Assurance of Confidentiality, and sign confidentiality pledges. Each employee of the agency has to sign a Non-Disclosure Agreement (NDA). Training should

be conducted annually for all agency personnel who have access to and review aggregate and client-level data.

(i) Conduct a privacy impact assessment (PIA) on all information systems acquired, developed, or used in conjunction with CDC data.

(j) Conduct annual reviews and validations of system user accounts to ensure continued need for access to system.

(k) Develop and ensure data security and confidentiality guidelines that meet the federal requirements; annually review security controls and measures to ensure continued compliance with federal information system and data security regulations and identify security vulnerabilities. The agency staff shall continually work in consultation with CDC and review security controls and measures to ensure continued compliance with federal information security regulations.

(l) Collect and submit additional information as required for interim and annual progress reports.

(3) QA Description

(a) Quality assurance measures to support components and activities being implemented and to improve program quality and accountability.

(b) Development and implementation of QA mechanisms and measures to ensure that:

- Services are provided in a technically competent manner and are consistent with current CDC guidelines and recommendations.
- Services are culturally and linguistically appropriate and staff are trained accordingly. (http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf)
- All staff have appropriate training for their respective roles.
- Positive test results are reported to the appropriate local or state surveillance and Partner Services programs, in accordance with applicable laws and regulations.
- Appropriate laboratory QA procedures for HIV testing are in place.

- QA policies and procedures are available and accessible to all staff working in this program and CDC.

Guidance on program monitoring and evaluation and performance measures will be provided by CDC on an ongoing basis throughout the project period.

Recommended Program Components:

In addition to addressing the required core components and activities, applicants with the resources, capacity, and program need may consider implementing the following recommended program components. Up to 25% of Category A funding resources may be allocated to the recommended program components. Applicants may implement all or a variety of the elements outlined under the recommended program components below.

Recommended program components that can, but are not required to, be implemented during the project period under Category A include: 1) Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk for Acquiring HIV; 2) Social Marketing, Media, and Mobilization; and 3) Pre-Exposure Prophylaxis (PrEP) and Non-Occupational Post-Exposure Prophylaxis (nPEP) Services.

1. **Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk of Acquiring HIV**
    a. Provide behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV, particularly those in an HIV-serodiscordant relationship.
    b. Implement community evidence-based interventions that reduce HIV risk.
    c. Support syringe services programs (SSPs), where allowable, and according to HHS and CDC guidelines. Programs that use federal funding for SSPs should adhere to state and local laws, regulations, and requirements related to such programs or services. Programs must have a certification signed by an authorized official. Funded grantees must, in turn, have documentation that local law enforcement and local public health authorities have agreed upon the location for

the operation of the SSPs. Copies of this documentation must be made available upon request by HHS and others, as appropriate. For required certification forms and additional information see Department of Health and Human Services Implementation Guidance for Syringe Services Programs, July 2010. http://www.cdc.gov/hiv/resources/guidelines/PDF/SSP-guidanceacc.pdf. For additional information regarding SSP implementation, refer to the SSP Guidance for Health Departments funded by Division of HIV/AIDS Prevention (DHAP).

2. Social Marketing, Media, and Mobilization

a. Support and promote social marketing campaigns targeted to relevant audiences (e.g., providers, high risk populations or communities) including the use of campaign materials developed and tested by CDC.

b. Support and promote educational and informational programs for the general population based on local needs, and link these efforts to other funded HIV prevention activities (e.g., pamphlets, hotlines, or social marketing campaigns).

c. Support and promote the use of media technology (e.g., Internet, texting, and web applications) for HIV prevention messaging to targeted populations and communities.

d. Encourage community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among family, friends, and neighbors.

3. Pre-Exposure Prophylaxis and Non-Occupational Post-Exposure Prophylaxis Services

a. Support Pre-Exposure Prophylaxis (PrEP) services to MSM at high risk for HIV consistent with CDC guidelines ("Preexposure Prophylaxis (PrEP) for the Prevention of HIV Infection in Men Who Have Sex with Men" guidelines in the *Morbidity and Mortality Weekly Report (MMWR)* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6003a1.htm?s_cid=mm6003a

1_w*).* Programs that use federal funding for PrEP-related activities should adhere to state and local laws, regulations, and requirements related to such programs or services. PrEP-related activities must be implemented as part of a comprehensive HIV prevention program that includes, as appropriate, linkage and referral to prevention and treatment services for STD, viral hepatitis, substance abuse, and mental health, and other prevention support services. Funds may **not** be used for PrEP medications (antiretroviral therapy), but may be used to support the following PrEP services for MSM:

(1) Planning how to most effectively incorporate PrEP into prevention education and services.

(2) Educational materials about how to use PrEP in conjunction with other HIV prevention and care services, as well as STD, viral hepatitis, mental health and substance abuse treatment.

(3) Development and delivery of the HIV risk-reduction counseling and behavioral interventions that must be provided with PrEP.

(4) Communication activities related to PrEP (e.g., webcast).

(5) Evaluation of PrEP-related activities.

(6) Personnel (e.g., program staff) conducting the above PrEP-related activities. *For further information see Attachment IX: CDC PrEP Program Guidance for HIV Prevention Health Department Grantees.*

b. Offer Non-Occupational Post-Exposure Prophylaxis (nPEP) to populations at greatest risk. (Smith DK, Grohskopf LA, Black RJ, et al. Antiretroviral post-exposure prophylaxis after sexual, injection-drug use, or other non-occupational exposure to HIV in the United States. *MMWR*. 2005; 54:1-20, http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm.)

Category B: Expanded HIV Testing for Disproportionately Affected Populations (*Limited eligibility and optional)*

In 2007, CDC implemented a new HIV testing program, CDC-RFA-PS07-768: *Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African Americans,* aimed at significantly increasing the number of persons tested each year in jurisdictions with a high incidence of HIV among disproportionately affected populations and supporting dissemination and implementation of its *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings.* Through CDC-RFA-PS07-768, grantees achieved several notable successes:

- Conducted over 2.7 million HIV tests, in the first three years.
- Established new relationships with, and initiated routine HIV screening programs in, a variety of healthcare settings, including emergency departments, STD clinics, TB clinics, state and local jails, urgent care clinics, and community health centers.
- Successfully targeted African Americans: In the first three years, approximately 60% of tests were among African Americans.
- Achieved high success rates in linking persons with newly diagnosed HIV infection to medical care (75%), Partner Services (83%), and other support services (e.g., housing assistance).
- Strengthened public health and preventive care infrastructure, particularly in venues and communities serving disproportionately affected populations.

Testing efforts under CDC-RFA-PS07-768 were sustained and expanded in 2010-11 under FOA CDC-RFA-PS10-10138. Category B of this FOA is intended to further progress made under announcements CDC-RFA-PS07-768 and CDC-RFA-PS10-10138 and expand routine testing services to new venues to reach at-risk populations.

The purpose of Category B is to support health departments to implement expanded HIV testing efforts for populations disproportionately affected by HIV – African Americans, Hispanics, MSM, and IDUs, primarily in healthcare settings. The goal for Category B is to increase the number of persons who receive HIV testing, and the number and proportion of HIV-infected persons who are aware of their infection by:

- Providing routine HIV screening in healthcare settings serving these populations.
- Expanding targeted HIV testing in non-healthcare settings or venues where high-risk members of these populations can be accessed.
- Ensuring that persons testing positive for HIV infection (new positives and previously diagnosed positives not in care) receive HIV test results, prevention counseling and linkage to medical care, Partner Services, and HIV prevention services.

Category B also supports integration of HCV, HBV, STD, and TB testing with testing and prevention services for HIV, and adoption of sustainable, routine HIV testing programs in healthcare facilities, consistent with CDC's 2006 *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*.

Applicants eligible for Category B are limited to state, local and territorial health department jurisdictions or their Bona Fide Agents with at least 3,000 Black/African American and Hispanic/Latino adults and adolescents (unadjusted number) living with a diagnosis of HIV infection as of year-end 2008. At least 70% of Category B funding must be allocated to the delivery of services in healthcare settings. Up to 30% may be used to support targeted testing efforts in non-healthcare settings.

National-level Objectives and Performance Standards

The following are the National-level objectives and performance standards that will be used for HIV testing, linkage to care, and other related activities funded under Category B.

Among all funded jurisdictions, CDC expects that approximately 1.1 million HIV tests are provided and approximately 5,500 HIV-infected persons who were previously unaware of their infection are identified in the first year of funding. When the program is fully implemented, funded jurisdictions should provide approximately 1.3 million HIV tests and identify approximately 6,500 HIV-infected persons who were previously unaware of their infection annually.

CDC expects each funded jurisdiction to achieve the following performance standards, when the program is fully implemented:

- For targeted HIV testing in non-healthcare settings or venues, achieve at least a 2.0% rate of newly identified HIV-positive tests annually.
- At least 85% of persons who test positive for HIV receive their test results.
- At least 80% of persons who receive their HIV-positive test results are linked to medical care and attend their first appointment.
- At least 80% of persons who receive their HIV-positive test results are referred and linked to Partner Services.
- At least 80% of persons who receive their HIV-positive test results receive prevention counseling or are referred to prevention services.
- Over the course of the project, increase the number of healthcare facilities that have implemented sustainable, routine HIV testing programs consistent with CDC's 2006 guidelines.
- Over the course of the project, increase the number of venues offering integrated testing programs for HIV, HCV, HBV, other STDs, and TB.

Key components to be conducted under CDC-RFA-PS12-1201, *Category B: Expanded HIV Testing for Disproportionately Affected Populations* and implemented during the project period include the following: 1) Expanded HIV Testing in Healthcare Settings (*required*); 2) Expanded HIV Testing in Non-healthcare Settings *(optional)*; and 3) Service Integration *(optional).*

Applicants applying for funding under Category B can apply to implement services only in healthcare settings or in both healthcare and non-healthcare settings. Applicants cannot solely apply for funding of non-healthcare settings. Service integration is an optional component. HIV testing activities described in Category B are in addition to HIV testing activities for Category A.

1. HIV Testing in Healthcare Settings (*Required*)

Applicants funded under Category B: Healthcare Settings will promote integration of routine HIV testing into healthcare settings in accordance with CDC's 2006 *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*.

Components under Category B: HIV Testing in Healthcare Settings are as follows:

a. Use the jurisdictional HIV prevention plan, epi profile, and other available data to identify areas with high HIV incidence or prevalence and healthcare facilities that serve the target population(s) that will not be covered under Category A.
b. Promote routine HIV testing to administrators, managers, and clinical directors at candidate healthcare facilities and engage them to support, develop, implement, and maintain routine HIV testing programs in their facilities.
    (1) For those already doing routine HIV testing, promote expansion of the program (e.g., expanding the program to include new areas or departments in the facility or increasing the number of days or hours during which routine screening is done).
    (2) For those not already doing routine HIV testing, promote development of new programs.
c. Ensure that participating healthcare programs:
    (1) Promote the program to staff, educate providers and other appropriate staff about routine HIV testing, and gain their support for the program.
    (2) Promote and provide routine, voluntary testing to patients/clients ages 13 - 64 in accordance with current guidelines and recommendations.
    (3) Use test technologies (e.g., conventional testing with rapid turn-around, rapid tests) and strategies that will maximize the proportion of persons tested who receive their results.
    (4) Deliver all services in a culturally and linguistically appropriate manner.
d. Encourage the use of opt-out consent procedures, where allowable and appropriate. For states that do not allow opt-out consent, or in settings in which opt-out consent is not appropriate, ensure that all patients are actively offered screening, in accordance with appropriate consent procedures.

e. Ensure that patients/clients receive their test results, especially those who test positive for HIV. If using rapid HIV tests, ensure that individuals with reactive rapid tests (i.e., preliminary positive results) receive confirmatory tests.

f. Ensure that individuals who test positive for HIV (including individuals newly diagnosed with HIV, and when appropriate, individuals previously diagnosed) receive prevention counseling, linkage to medical care (including recommended screening for STDs, TB, and viral hepatitis), and initiation of Partner Services in accordance with CDC recommendations and state and local requirements. *If implementing this program in correctional facility clinics, develop and implement strategies for linking inmates who test positive to medical care at the time of release.*

g. Identify opportunities for improving timely linkage to care, particularly among priority populations and populations experiencing HIV-related health disparities, and develop strategies for taking advantage of those opportunities that can be implemented throughout the duration of the program.

h. Maximize the likelihood that the programs developed will be sustainable (e.g., consider "integrated" models using regular clinic staff, rather than "parallel" models that rely on special staff).

   (1) Use all available mechanisms to obtain reimbursement for HIV testing from third party payers (e.g., Medicare, Medicaid, private insurance, HMO programs).

   (2) If necessary, use funds from this FOA for testing persons not eligible for other coverage for HIV testing (e.g., provide test kits if doing rapid testing; reimburse facilities for cost of testing [rapid or conventional]; develop "fee for service" schedules that incentivize testing and other key outcomes, such as linkage to medical care and Partner Services).

i. Explore opportunities for integrating HIV testing into other screening programs conducted at participating facilities (e.g., blood pressure, diabetes, and cholesterol screening).

j. Facilitate voluntary screening and testing for other STDs (e.g., syphilis, gonorrhea, chlamydial infection), HBV, HCV, and TB, in conjunction with HIV testing, and in accordance with current CDC guidelines and recommendations.

k. Explore strategies for promoting routine HIV testing at non-candidate healthcare facilities. This may include providing or coordinating training and technical assistance.

Potential venues in which HIV testing may be conducted under Category B: Healthcare Settings include, but are not limited to the following: emergency departments (EDs), urgent care clinics (UCCs), inpatient settings, primary care facilities, community health centers (CHCs), Health Maintenance Organizations (HMOs), family planning and reproductive health clinics, college and university student health clinics, pharmacy-based clinics (i.e., clinics located in pharmacy facilities), retail clinics (i.e., clinics located in retail store facilities), STD clinics, TB clinics, other public health clinics, dental clinics, correctional facility clinics, and substance abuse treatment facilities (including methadone clinics).

2. HIV Testing in Non-healthcare Settings (*Optional*)

Applicants funded under Category B: HIV Testing in Non-healthcare Settings will work with CBOs or other service organizations to develop and implement programs for HIV testing in non-healthcare settings. These programs should primarily target MSM, transgender persons, and IDUs, regardless of race or ethnicity. In addition, groups such as Black/African American and Hispanic/Latino(a) men and women at risk may be targeted if this is supported by available data and analysis of service gaps. Up to 30% of Category B funding may be allocated to the delivery of services in non-healthcare settings. Activities conducted in these programs should be consistent with current CDC guidelines and recommendations for HIV testing in non-healthcare settings.

Components under Category B: HIV Testing in Non-healthcare Settings are as follows:

a. Identify and fund CBOs or other service organizations that have experience providing HIV testing services in non-healthcare settings and experience working with the target populations. Ensure that these programs:
   (1) Use the jurisdictional HIV prevention plan, epi profile, and other available data to identify areas with high HIV incidence or prevalence and community-based organizations or other service organizations that serve the target population(s) to participate in this program.
   (2) Identify specific settings or venues in which high-risk members of the target population(s) can be accessed.
   (3) Work with gatekeepers to gain access to targeted settings and venues.
   (4) Promote the program to members of the target population(s), key stakeholders, and other potential supporters.
   (5) Recruit high-risk members of the target population(s) who do not know their HIV status.
   (6) Obtain informed consent for testing, using appropriate consent procedures that adhere to all state and local requirements.
   (7) Provide HIV tests to clients who give informed consent.
   (8) Use test technologies (e.g., rapid tests) and strategies (e.g., use of incentives) that will maximize the proportion of persons tested that receive their results.
   (9) Achieve at least a 2% rate of newly identified positive tests when the program is fully implemented (i.e., all contracts with participating CBOs or other service organizations have been executed, health department and subcontractor staff have been hired and trained, all necessary policies and procedures have been developed and implemented, all necessary supplies and materials have been procured, and necessary technical assistance has been provided).
   (10) Take corrective actions if the rate of newly diagnosed positive tests is below 2%.
   (11) Deliver all services in a manner consistent with current CDC guidelines and recommendations.

(12) Educate program staff about Partner Services and gain their support for these services.

(13) Deliver all services in a culturally and linguistically appropriate manner.

b. Ensure that clients receive their test results, especially those who test positive for HIV.

(1) If using rapid HIV tests, ensure that individuals with reactive rapid tests (i.e., preliminary positive results) receive confirmatory tests.

c. Ensure that persons who test positive for HIV (including persons newly diagnosed with HIV and, when appropriate, persons previously diagnosed) receive the following services:

(1) Prevention counseling and, if needed, referral to other prevention services.

(2) Linkage to medical care (including recommended screening for STDs, TB, and viral hepatitis) as soon as possible after diagnosis.

(3) Initiation of Partner Services as soon as possible after diagnosis, in accordance with CDC recommendations and state and local requirements.

(4) Referral to other services (e.g., housing, legal services, partner violence prevention services), as needed.

d. Ensure that persons who test negative for HIV but are at high risk for becoming infected, receive prevention counseling (and referral to other prevention services, if needed).

e. Use the jurisdictional HIV prevention plan, epi profile, and other data (e.g., data from STD, TB, and hepatitis surveillance) to assess the potential value and feasibility of integrating screening and testing for other STDs (e.g., syphilis, gonorrhea, chlamydial infection), HBV, HCV, and TB into the HIV testing programs funded under this category. If feasible, implement the appropriate integrated screening identified in the assessment.

Potential venues or settings in which HIV testing may be provided under Category B: HIV Testing in Non-healthcare Settings include places where high-risk members of the target population(s) can be accessed. Examples include, but are not limited to, the following: established counseling and testing sites (e.g., on-site testing at a CBO, existing

mobile units), homeless shelters/transitional housing, bathhouses, bars, public places where high-risk persons congregate (e.g., street locations, parks, beaches, Internet cafés), commercial sex locations (e.g., strip clubs, gentlemen's clubs), dance clubs or circuit parties, Gay Pride events, syringe services programs, commercial locations (e.g., tattoo parlor, adult bookstore), internet (e.g., chat rooms, online dating services), college and university student centers, and faith-based settings (e.g., churches, synagogues, mosques, temples).

3. Service Integration (*Optional*)

Funds from this category may be used for other screening tests if done in conjunction with HIV screening, are justified by epidemiologic data, and are in accordance with current CDC guidelines and recommendations. Funds from this category may not be used for clinical services (e.g., treatment of HIV, STDs, viral hepatitis, TB, or TB infection; vaccination against hepatitis A or B). Referrals and linkages for these clinical services should be made through collaboration with STD, hepatitis, and TB programs or other clinical care providers.

If implementing integrated screening activities (e.g., screening for STDs, hepatitis, and TB) under Category B, applicants should do the following:

a. Collaborate with key staff of the participating facilities to plan, develop, and implement the integrated screening activities for STDs, TB, or hepatitis, in accordance with CDC guidelines and recommendations.
b. Collaborate with STD, hepatitis, and TB programs to design, develop, and implement the activities, including referral and linkage to appropriate evaluation, treatment, and vaccination (e.g., hepatitis A and B vaccination).
c. Use all available mechanisms to obtain reimbursement for these integrated screening activities from third party payers (e.g., Medicare, Medicaid, private insurance, HMO programs). This is applicable to healthcare settings only.
d. Ensure that patients/clients receive their test results, especially those who test positive.

e. Ensure that patients/clients who test positive are linked to medical care and receive timely and appropriate evaluation and treatment.
f. For patients/clients who test positive for other STDs, ensure that Partner Services are initiated as soon as possible after diagnosis, in accordance with CDC recommendations and state and local requirements.
g. Periodically review monitoring data with the participating facilities to assess the value of continuing screening for other STDs, viral hepatitis, and TB.

Examples of Service Integration and an overview of the approach can be found in the NCHHSTP PCSI White Paper.

4. Capacity Building and Technical Assistance

a. As part of the Comprehensive Program Plan (described under the Program Planning, M&E, and QA section), include a description of capacity-building needs for implementing routine HIV testing in healthcare settings and HIV testing in non-healthcare settings.
b. Provide or collaborate with partners within or external to the health department (e.g., capacity building assistance providers, AIDS Education and Training Centers, STD/HIV Prevention Training Centers) to offer capacity building assistance to HIV prevention service providers and other prevention agencies and partners.
c. Ensure that all health department staff are appropriately trained for their respective job responsibilities under this program.
d. Provide or coordinate training and technical assistance (e.g., interventions, organizational infrastructure, HIV testing efforts, policies for data reporting to surveillance) for staff of participating healthcare facilities and CBOs or other service organizations. Refer to http://www.cdc.gov/hiv/topics/cba/index.htm for examples of topic areas in which training or technical assistance may be needed.
e. Document and track the provision of training and technical assistance to health department staff, staff of participating healthcare facilities and CBOs or other service organizations.

f. Facilitate exchange of information and peer-to-peer consultation and technical assistance among sites (e.g., convening jurisdiction-level workshops, development of collaborations, referral networks).

5. Program Planning, Monitoring and Evaluation, and Quality Assurance

a. Utilize the most current epidemiologic and surveillance data and other available data sources to assist in program planning and evaluation.

(1) Coordinate with surveillance programs to collect data needed for HIV incidence and surveillance efforts.

b. Develop and submit to CDC a detailed comprehensive program, M&E, and QA plan, referred to as Comprehensive Program Plan. CDC will work with health department programs to establish targets and performance measures for HIV program activities that are meaningful at the local level and incorporate measures that are consistent with NHAS and CDC. *Category B activities should be included in the single Comprehensive Program Plan outlined under Category A to be submitted to CDC within six months after the start of the project period. Guidance on program monitoring and evaluation and performance measures will be provided by CDC on an ongoing basis throughout the project period.* The comprehensive program plan should include the following for Category B activities:

(1) Program Description

(a) Annual and five year program goals and SMART objectives for each required testing component and activities, to include program performance targets.

(b) Activities that will be conducted to meet the objectives.

(c) Capacity building needs.

(d) Timeline for implementation of the activities.

(2) M&E Description

(a) Questions about program performance to be answered through program monitoring and evaluation.

(b) Qualitative and quantitative measures that will be used and data that will be needed to answer the M&E questions. M&E questions will be developed in conjunction with CDC and will incorporate targets needed for national and local monitoring.

(c) Local monitoring and evaluation activities to answer M&E questions. The applicant should include:

- Healthcare settings: The processes for monitoring the yield of newly diagnosed HIV infections in individual healthcare facilities. It must also include plans for addressing situations in which the yield is below 0.1%, including selecting alternative sites.
- Non-healthcare settings (CBOs or other service organizations): The processes for monitoring the rate of positive HIV tests and the yield of newly diagnosed HIV infections to assess the effectiveness of targeting. It must also include plans for working with CBOs or other service organizations that are achieving low yield (e.g., a new positive rate of less than 2%), including improving targeting or selecting new sites.
- Service integration: If applicable, process for monitoring and evaluating service integration activities.

(d) If funds from this Category will be used to support integrated screening for other tests (e.g., syphilis, gonorrhea, chlamydial infection, hepatitis B, hepatitis C, TB) in conjunction with HIV screening, the comprehensive plan must include monitoring and evaluation of the planned service integration activities.

(e) Develop and establish data security and confidentiality procedures, consistent with CDC guidelines. The applicant is required to comply with the applicable provisions of the Privacy Act and to undertake other safeguards for individuals and establishments against invasion of privacy. To provide these safeguards in performance of the contract, the applicant must:

- Agree to sign the following documents as applicable indicating that all information will be adequately protected according to H.19 308(d) Contract Clause for Safeguards for Individuals and Establishments against Invasions of Privacy (*See Attachments V – VI*):
  - Assurance of Confidentiality (AOC) – Covers the full period of funding,
  - Memorandum of Understanding (MOU) – CPEMS System Administrator,
  - MOU – Non-CPEMS System Administrator.

(f) Comply with all federal (i.e., HHS, and/or CDC) information systems and information processing security policies and regulations in performance of the security requirements and deliverables and be bound by the Assurance of Confidentiality. This includes developing local policies and procedures that clearly describe the physical security of the facility/facilities that will be used during the project; the procedures for protection, controlling, and handling of data during performance of the project, including any development and testing activities; any required limitations on employees concerning the reproduction, transmission, or disclosure of data and project information; the physical storage procedures to protect data; the procedures for the destruction of source documents and other contract-related waste material; and personnel security procedures.

(g) Develop and maintain rules of behavior for data systems under the agency's responsibility. State/local data system rules of behavior needs to be responsive to CDC policies and the applicant agree to sign and submit annually the following documents to CDC:

- Rules of Behavior (ROB) – CPEMS System Administrator,
- ROB – Non-CPEMS System Administrator,
- ROB – CPEMS Users,
- ROB – Non-CPEMS Users *(See Attachments VII-VIII)*

(h) Ensure that all agency personnel having access to identifiable and confidential information receive appropriate training, read the Assurance

of Confidentiality and sign confidentiality pledges. Each employee of the agency has to sign a Non-Disclosure Agreement. Training should be conducted annually for all agency personnel who have access to and review aggregate and client level data.

(i) Conduct a privacy impact assessment on all information systems acquired, developed, or used in conjunction with CDC data.

(j) Conduct annual reviews and validations of system user accounts to ensure continued need for access to system.

(k) Develop and ensure data security and confidentiality guidelines meet the federal requirements; annually review security controls and measures to ensure continued compliance with federal information system and data security regulations and identify security vulnerabilities. The agency staff shall continually work in consultation with CDC and review security controls and measures to ensure continued compliance with federal information security regulations.

(l) Collect and submit additional information as required for interim and annual progress reports.

(3) QA Description

(a) Quality assurance measures to support components and activities being implemented and to improve program quality and accountability.

(b) Develop and implement QA mechanisms and measures to ensure that:

- Services are provided in a technically competent manner and are consistent with current CDC guidelines and recommendations.
- Services are culturally and linguistically appropriate and staff are trained accordingly.
- All staff have appropriate training for their respective roles.
- Positive test results are reported to the appropriate local or state surveillance and Partner Services programs, in accordance with applicable laws and regulations.
- Appropriate laboratory QA procedures for HIV testing are in place.

- QA policies and procedures are available and accessible to all staff working in this program and CDC.

Category C: Demonstration Projects *(Optional and Competitive)*

Applicants can enhance their programs by requesting funding to implement *Category C: Demonstration Projects to Implement and Evaluate Innovative, High Impact HIV Prevention Interventions and Strategies*. Proposed projects must address the NHAS goals of reducing new HIV infections, increasing access to care and reducing HIV-related disparities and health inequities.

This funding will support implementation and evaluation of innovative, high impact HIV prevention activities that address any of the following focus areas: (1) structural, behavioral, and/or biomedical interventions, or a combination thereof, that will have a high impact in reducing HIV incidence; (2) innovative testing activities that increase identification of undiagnosed HIV infections and/or improve the cost effectiveness of HIV testing activities; (3) enhanced linkage to and retention in care for persons with new and prior diagnosis of HIV infection; (4) advanced use of technology (e.g., Internet Partner Services, Electronic Medical Record); or (5) programmatic and epidemiologic use of CD4, viral load and other surveillance data to assess and reduce HIV transmission risk.

Applications for demonstration project funding may be submitted annually for the first, third, and fourth year of the project period of this announcement. ***Applicants may submit up to two proposals. Single-focus area proposals must be for different focus areas; however, if multiple focus areas are included within a single proposal, overlap is permitted.***

1. Required Activities

Demonstration projects conducted under CDC-RFA-PS12-1201, Category C and implemented during the project period should include the following:

a. Implementation and evaluation of existing or promising HIV prevention practices that support achievement of the NHAS goals. Activities should focus on structural, behavioral, and/or biomedical interventions (or a combination thereof); innovative testing; enhanced linkage and retention in care; advanced use of technology; or programmatic and epidemiologic use of CD4, viral load and other surveillance data. The applicant must:
   (1) Provide a rationale (e.g., epidemiologic and surveillance data, identified need or opportunity, or other data) for selecting the specific project(s) and demonstrate how the project(s) can have a cost-effective impact on the local epidemic.
   (2) Describe how components of the project(s) will be focused and coordinated to meet stated goals and objectives of the project.
   (3) Develop a logic model that graphically describes the relationship between the project and expected outcomes.
   (4) Develop and submit to CDC a detailed project plan to include monitoring and evaluation, and quality assurance. *Applicants may include a 3-6 month start-up period. A draft of the project plan is due with the application and the final project plan for Category C should be included in the single Comprehensive Program Plan that is due to CDC six months after initial funding.*
      (a) Describe how collaboration with internal and external partners to accomplish project plan goals, objectives, activities, and program evaluation will be achieved.
      (b) Include process and outcome evaluation to measure effectiveness and potential impact of the project.
      (c) Include timeline for project implementation and evaluation activities.
      (d) Include plans for conducting cost analysis of the proposed project.
   (5) Collaborate with CDC or other technical assistance providers to provide ongoing training, technical assistance, and consultation to all staff conducting the demonstration project.

(6) Collaborate with CDC on the development and analysis of quantitative and qualitative data collected in the demonstration project and use information from this analysis, as well as from ongoing use of program monitoring data, to assess and improve performance in delivering the intervention or strategy.

(7) Develop and submit to CDC a detailed final report to include process, outcome, impact, and cost data and qualitative and quantitative findings, including successes, challenges and lessons learned from the demonstration project.

2. Required Program Planning, Monitoring and Evaluation, and Quality Assurance Activities

a. Utilize the most current epidemiologic and surveillance data and other available data sources to assist in planning and evaluation of the demonstration project.

b. Develop and submit to CDC a project plan, which includes monitoring and evaluation, and quality assurance. *A draft plan is due with the application. The applicant must provide a single final comprehensive program plan for Categories A, B (if applicable), and C (if applicable) that is due to CDC six months after the start of the project period. Guidance on program monitoring and evaluation and performance measures will be provided by CDC on an ongoing basis throughout the project period.* The plan should include:

(1) Description of the project

(a) Annual project goals and SMART annual objectives for each activity.

(b) Activities that will be conducted to meet the objectives.

(c) Capacity building needs.

(d) Timeline for implementation of the activities.

(2) M&E Description

(a) Questions about program performance to be answered through project monitoring and evaluation.

(b) Qualitative and quantitative measures that will be used and data that will be needed to answer the M&E questions.

(c) Ensure that data collection, entry, management, submission, analysis, utilization, dissemination, and security and confidentiality procedures are consistent with CDC guidelines. Collect and report data on outcome and impact measures for project activities.

(d) Comply with all federal (i.e., HHS, and/or CDC) information systems and information processing security policies and regulations in performance of the security requirements and deliverables and be bound by the Assurance of Confidentiality.

(3) QA Description

(a) Quality assurance measures to support activities being implemented that include, but are not limited to ensuring that:

- Services are provided in a technically competent manner and are consistent with current CDC guidelines and recommendations.
- Services are culturally and linguistically appropriate and staff are trained accordingly.
- All staff have appropriate training for their respective roles.

CDC encourages applicants to partner with universities, educational institutions, health agencies, or other health or subject matter experts for the planning, implementation, and evaluation of the demonstration projects.

Other Required Activities

In addition to the components and activities outlined under Categories A, B, and C, applicants must adhere to additional requirements.

1. Ensure that appropriate health department and community representatives attend **required** CDC-sponsored meetings.
2. Adhere to CDC policies for securing prior approval for CDC-sponsored conferences and meetings.
3. Submit any newly developed public information resources and materials to the CDC National Prevention Information Network (NPIN) to be added to the database and accessed by other organizations and agencies.

4. If using materials that include the name or logo of either CDC or the Department of Health and Human Services, submit a copy of the proposed material to CDC for approval.
5. Comply with the requirements set forth in the HIV Content Review Guidelines.
6. In addition to funding under this announcement, demonstrate effort to sustain HIV prevention efforts throughout the jurisdiction.
7. Facilitate efforts to coordinate and collaborate among existing categorical program.
8. Develop and maintain strategic partnerships within and external to the health department for shared planning, implementation, and sustainability of program efforts.
9. Ensure ongoing communication and information sharing between the state and local health departments and other providers.
10. Collect and submit additional information as required for interim and annual progress reports.
11. Collect and submit additional data requirements according to the most recent National HIV Monitoring and Evaluation Guidance.

CDC Activities

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

1. Provide consultation and technical assistance to grantees on all aspects of the implementation of the funding program as well as all protocols, procedures, and instruments related to the plan, both directly and through CDC's network of grantees and partners.
2. Work with grantees to address training and CBA/TA needs that are crucial to the successful execution of the plan, and that are not addressed by other funding sources.
3. Facilitate coordination, collaboration, and, where feasible, service integration among other CDC programs, health departments and their programmatic divisions, local planning groups, directly-funded CBOs, national capacity building assistance providers, care providers, and other critical partners working with at risk populations

and towards common goals of risk reduction, disease detection, and a continuum of HIV prevention, care, and treatment.

4. Monitor grantee progress in implementing the program and work with grantees through consultation via site visits, email, telephone, and review of progress reports to support implementation of the program plan.
5. Monitor grantee progress in conducting monitoring and evaluation activities. Work with grantees through consultation via site visits, email, telephone, and review of progress reports and other data reports to support progress, program improvement, and reductions in HIV transmission.
6. Provide requirements and expectations for standardized and other data reporting and support monitoring and evaluation activities with technical assistance, web-based training on M&E, M&E-related materials such as data collection tools, and on-line TA via the National HIV Monitoring and Evaluation Service Center.
7. Facilitate necessary CDC and other clearances.
8. Plan, convene, and facilitate grantee meetings during the project period.

II. AWARD INFORMATION

1. **Category A: HIV Prevention Programs for Health Departments**

   Type of Award: Cooperative Agreement.

   Award Mechanism: U62 - Surveillance Activities and Studies of Acquired Immunodeficiency Syndrome (AIDS) 32

   Fiscal Year Funds: 2012

   Approximate Current Fiscal Year Funding: $284,000,000

   Approximate Total Project Period Funding: $1,700,000,000

   This amount is an estimate, and is subject to availability of funds. It includes direct and indirect costs.

   Approximate Number of Awards: 69

Approximate Average Award: See "Category A Anticipated Award" amounts included in the FY 2012 funding tables in Attachment X. This amount is for the first 12-month budget period, and includes both direct and indirect costs. Awards
Floor of Individual Award Range: See "Category A Floor" amounts included in the FY 2012 funding table in Attachment X.
Ceiling of Individual Award Range: See "Category A Ceiling" amounts included in the FY 2012 funding table in Attachment X. This ceiling is for the first 12-month budget period. It includes direct and indirect costs.
Anticipated Award Date: January 1, 2012
Budget Period Length: 12 months
Project Period Length: 5 years

2. **Category B: Expanded HIV Testing for Disproportionately Affected Populations**

Type of Award: Cooperative Agreement.
Award Mechanism: U62 - Surveillance Activities and Studies of Acquired Immunodeficiency Syndrome (AIDS) 32
Fiscal Year Funds: 2012
Approximate Current Fiscal Year Funding: $54,830,000
Approximate Total Project Period Funding: $342,000,000
This amount is an estimate, and is subject to availability of funds. It includes direct and indirect costs.
Approximate Number of Awards: 36
Approximate Average Award: See "Category B Anticipated Award" amounts included in the FY 2012 funding table in Attachment X. This amount is for the first 12-month budget period, and includes both direct and indirect costs.
Floor of Individual Award Range: See "Category B Floor" amounts included in the FY 2012 funding table in Attachment X.
Ceiling of Individual Award Range: See "Category B Ceiling" amounts included in the FY 2012 funding table in Attachment X. This ceiling is for the first 12-month budget period. It includes direct and indirect costs.

Anticipated Award Date: January 1, 2012

Budget Period Length: 12 months

Project Period Length: 5 years

3. **Category C: Demonstration Projects**

Type of Award: Cooperative Agreement.

Award Mechanism: U62 - Surveillance Activities and Studies of Acquired Immunodeficiency Syndrome (AIDS) 32

Fiscal Year Funds: 2012

Approximate Current Fiscal Year Funding: $20,000,000

Approximate Total Project Period Funding: $150,000,000

This amount is an estimate, and is subject to availability of funds. It includes direct and indirect costs.

Approximate Number of Awards: 34 (first year). The number of new awards made in subsequent years will be based on the availability of funding.

Approximate Average Award:

In an effort to maximize the available funding, ensure a wide distribution in the size and scope of demonstration projects, encourage maximum participation from the 69 eligible entities (thus achieving wider geographic diversity in the distribution of projects,) awards for Category C will be distributed in the following manner:

Funding Range	Number of Awards
$1,000,000 - $2,000,000	**Approximately 4 awards**
$500,000 - $1,000,000	**Approximately 8 awards**
Up to $500,000	**Approximately 24 awards**

If not enough applications are submitted in any range to make the estimated number of awards, the estimated number of award for the other ranges may be increased. These amounts are for the first 12-month budget period, and includes both direct and indirect costs.

Floor of Individual Award Range: None.

Ceiling of Individual Award Range: $2,000,000 per proposal. This ceiling is for the first 12-month budget period. It includes direct and indirect costs.

Anticipated Award Date: First Cycle - January 1, 2012

Second Cycle - January 1, 2014

Third Cycle – January 1, 2015

Budget Period Length: 12 months

Project Period Length: Up to 4 years

Additional funds may become available during the five-year project period that can be used to support additional demonstration projects (Category C).

Applicants with the capacity to implement integrated screening activities (e.g., screening for STDs, viral Hepatitis, and/or TB) should continue implementing service integration activities and are eligible to utilize up to 5% of the requested total funding amount to enhance these efforts.

Applicants may request federal personnel, equipment, or supplies as Direct Assistance (DA) to support Category A and Category B activities, in lieu of a portion of financial assistance (FA).

The attached budget tables display the annual anticipated award amounts under Category A and Category B. The award amounts for Category A were allocated based on a formula that considered the unadjusted number of adults and adolescents living with a diagnosis of HIV through 2008 in each jurisdiction. The Category B award amounts were determined in a similar fashion but using the unadjusted number of Black/African American and Hispanic/Latino adults and adolescents living with a diagnosis of HIV infection as of year-end 2008. In both cases, the funding reflects each jurisdiction's proportionate share of the disease burden.

The anticipated amounts for Category A awards will change annually over the course of the **five** years of the project period. This gradual approach was intended to allow for a

scale up or scale down of activities in each jurisdiction. The funding levels for Category B awards are not expected to change substantially from year to year. Funding for Category C will be based on merit; not based on a formula.

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, 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.

III. ELIGIBILITY INFORMATION

Eligible Applicants

Category A: HIV Prevention Programs for Health Departments

Eligible applicants are limited to state, local and territorial health departments or their Bona Fide Agents. This includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, and Republic of Palau. Also eligible are the local (county or city) health departments serving the 10 specific Metropolitan Statistical Areas (MSAs) or specified Metropolitan Divisions (MDs) that have the highest unadjusted number of persons living with a diagnosis of HIV infection as of year-end 2008. These ten eligible areas comprise approximately 37% of the total persons living with HIV in the United States as of the end of 2008.

The eligible entities within the Metropolitan Divisions will be the city health departments. If no city health department exists, the county health department will be the eligible entity. The eligible entity within a Metropolitan Statistical Areas will be the city health department in the county with the greatest number of persons living with HIV. If no city health department exists, the county health department will be the eligible entity.

Eligible Applicant	Corresponding MSA/MD

New York City Department of Health and Mental Hygiene	New York Division-White Plains-Wayne
Los Angeles County Public Health Department	Los Angeles Division
Broward County Health Department	Fort Lauderdale Division
Chicago Department of Public Health	Chicago Division
Fulton County Department of Health and Wellness	Atlanta-Sandy Springs-Marietta, GA
Miami-Dade County Health Department	Miami Division
City of Philadelphia Public Health Department	Philadelphia Division
Houston Department of Health and Human Services	Houston-Baytown-Sugar Land, TX
San Francisco Department of Public Health	San Francisco Division
Baltimore City Health Department	Baltimore-Towson, MD

Jurisdictions with eligible state and local (city or county) health departments must discuss how the state and local area will work collaboratively during the project period to ensure appropriate provision of services within the MSA or MD and document any agreements reached in a letter or agreement (LOA), which must be submitted by both parties as part of their application. City or county health departments will be responsible for providing services to the entire MSA or specified MD. **However, in the event the city or county health department declines to provide services for the entire MSA or MD or decides by mutual agreement to share the responsibility of providing services with the state, the state may assume responsibility for any geographic or program areas left uncovered and apply for a portion of the city or county's funding allocation commensurate with the additional responsibilities and resource needs.** City and county health departments may opt not to apply; if this occurs, their funding allocation will then be available to the state to provide services for that MSA. At a minimum, the LOA must include the following:

- Name and address of entity providing HIV prevention services
- Funding source (i.e., CDC-RFA-PS12-1201)

- Scope of services to be provided (i.e., a statement of the funding requested by each eligible entity, the assignment of responsibility for geographic areas, and general services to be provided)
- Date agreement is in effect
- Signature of authorized representatives and dated.

See the Letter of Agreement template provided in Attachment XI.

Eligible areas may use a Bona Fide Agent to apply on their behalf. A Bona Fide Agent is an agency/organization identified by the state, city, island, or county as eligible to submit an application under their eligibility in lieu of their application. If applying as a Bona Fide Agent of an eligible state, local, or territorial government, a Memorandum of Agreement (MOA) with the eligible state or local government as documentation of the status is required and must be submitted with the application. At a minimum, the MOA must include the following:

- Roles and responsibilities of the state or local government agency.
- Roles and responsibilities of the Bona Fide Agent.
- Key personnel contacts for the state or local government agency.
- Key personnel contacts for the Bona Fide Agent.

Attach the MOA with "Other Attachment Forms" when submitting via www.grants.gov.

Category B: Expanded HIV Testing for Disproportionately Affected Populations

Eligibility for Category B is limited to health department jurisdictions with at least 3,000 Black/African American and Hispanic/Latino adults and adolescents (unadjusted number) living with a diagnosis of HIV infection as of year-end 2008. Eligible jurisdictions, based on this criterion, are listed below:

Alabama	Massachusetts
Atlanta-Sandy Springs-Marietta, GA	Miami Division
Arizona	Michigan
Baltimore-Towson, MD	Mississippi
California	Missouri

Chicago Division	New Jersey
Colorado	New York State
Connecticut	New York-White Plains-Wayne Division
District of Columbia	North Carolina
Florida	Ohio
Fort Lauderdale Division	Pennsylvania
Georgia	Philadelphia Division
Houston-Baytown-Sugar Land, TX	Puerto Rico
Illinois	San Francisco Division
Indiana	South Carolina
Los Angeles Division	Tennessee
Louisiana	Texas
Maryland	Virginia

Similar to Category A, if a city and county health departments opts not to apply, they may rely on the state to provide services for that MSA. They may also opt to make an alternative agreement to share responsibility for serving the entire MSA or MD and allocate resources accordingly. In states that have directly-funded cities, both eligible entities must submit a LOA detailing the understanding that has been reached regarding the delivery of service within the directly funded city. At a minimum, the LOA must include the following:

- Name and address of entity providing HIV prevention services
- Funding source (i.e., CDC-RFA-PS12-1201)
- Scope of services to be provided (i.e., a statement of the funding requested by each eligible entity, the assignment of responsibility for geographic areas, general services to be provided)
- Date agreement is in effect
- Signature of authorized representatives and dated.

See the Letter of Agreement template provided in Attachment XI.

Category C: Demonstration Projects

Eligibility criteria for Category C are the same as for Category A. **Additionally, applicants may submit up to two proposals for Category C. Single-focus area proposals must be for different focus areas; however, if multiple focus areas are included within a single proposal, overlap is permitted.**

Because of the necessary infrastructure in place and legal authority to perform the required components and activities, eligibility is limited to health departments or their Bona Fide Agents for Categories A, B and C.

Required Registrations

Registering your organization through www.Grants.gov, the official agency-wide E-grant website, is the first step in submitting an application online. Registration information is located in the "Get Registered" section of www.Grants.gov. Please visit www.Grants.gov at least 30 days prior to submitting an application to become familiar with the registration and submission processes. The "one-time" registration process will take three to five days to complete. However, the Grants.gov registration process also requires that applicants register their organization with the Central Contractor Registry (CCR). The CCR registration can require an additional one to two days to complete. Applicants are required to maintain a current registration in CCR.

Central Contractor Registration and Universal Identifier Requirements

All applicant organizations **must obtain** a DUN and Bradstreet (D&B) Data Universal Numbering System (DUNS) number as the Universal Identifier when applying for federal grants or cooperative agreements. The DUNS number is a nine-digit number assigned by Dun and Bradstreet Information Services. An AOR should be consulted to determine the appropriate number. If the organization does not have a DUNS number, an AOR should complete the **D&B D-U-N-S Number Request Form** or contact Dun and Bradstreet by telephone directly at 1-866-705-5711 (toll-free) to obtain one. A DUNS number will be provided immediately by telephone at no charge. Note: This is an organizational number.

Individual Program Directors/Principal Investigators do not need to register for a DUNS number.

Additionally, all applicant organizations must register in the Central Contractor Registry and maintain the registration with current information at all times during which they have an application under consideration for funding by CDC and, if an award is made, until a final financial report is submitted or the final payment is received, whichever is later. CCR is the primary registrant database for the federal government and is the repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the CCR internet site at https://www.bpn.gov/ccr/default.aspx.

If an award is granted, the grantee organization must notify potential sub-recipients that no organization may receive a sub-award under the grant unless the organization has provided its DUNS number to the grantee organization.

Cost Sharing or Matching

Cost sharing or matching funds are not required for this program.

Other

Category A & B: Applications with requested funding amounts above the ceiling or below the floor will be considered responsive and entered into the review process.

Category C only: If a funding amount greater than the ceiling of the award range is requested, the application will be considered non-responsive and will not be entered into the review process. The applicant will be notified that the application did not meet the eligibility requirements.

The successful applicant will be responsible for planning, implementing, and coordinating infrastructure development requirements supporting the primary public health purpose of this FOA.

Special Requirements:

If the application is incomplete or non-responsive to the special requirements listed in this section, it will not be entered into the review process. The applicant will be notified the application did not meet submission requirements.

- Late applications will be considered non-responsive. See Section IV.3." Submission Dates and Times" for more information on deadlines.
- If the applicant organization is a Bona Fide agent of the health department, the organization must be located in the eligible jurisdiction and provide a letter from the state or local government as documentation of their Bona Fide agent status. Place this documentation behind the first page of the application form.
- Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive federal funds constituting a grant, loan, or an award.

Note: *All information submitted with the application is subject to verification during a post-award site visits and/or recipient capability assessments (RCA).*

Maintenance of Effort

Maintenance of Effort is not required for this program.

IV. APPLICATION AND SUBMISSION INFORMATION

Obtain an Application Package

Applicants must download the application package associated with this funding opportunity from www.grants.gov. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms on-line, contact the HHS/CDC

Procurement and Grant Office, Technical Information Management Section (PGO TIMS) staff at 770-488-2700 for further instructions. CDC Telecommunications for the hearing impaired or disabled is available at: TTY 1-888-232-6348.

If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov customer service. The Grants.gov Contact Center is available 24 hours a day, 7 days a week, with the exception of all federal holidays. The Contact Center provides customer service to the applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service is received any time it is needed. Grants.gov Support Center can be reached at 1-800-518-4726 or by email at support@grants.gov. Submissions sent by e-mail, fax, CDs or thumb drives will not be accepted.

Content and Form of Application Submission

Applicants should submit **one**, **single** application package, to include separate sections for each Category to which the applicant is applying. Unless specifically indicated, this announcement requires submission of the following information. Refer to Attachment XIII: Application Checklist (pgs. 137-138) for items to be included with the application.

- A table of contents must be included with the application. The table of contents will not count toward the page limit of the project narrative for HIV prevention programs. It must include page numbers where each section starts and a list of all application sections and appendices within the application package. A cover letter is required with the application. The cover letter must contain the following information:
  - The applicant's name, address, and the name of the principle investigator/program director.
  - A statement about the categories under which the applicant is applying (i.e., Category A, B, and/or C).
  - A statement indicating the service area for program implementation.
  - A statement of the total amount of funding requested.

- The application cover letter must be written in the following format:
  - Maximum number of pages: 2
  - Font: 12-point unreduced, Times New Roman.
  - Single-spaced
  - Paper size: 8.5 by 11 inches
  - Page margin size: 1 inch
  - Print only on one side of the page

CDC Assurances and Certifications can be found on the CDC website at the following Internet address: http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm

Letter of Intent

Only prospective applicants for Category C: Demonstration Project are required to submit a letter of intent (LOI) that includes the following information:

- Number and title of this funding opportunity
- Descriptive title of proposed project
- Focus area(s) that the project will address
- Name, address and telephone number of the Principal Investigator/Project Director
- Participating institutions
- Maximum number of pages: 1
- Font size: 12-point unreduced, Times New Roman
- Single spaced
- Paper size: 8.5 by 11 inches
- Page margin size: one inch
- Printed only on one side of page
- Written in plain language, avoiding jargon

LOIs must be received no later than the date indicated in Section I "Authorization and Intent."

Submit the LOI by **email** to HDFOA@cdc.gov.

Attention:
Erica Dunbar – CDC-RFA- PS12-1201
Department of Health and Human Services
CDC Division of HIV/AIDS Prevention
Prevention Program Branch

Application

If the applicant is requesting more than one category of funding, the application must include complete, stand-alone sections (e.g., project abstract, narrative, budget and budget justification) for each requested funding category (A, B, and C) so that each request for a funding category can be identified and provided to the respective review panel. Each section and appendix of the application submitted to Grants.gov should clearly identify the category of funding for which it is submitted. Applicants may label each file with the state abbreviation and the category of funding (e.g., AL for Alabama, HPPHD for HIV Prevention Programs for Health Departments, ETP for Expanded HIV Testing Program, and DP for Demonstration Project). Each detailed budget and narrative justification should support the activities for the first year of funding in response to this FOA and a summary narrative for the entire project period.

A **project abstract** must be completed in the Grants.gov application forms. The Project Abstract must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This abstract must not include any proprietary/confidential information. It must be submitted in the following format:

- Maximum of 2 pages (if attaching PDF document to the provided form)
- Font size: 12-point unreduced, Times New Roman
- Single spaced

- Paper size: 8.5 by 11 inches
- Page margin size: one inch

A **project narrative** must be submitted with the application forms. The project narrative must be uploaded in a PDF file format when submitting via Grants.gov. The narrative must be submitted in the following format:

- Maximum number of pages: 50 pages for HIV Prevention Programs for Health Departments, 30 pages for Expanded HIV Testing Program, and 10 pages for the Demonstration Project. If your narrative exceeds the page limit for Category B and C, only the pages within the page limit will be reviewed
- Font size: 12 point unreduced, Times New Roman
- Double spaced
- Paper size: 8.5 by 11 inches (preferred), or generally accepted paper size
- Page margin size: One inch
- Number all pages of the application (excluding the forms provided in the application package) sequentially from page one (Application Face Page) to the end of the application, including charts, figures, tables, and appendices
- Printed only on one side of the page

The narrative should address activities to be conducted over the entire project period and provide more specific information for the activities during the first year of funding. It must include the following items in the order listed:

Category A: HIV Prevention Programs for Health Department
(Narrative portion should not exceed 50 pages)

A. Background and Need

1. Provide a brief description of the overall HIV epidemic within the jurisdiction.
2. Specify the MSA or Metropolitan Divisions within the jurisdiction that have at least 30% of persons living with HIV.

3. Specify the highest risk populations in the target area. Summarize the epidemiologic data that quantifies these populations as representing the highest proportion of cases in the jurisdiction. Briefly describe the behaviors, social determinants, and contexts that put each of these populations at risk.
4. Summarize the current HIV prevention situation including gaps in scope, reach, coordination, and services.
5. Describe experience, expertise, and existing capacity to provide services that address the HIV epidemic within the jurisdiction.

B. Program Description

1. Briefly describe how the applicant proposes to address the following **HIV testing** elements:
    a. Implement and/or coordinate opt-out HIV testing of patients ages 13-64 in healthcare settings.
    b. Implement and/or coordinate HIV testing in non-healthcare settings to identify undiagnosed HIV infection.
    c. Support HIV testing activities in venues which reach persons with undiagnosed HIV infections.
    d. Ensure the provision of test results, particularly to clients testing positive.
    e. Promote routine, early HIV testing for all pregnant women, according to current CDC recommendations.
    f. Encourage and support health department and non-health department providers to increase the number of persons diagnosed with HIV through strengthening current HIV testing efforts or creating new services.
    g. Facilitate voluntary testing for other STDs (e.g., syphilis, gonorrhea, chlamydial infection), HBV, HCV, and TB, in conjunction with HIV testing, including referral and linkage to appropriate services, where feasible and appropriate and in accordance with current CDC guidelines and recommendations.

h. Ensure that testing laboratories provide tests of adequate quality, report findings promptly, and participate in a laboratory performance evaluation program for testing.
i. Incorporate new testing technologies, where feasible and appropriate.

Within the description addressing the **HIV testing** elements include the following:

j. Methods and data sources that will be used to identify healthcare and non-healthcare settings in areas with high HIV incidence and/or prevalence.
k. Proposed number of settings and types of settings (i.e. healthcare or non-healthcare setting) in which HIV testing activities will be supported.
l. How the applicant will decide which healthcare or non-healthcare facility it will recruit or target for this program.
m. If healthcare facilities that will be recruited for this program have already been identified, include that information, along with the rationale for selecting them and information about their experience with HIV testing:
    (1) If agreements to participate in the program have already been established with any healthcare or non-healthcare facilities, provide copies of MOUs or MOAs.
n. How the applicant proposes to ensure that the selected providers address each of the following:
    (1) Promoting HIV testing to target populations including pregnant women.
    (2) Guaranteeing that testing laboratories provide tests of adequate quality, report findings promptly, and participate in a laboratory performance evaluation program for testing.
    (3) Using test technologies and strategies that will maximize the proportion of persons tested who receive their results.
    (4) Delivering all services in a culturally and linguistically appropriate manner.
    (5) Delivering all services in a manner consistent with applicable CDC guidelines and recommendations.

o. Type(s) of consent procedure(s) that will be used (e.g., opt-out, opt-in) and the rationale for this approach. Include a description of any state or local laws or regulations regarding consent for HIV screening and testing.
p. Expected outcomes for each proposed HIV testing service.
q. How test results will be provided to patients/clients, especially those who test positive for HIV.
    (1) If rapid HIV tests will be used, describe how individuals with reactive rapid tests (i.e., preliminary positive results) will receive confirmatory tests. Include state or local requirements for providing confirmatory testing.
r. How the following services will be provided to persons who test positive for HIV (including persons newly diagnosed with HIV and, when appropriate, persons previously diagnosed):
    (1) Prevention counseling.
    (2) Linkage to medical care as soon as possible after diagnosis. If implementing this program in correctional facility clinics, describe how inmates who test positive for HIV will be linked to medical care at the time of release.
    (3) Initiation of Partner Services as soon as possible after diagnosis.

2. Briefly describe how the applicant proposes to address the following **Comprehensive Prevention with Positives** elements:

a. Provide linkage to HIV care, treatment, and prevention services for those persons testing HIV positive or currently living with HIV/AIDS.
b. Promote retention or re-engagement in care for HIV-positive persons.
c. Offer referral and linkage to other medical and social services such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and other services as needed for HIV-positive persons.
d. Provide ongoing Partner Services for HIV-positive persons and their partners.

(1) Collaborate and coordinate with STD programs, and HIV and/or STD surveillance programs to utilize data to maximize the number of persons identified as candidates for Partner Services.

(2) Partner with non-health department providers, including CBOs and private medical treatment providers, to identify more opportunities to provide Partner Services.

e. Assure that HIV-positive pregnant women receive the necessary interventions for the prevention of perinatal transmission.

f. Conduct sentinel event case review and community action to address local systems issues that lead to missed perinatal HIV prevention opportunities by utilizing the FIMR-HIV Prevention Methodology, where appropriate and based on local need and the availability of resources.

g. Support behavioral and clinical risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV.

h. Support implementation of behavioral, structural, and/or biomedical interventions (including interventions focused on treatment adherence) for HIV infected persons.

i. Support and/or coordinate integrated hepatitis, TB, and STD screening, and Partner Services, for HIV-infected persons, according to existing guidelines.

j. Support reporting of CD4 and viral load results to health departments and use of these data for estimating linkage and retention in care, community viral load, quality of care, and providing feedback of results to providers and patients, as deemed appropriate.

k. Promote and support the provision of ART in accordance with current treatment guidelines.

Within the description addressing the **Comprehensive Prevention with Positives** element include the following:

l. Strategy for developing and coordinating a linkage network/system to ensure that clients identified through the program have easy access to medical care, treatment, prevention services and other medical and social services.
m. Documentation of existing agreements (MOAs, MOUs) with providers and other agencies where clients may be linked to services.
n. Process for tracking linkage activities and outcomes.
o. Process for promoting retention or re-engagement in care for HIV-positive persons.
p. Collaboration strategies and role/responsibilities of collaborators for Partner Services.
q. Expected Partner Services outcomes.
r. Strategies for assuring that HIV-positive pregnant women receive the necessary interventions and treatment for the prevention of perinatal transmission and conducting sentinel event case review and community action to address local systems issues that lead to missed perinatal HIV prevention opportunities.
s. Identification of the interventions to be used within the jurisdiction.
t. Expected behavioral, biomedical, or structural intervention outcomes.
u. Process for tracking reductions in community viral load through CD4 and viral load testing, as deemed appropriate.
v. Promotion of antiretroviral therapy in accordance with current treatment guidelines.
w. Procedure for ensuring that the providers address each of the following:
    (1) Promoting and completing linkage to care, treatment and prevention services.
    (2) Providing behavioral risk screening and risk reduction interventions.
    (3) Implementing behavioral, biomedical or structural interventions (including interventions focused on treatment adherence).
    (4) Supporting and/or coordinating integrated hepatitis, TB, and STD testing, and Partner Services, according to existing guidelines.

(5) Delivering all services in a culturally and linguistically appropriate manner.

(6) Delivering all services in a manner consistent with applicable CDC and/or state/local guidelines and recommendations.

3. Briefly describe how the applicant proposes to address the following **Condom Distribution** elements:
    a. Prioritize and coordinate condom distribution to target HIV-positive persons and persons at highest risk of acquiring HIV infection.

Within the description addressing the **Condom Distribution** element include the following:

b. Methods and data sources that will be used to identify settings that serves high risk populations and healthcare or non-healthcare facilities that will be recruited for condom distribution.
c. Proposed number of settings and types of settings (i.e., healthcare or non-healthcare setting) in which condom distribution activities will be supported.
d. Any state or local laws or regulations regarding condom distribution.
e. Expected condom distribution outcomes.
f. How the proposed condom distribution strategy aligns with NHAS.

4. Briefly describe how the applicant proposes to address the following **Policy Initiatives** elements:
    a. Support efforts to align structures, policies, and regulations in the jurisdiction with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts, where applicable, subject to lobbying restrictions under federal law.

Within the description addressing the **Policy Initiatives** element include the following:

b. Existing structures, policies, and regulations that can be changed or enhanced to create an enabling environment for optimal HIV prevention, care, and treatment.
c. Proposed strategies and collaborators/partners that will address the proposed change or enhancement to existing structures, policies, and regulations. Include expected policy outcomes.

*For those applicants proposing to implement any **recommended HIV program component**, provide the following information requested only for the chosen elements.*

1. Briefly describe how the applicant proposes to address the following elements for **Evidence-based HIV Prevention Interventions** for HIV-negative persons at highest risk of acquiring HIV:
   a. Provide behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV, particularly those in an HIV-serodiscordant relationship.
   b. Implement community evidence-based interventions that reduce HIV risk.
   c. Support syringe services program, where allowable and in accordance with HHS and CDC guidelines.

Within the description addressing the **Evidence-based HIV Prevention Interventions** for HIV-negative persons at highest risk of acquiring HIV element include the following:

d. Strategy for recruiting and providing behavioral risk screening followed by individual and group-level evidence-based interventions to high risk negative and serodiscordant couples. Identify and provide the rationale for selected interventions and describe target populations to be addressed by these interventions.
e. List of and rationale for selected community evidence-based interventions that reduce HIV risk. Describe target populations and areas to be served by these interventions.

f. Detail the strategies and activities to support syringe services program, where allowable and according to HHS and CDC guidelines.
g. Documentation of existing agreements (MOAs, MOUs) with providers and other agencies where the target populations will be served.
h. Procedure for identifying populations and communities at greatest risk for acquiring HIV to conduct outreach and condom distribution.
i. Description of expected interventions outcomes.
j. Strategy for ensuring that the providers address each of the following:
   (1) Delivering all services in a culturally and linguistically appropriate manner.
   (2) Delivering all services in a manner consistent with applicable CDC and/or state/local guidelines and recommendations.

2. Briefly describe how the applicant proposes to address the following **Social Marketing, Media, and Mobilization** elements:
   a. Support and promote social marketing campaigns targeted to relevant audiences (e.g., providers, high-risk populations or communities), including the use of campaign materials developed and tested by CDC.
   b. Support and promote educational and informational programs for the general population based on local needs and linked to other funded HIV prevention activities (e.g., pamphlets, hotlines, or social marketing campaigns).
   c. Support and promote media technology (e.g., Internet, texting, and web applications) for HIV prevention messaging to targeted populations and communities.
   d. Encourage community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among family, friends, and neighbors.

Within the description addressing the **Social Marketing, Media, and Mobilization** element include the following:

e. Detail and explain rationale for selecting health issue(s) addressed in marketing campaign, message(s) to be promoted, proposed target populations and the media and/or methodology to be used.
f. Detail and explain rationale for community mobilization strategies, message(s) to be promoted, proposed target populations, and the methodology to be used.
g. Describe how the social marketing campaign, media messages, and/or community mobilization strategies will be evaluated.

3. Briefly describe how the applicant proposes to address the **Pre-Exposure Prophylaxis and Non-Occupational Post-Exposure Prophylaxis services** elements:
   a. Support Pre-Exposure Prophylaxis services for MSM populations at high risk for HIV.
   b. Offer Non-Occupational Post-Exposure Prophylaxis to populations at greatest risk.

Within the description addressing the **Pre-Exposure Prophylaxis and Non-Occupational Post-Exposure Prophylaxis Services** element include the following:

c. A description of how PrEP and/or nPEP services will be made available within the jurisdiction.
d. A description of services (e.g., educational materials, training) to be provided.
e. How applicant will ensure that populations at greatest risk will be served.
f. Communication activities related to PrEP (e.g., webcast).
g. Evaluation of PrEP and nPEP-related activities.

*The following elements apply to all applicants as outlined in the **required activities**.*

Provide the following required information regarding **Jurisdictional HIV Planning**:

1. Describe plans to develop a **jurisdictional HIV prevention plan** to include:

   a. Proposal for developing a jurisdictional HIV prevention plan that aligns with NHAS. For directly funded cities, the city jurisdictional plan should complement the state jurisdictional plan. The jurisdictional HIV prevention plan should include:

      (1) A description of existing resources, HIV prevention services and care and treatment, to include key features on how the prevention services, interventions, and/or strategies are currently being used or delivered in the jurisdiction,

      (2) Need (i.e., resources, infrastructure, and service delivery),

      (3) Gaps to be addressed and rationale for selection,

      (4) Prevention activities and strategies to be implemented within the jurisdiction,

      (5) Scalability of activities *(see Attachment I for definition of scalable),*

      (6) Responsible agency/group to carry out the activity (i.e., Prevention Unit, Ryan White-funded agencies, HOPWA), and

      (7) Relevant timelines

   If a plan is already developed, applicants may use and/or update the existing plan. The jurisdictional plan must be submitted to CDC within six months after the start of the project period.

   b. Proposed plans to facilitate a collaborative HIV prevention planning process that contributes to the reduction of HIV infection in the jurisdiction.

      (1) Group composition of HIV prevention planning group (e.g., representatives of populations at greatest risk for HIV infection, PLWHA, key stakeholders/partners, care/Ryan White planning groups, community-based organizations, care providers for the public and private sector, community health centers, mental health and substance abuse services, local communities, and other appropriate governmental and non-governmental entities).

(2) Proposed strategies that will increase coordination of HIV programs across the state, jurisdiction, tribal and local government (in alignment with NHAS).

c. Plans to ensure that the HIV Prevention Planning Group participates in the development of the **Engagement Process**.

Note: A letter of concurrence, concurrence with reservations, or non-concurrence from the jurisdiction's HIV Prevention Planning Group should be submitted within six months after funding with the jurisdictional HIV prevention plan and annually for the following years. During the funding period, jurisdictions will implement their Comprehensive Program Plan (as described under Program Planning, Monitoring and Evaluation, and Quality Assurance), which should be aligned with Category A, Category B and Category C activities identified in this FOA. Program plans are not needed for the application; however, these program plans will need to be developed and submitted to CDC within six months after the start of the project period.

Provide the following required information regarding **Capacity Building and Technical Assistance**:

2. Briefly describe how the applicant proposes to conduct **Capacity Building and Technical Assistance** activities to include:
   a. Plans to conduct or update the capacity building needs assessment of the health department, HIV prevention service providers, and other prevention agencies/partners, including CBOs.
   b. Plans to provide or collaborate with partners within or external to the health department to offer capacity building assistance to HIV prevention service providers and other prevention agencies and partners.
   c. How health department staff will be appropriately trained for their respective job responsibilities under this program.

d. How training and technical assistance needs for providers and staff (health department, participating healthcare facilities, CBOs, or other service organizations) will be identified and provided.
e. How training and technical assistance to health department staff and staff of participating healthcare facilities and CBOs or other service organizations will be tracked.
f. Plans to facilitate exchange of information and peer-to-peer consultation and technical assistance among service providers.

C. Program Planning, Monitoring and Evaluation, and Quality Assurance

1. Describe how the most current epidemiologic and surveillance data and other available data sources will be used to assist in program planning and evaluation. A current copy of the jurisdictional HIV/AIDS Epi Profile should be submitted to CDC with the application.
   a. Identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction and describe how applicant proposes to ensure that funding and prevention resources will be allocated to the local areas within the jurisdiction with the greatest burden of HIV disease. Funded jurisdictions will be required to report annually to CDC the amount of funding allocated to that area and how the funds were used.
   b. Proposed plans to coordinate with state and local surveillance programs to collect data needed for HIV incidence and surveillance efforts.
   c. Proposed plans to collaborate with local NHBS staff to assess exposure to, utilization of, and effect of HIV prevention programs.
2. Submit current copy of the jurisdictional HIV/AIDS Epidemiological Profile (referred to as Epi Profile) with the application.
3. For this application, provide a brief program description to include a draft of the proposed program goals and SMART objectives for each required core component and activity. Include program goals and annual objectives for the recommended components, if applicable.

4. Provide a brief description for data collection, entry, management, and submission; procedures in place for data security and confidentiality in accordance with the CDC HIV data security and confidentiality guidelines; and ability to collect and submit data for performance measures.

Within six months after the start of the project period, the comprehensive program plan must be submitted and should include the following:

1. Program Description
    a. Annual and five year program goals and SMART objectives for each required core component and activity. If applicable, include program goals and annual objectives for the recommended components. Some activities for your consideration are as follows:
        (1) Propose annual and five-year targets for HIV testing.
        (2) Propose annual and five-year targets for assuring that newly diagnosed HIV positive persons are linked to medical care within three months of diagnosis.
        (3) Propose annual and five-year targets for assuring that newly diagnosed HIV-positive persons are referred to and provided with Partner Services within three months of diagnosis.
    b. Activities that will be conducted to meet the objectives.
    c. Capacity building needs.
    d. A timeline for the five-year project period that shows the implementation of each of the selected interventions and strategies. Activities should be more descriptive for the first year of funding.
2. M&E Description
    a. Questions about program performance to be answered through program monitoring and evaluation.
    b. Qualitative and quantitative measures that will be used and data that will be needed to answer the M&E questions.
    c. Details of systems in place for:
        (1) Data collection and management, entry, submission, and data analysis.

(2) Data usage: how, by whom, and when data will be used to support program planning, resource allocation, and evaluation; measure progress toward meeting objectives; and improve program performance, quality, and accountability.

(3) Data dissemination and sharing with participating healthcare/non-healthcare facilities, CBOs, or other service organizations, and key stakeholders.

d. Local monitoring and evaluation activities to answer M&E questions. The applicant should include:

(1) Healthcare settings: The processes for monitoring the yield of newly diagnosed HIV infections in individual healthcare facilities. It must also include plans for addressing situations in which the yield is below 0.1%, including selecting alternative sites.

(2) Non-healthcare settings (CBOs or other service organizations): The processes for monitoring the rate of positive HIV tests and the yield of newly diagnosed HIV infections to assess the effectiveness of targeting. It must also include plans for working with CBOs, testing providers or other service organizations that are achieving low yield (e.g., a seropositivity rate of less than 1%), including improving targeting or selecting new sites.

(3) Service integration: If applicable, implement a process for monitoring and evaluating service integration activities.

e. Procedures in place for data security and confidentiality. These procedures must be in accordance with the CDC HIV data security and confidentiality guidelines. This includes signing a MOU that these requirements are being met. The MOU will be attached to CDC's Assurance of Confidentiality, which will be available at the time that awards are made. Develop and maintain rules of behavior.

3. QA Description

a. Outline of quality assurance measures to support components and activities being implemented and to improve program quality and accountability.

b. Description of QA mechanisms and measures to ensure that:

(1) Services are provided in a technically competent manner and are consistent with current CDC guidelines and recommendations.
(2) Services are culturally and linguistically appropriate and staff are trained accordingly.
(3) All staff have appropriate training for their respective roles.
(4) Positive test results are reported to the appropriate local or state surveillance and Partner Services programs, in accordance with applicable laws and regulations.
(5) Appropriate laboratory QA procedures for HIV testing are in place.
(6) QA policies and procedures are available and accessible to all staff working in this program and CDC.

D. Staffing and Management

1. Describe how all aspects of the program will be planned, managed, and overseen.
2. Submit a management plan that describes proposed staff, staff experience and background, and job descriptions for both proposed and current budgeted staff to support and carry out the activities of the program including evaluation. Submit curriculum vitae or resume (limited to two pages per person) for each professional staff member named in the proposal.
3. Describe how the applicant will manage, monitor, and maintain collaborations with other programs (e.g., surveillance, STD, laboratory).
4. Submit an organizational chart of the health department's HIV prevention program.

E. Budget and Budget Justification

The budget justification **will not be counted** in the 50 page limit. Approximately 75% of Category A funding resources must be allocated to the required core components and activities. To ensure that resources are reaching the areas of greatest need, funded jurisdictions will be required to report annually to CDC on the amount of funding allocated to the areas with 30% or greater of the HIV epidemic and how the funds were used. In accordance with Form CDC 0.1246 (E)

(www.cdc.gov/od/pgo/forms/01246.pdf), applicants are required to provide a line-item budget and narrative justification for all requested costs that are consistent with the purpose, objectives, and proposed program activities. The budget and budget justification should be placed in the application's attachments and named *Budget and Budget Justification.*

Within the budget, include the following:

1. A detailed line-item budget and justification (also known as a budget narrative).
2. A line-item breakdown and justification for all personnel that includes name, position title, actual annual salary, percentage of time and effort, and amount requested.
3. A line-item breakdown and justification for all consultants, including:
    a. Name of consultant
    b. Organizational affiliation (if applicable)
    c. Nature of services to be rendered
    d. Relevance of service to the project
    e. The number of days of consultation (basis for fee) or period of performance (dates)
    f. The expected rate of compensation (travel, per diem, other related expenses)-list a subtotal for each consultant in this category.
4. A line-item breakdown and justification for all contractor(s), including:
    a. Name of contractor
    b. Method of selection
    c. Period of performance
    d. Scope of work
    e. Method of accountability
    f. Itemized Budget and Justification.

If the above information is unknown for any contractor/consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget.

5. Justification for any requests for direct assistance.

6. Allocated funds must be included for two to three persons to attend at least two CDC-sponsored conferences or meetings each year. This includes events such as the grantee orientation meeting, the National HIV Prevention Conference, the HIV Prevention Leadership Summit (HPLS) etc.

Category B: Expanded HIV Testing for Disproportionately Affected Populations
(Narrative portion should not exceed 30 pages)

A. Background and Need

1. Healthcare Settings

a. Describe the applicant's experience with routine HIV testing programs in healthcare settings, including experience providing or supporting similar programs in the past or currently, and the length of time. If the applicant has previous or current experience with such programs, please address the following:
   (1) The types of healthcare facilities and settings where such programs have been provided or supported.
   (2) The yield of these programs in terms of number of tests done and number of persons with newly diagnosed HIV infection.
   (3) Experience with training and technical assistance needs associated with such programs.

b. Describe the target population(s) that the applicant plans to reach through the proposed program for routine HIV screening in healthcare settings (e.g., demographic and risk behavior characteristics, geographic location). Include an explanation of the rationale behind the selection of the target population(s).

c. Describe current collaboration(s) to plan, develop and implement integrated screening activities for STDs, TB or hepatitis (if applicable).

2. Non-Healthcare Settings *(If applicable)*

a. Describe the applicant's experience with HIV testing programs in non-healthcare settings, including experience providing or supporting similar

programs in the past or currently, and for what length of time. If the applicant has previous or current experience with such programs, please address the following:

(1) The types of venues and settings where such programs have been provided or supported.

(2) The yield of these programs in terms of number of tests done and number of persons newly diagnosed with HIV infection.

b. Describe the target population(s) the applicant plans to reach through the proposed program for HIV testing in non-healthcare settings (e.g., demographic and risk behavior characteristics, geographic location). Include an explanation of the rationale behind the selection of the target population(s).

c. Describe current collaboration(s) to plan, develop and implement integrated screening activities for STDs, TB or hepatitis (if applicable).

B. Program Description

1. Healthcare Settings

a. Describe the methods and the data sources that will be used to identify areas with high HIV incidence or prevalence and healthcare facilities that serve the target population(s) (i.e., candidate healthcare facilities) that will not be covered under Category A. The description should include the following information:

(1) The proposed number of healthcare facilities and types of healthcare settings (e.g., emergency departments, primary care clinics, STD clinics, correctional facility clinics) in which routine HIV screening activities will be supported.

(2) How the applicant will decide which candidate healthcare facilities to recruit for this program.

(a) If agreements to participate in the program have already been established with any healthcare facilities, provide copies of MOUs or MOAs.

b. Describe how routine HIV testing will be promoted to administrators, managers, and clinical service directors at candidate healthcare facilities and how they will be engaged to support, develop, implement, and maintain routine HIV testing programs in their facilities.
c. Describe how the applicant proposes to address each of the following:
   (1) Promoting the program to staff, educating providers and other appropriate staff about routine HIV testing, and gaining their support for the program.
   (2) Promoting and providing HIV testing to patients/clients.
   (3) Using test technologies and strategies that will maximize the proportion of persons tested who receive their results.
   (4) Delivering all services in a culturally and linguistically appropriate manner.
   (5) Delivering all services in a manner consistent with applicable CDC guidelines and recommendations.
d. Describe the type(s) of consent procedure(s) that will be used for testing in healthcare settings and the rationale for this approach. Include a description of any state or local laws or regulations regarding consent for HIV testing.
e. Describe how test results will be provided to patients/clients, especially those who test positive for HIV. If rapid HIV tests will be used, describe how individuals with a reactive rapid test (i.e., preliminary positive results) will receive a confirmatory test. Describe any state or local requirements for providing confirmatory testing.
f. Describe how the following services will be provided to persons who test positive for HIV (including persons newly diagnosed with HIV and, when appropriate, persons previously diagnosed): prevention counseling, linkage to medical care as soon as possible after diagnosis, and initiation of Partner Services as soon as possible after diagnosis. If implementing this program in correctional facility clinics, describe how inmates who test positive for HIV will be linked to medical care at the time of release.
g. Describe opportunities for improving timely linkage to care, particularly among priority populations and populations experiencing HIV-related health

disparities, and develop strategies for taking advantage of those opportunities that can be implemented throughout the duration of the program.

h. Describe how the applicant will maximize the likelihood that the programs developed will be sustainable. In the response, please include the following:
   (1) A plan on how to obtain reimbursement for HIV screening from third party payers (e.g., Medicare, Medicaid, private insurance, HMO programs). How funds received from reimbursement by third party payers will be used to sustain or expand this program.
   (2) How and under what circumstances the applicant plans to use funds from this FOA to cover the cost of HIV testing.

i. Describe how opportunities will be explored to integrate HIV testing into other screening programs conducted at participating facilities (e.g., screening programs for blood pressure, diabetes, and cholesterol).

j. Describe the methods and the data sources that will be used to assess the potential value and feasibility of integrating screening and testing for other STDs, HBV, HCV, and TB into the HIV testing programs funded under this FOA.

k. Describe what strategies will be explored to promote routine HIV testing at other healthcare facilities (i.e., facilities other than those with which the applicant will be directly collaborating on this program).

2. Non-Healthcare Settings *(If applicable)*

a. Describe process for identifying and funding CBOs or other service organizations that have experience providing HIV testing services in non-healthcare settings and experience working with the target populations. Describe how the applicant will work with the participating CBOs or other service organizations to conduct formative work to do the following:
   (1) Identify specific settings or venues in which high-risk members of the target population(s) can be accessed.
   (2) Work with gatekeepers to gain access to targeted settings and venues.

(3) Promote the program to members of the target population(s), key stakeholders, and other potential supporters.

(4) Recruit high-risk members of the target population(s) who do not know their HIV status.

(5) Obtain informed consent for testing, using appropriate consent procedures that adhere to all state and local requirements.

(6) Provide HIV tests to clients who give informed consent.

(7) Use test technologies (e.g., rapid tests) and strategies (e.g., use of incentives) that will maximize the proportion of persons tested that receive their results.

(8) Achieve at least a 2% rate of newly identified positive tests when the program is fully implemented (i.e., all contracts with participating CBOs or other service organizations have been executed, health department and subcontractor staff have been hired and trained, all necessary policies and procedures have been developed and implemented, all necessary supplies and materials have been procured, and necessary technical assistance has been provided).

(9) Take corrective actions if the rate of newly diagnosed positive tests is below 2%.

(10) Deliver all services in a manner consistent with current CDC guidelines and recommendations.

(11) Educate program staff about Partner Services and gain their support for these services.

(12) Deliver all services in a culturally and linguistically appropriate manner.

b. If the CBOs or other service organizations that the applicant will contract with for this program have already been identified, please include that information, along with the rationale for selecting them and information about their experience with providing HIV testing in non-healthcare settings, including rates of new HIV diagnoses, and experience working with the target population(s). If agreements to participate in this program have already been

established with any CBOs or other service organizations, provide copies of MOUs or MOAs.

c. Describe how the applicant will work with participating CBOs or other service organizations to develop and implement detailed plans for providing HIV testing services, based on the formative work previously conducted.
d. Describe how test results will be provided to clients, especially those who test positive for HIV. If rapid HIV tests will be used, describe the following:
   (1) How individuals with reactive rapid tests will receive confirmatory tests.
   (2) State or local requirements for providing confirmatory testing.
e. Describe how the following services will be provided to persons who test positive for HIV (including persons newly diagnosed with HIV and, when appropriate, persons previously diagnosed):
   (1) Prevention counseling and, if needed, referral to other prevention services.
   (2) Linkage to medical care as soon as possible after diagnosis.
   (3) Initiation of Partner Services as soon as possible after diagnosis.
   (4) Referral to other services (e.g. housing, legal services, partner violence services), as needed.
f. Describe how prevention counseling (and referral to other prevention services, if needed) will be provided to persons who test negative for HIV, but are at high risk for becoming infected.
g. Describe the methods and the data sources that will be used to assess the potential value and feasibility of integrating screening and testing for other STDs, HBV, HCV, and TB infection into the HIV testing in non-healthcare settings programs funded under this FOA.

3. Service Integration *(Optional)*

If the applicant plans to implement integrated screening activities (e.g., screening for STDs, hepatitis, and TB) under Category B of this funding opportunity announcement, describe how each of the following will be addressed:

a. Collaboration with key staff of the participating facilities to plan, develop and implement integrated screening activities for STDs, TB or hepatitis, in accordance with CDC guidelines and recommendations.
b. Collaboration with STD, hepatitis, and TB programs to design, develop, and implement activities, including referral and linkage to appropriate evaluation, treatment and vaccination (e.g., hepatitis A and B vaccination).
c. Reimbursement for integrated screening activities from third party payers (applicable to healthcare settings only).
d. Ensure that patients/clients receive their test results, especially those who test positive.
e. Ensure that patients/clients who test positive for other STDs are linked to medical care and receive timely and appropriate evaluation and treatment.
f. For patients/clients who test positive for other STDs, ensure that Partner Services are initiated as soon as possible after diagnosis, in accordance with CDC recommendations and state and local requirements.
g. Periodically review monitoring data with the participating facilities to assess the value of continuing screening for other STDs, viral hepatitis, and TB.

C. Capacity Building and Technical Assistance

1. Describe any anticipated capacity-building needs for implementing routine HIV testing in healthcare settings and HIV testing in non-healthcare settings.
2. Describe plans to provide or collaborate with partners within or external to the health department to offer capacity building assistance to HIV prevention service providers and other prevention agencies and partners.
3. Describe plans to ensure that all health department staff are appropriately trained for their respective job responsibilities under this program.
4. Describe plans to provide or coordinate training and technical assistance (e.g., interventions, organizational infrastructure, HIV testing efforts, policies for data reporting to surveillance) for staff of participating healthcare facilities and CBOs or other service organizations. Refer to

http://www.cdc.gov/hiv/topics/cba/index.htm for examples of topic areas in which training or technical assistance may be needed.

5. Describe plans to document and track the provision of training and technical assistance to health department staff, staff of participating healthcare facilities and CBOs or other service organizations.
6. Describe plans to facilitate exchange of information and peer-to-peer consultation and technical assistance among sites (e.g., convening jurisdiction-level workshops, development of collaborations, referral networks).

D. Program Planning, Monitoring and Evaluation, and Quality Assurance

Category B activities should be included in the single Comprehensive Program Plan outlined under Category A. The final version of this comprehensive program plan will need to be submitted to CDC within six months after the start of the project period. Guidance on program monitoring and evaluation and performance measures will be provided by CDC on an ongoing basis throughout the project period.

1. Describe how the most current epidemiological and surveillance data and other available data sources will be used to assist in program planning and evaluation.
2. For this application, provide a brief program description to include a draft of the proposed program goals and SMART objectives and activities for expanded HIV testing. Provide a brief description for data collection, entry, management, and submission; procedures in place for data security and confidentiality in accordance with the CDC HIV data security and confidentiality guidelines; and ability to collect and submit data for performance measures.

Within six months after the start of the project period, the comprehensive program plan must be submitted and should include the following:

1. Program Description
    a. Annual and five year program goals and SMART objectives for each testing component, to include program performance targets.
    b. Activities that will be conducted to meet the objectives.
    c. Capacity building needs.

d. Timeline for implementation of the activities.

2. M&E Description

   a. Questions about program performance to be answered through program monitoring and evaluation.

   b. Qualitative and quantitative measures that will be used and data that will be needed to answer the M&E questions. M&E questions will be developed in conjunction with CDC and will incorporate targets needed for national and local monitoring.

   c. Details of systems in place for:

      (1) Data collection and management, entry, submission, and data analysis.

      (2) Data usage: how, by whom, and when data will be used to support program planning, resource allocation, and evaluation; measure progress toward meeting objectives; and improve program performance, quality, and accountability.

      (3) Data dissemination and sharing with participating healthcare/non-healthcare facilities, CBOs, or other service organizations, and key stakeholders.

   d. Local monitoring and evaluation activities to answer M&E questions. The applicant should include:

      (1) Healthcare settings: The processes for monitoring the yield of newly diagnosed HIV infections in individual healthcare facilities. It must also include plans for addressing situations in which the yield is below 0.1%, including selecting alternative sites.

      (2) Non-healthcare settings (CBOs or other service organizations): The processes for monitoring the rate of positive HIV tests and the yield of newly diagnosed HIV infections to assess the effectiveness of targeting. It must also include plans for working with CBOs, testing providers or other service organizations that are achieving low yield (e.g., a seropositivity rate of less than 1%), including improving targeting or selecting new sites.

      (3) Service integration: If applicable, implement a process for monitoring and evaluating service integration activities.

e. Procedures in place for data security and confidentiality. These procedures must be in accordance with the CDC HIV data security and confidentiality guidelines. This includes signing a MOU that these requirements are being met. The MOU will be attached to CDC's Assurance of Confidentiality, which will be available at the time that awards are made. Develop and maintain rules of behavior.

f. If funds from this category will be used to support integrated screening for other tests (e.g., syphilis, gonorrhea, chlamydial infection, hepatitis B, hepatitis C, TB) in conjunction with HIV screening, the comprehensive plan must include monitoring and evaluating the planned service integration activities.

3. QA Description

   a. Outline of quality assurance measures to support components and activities being implemented (i.e., services are provided in a technically competent manner, services are culturally and linguistically appropriate, staff appropriately trained, test results reported to appropriate local or state surveillance and Partner Services programs and appropriate laboratory procedures are in place).

   b. QA policies and procedures are available and accessible to all staff working in this program and CDC.

   c. Plans of system in place for data collection, entry, management, and submission.

E. Staffing and Management

1. Describe how all aspects of the program will be planned, managed, and overseen.
2. Submit a management plan that describes proposed staff, staff experience and background, and job descriptions for both proposed and current budgeted staff to support and carry out the activities of the program including evaluation. Submit curriculum vitae or resume (limited to two pages per person) for each professional staff member named in the proposal.

3. Describe how the applicant will manage, monitor, and maintain collaborations with other programs (e.g., surveillance, STD, laboratory).

F. Budget and Budget Justification

The budget justification **will not be counted** in the 30 page limit. In accordance with Form CDC 0.1246 (E) applicants are required to provide a line item budget and narrative justification for all requested costs that are consistent with the purpose, objectives, and proposed program activities. Individual budget and budget justifications should be submitted for each expanded testing component and should be placed in the application's attachments and named *Budget and Budget Justification.* Within the budget, include the following:

1. A detailed, line-item budget and justification
2. A line-item breakdown and justification for all personnel that includes name, position, title, actual annual salary, percentage of time and effort, and amount requested).
3. A line-item breakdown and justification for all consultants, including:
    a. Name of consultant
    b. Organizational affiliation (if applicable)
    c. Nature of services to be rendered
    d. Relevance of service to the project
    e. The number of days of consultation (basis for fee) or period of performance (dates)
    f. The expected rate of compensation (travel, per diem, other related expenses) - list a subtotal for each consultant in this category.
4. A line-item breakdown and justification for all contractor(s), including:
    a. Name of contractor
    b. Method of selection
    c. Period of performance
    d. Scope of work
    e. Method of accountability
    f. Itemized Budget and Justification.

If the above information is unknown for any contractor/consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget.

5. Justification for any requests for direct assistance.
6. Allocated funds must be included for two to three persons to attend at least two CDC-sponsored conferences or meetings each year. This includes events such as the grantee orientation meeting, the National HIV Prevention Conference, the HIV Prevention Leadership Summit (HPLS) etc.

Category C: Demonstration Projects (Narrative portion should not exceed 10 pages)
A project narrative must be submitted with the application forms. Each applicant may submit only one project narrative for Category C and indicate the focus area addressed by the proposed demonstration project. The focus areas are: (1) structural, behavioral, and/or biomedical interventions, or a combination thereof, that will have a high impact on reducing HIV incidence; (2) innovative testing activities that increase identification of undiagnosed HIV infections and/or improve the cost effectiveness of HIV testing activities; (3) enhanced linkage to and retention in care for persons with new and prior diagnosis of HIV infection; (4) advanced use of technology (e.g. internet Partner Services) or; (5) programmatic and epidemiologic use of CD4, viral load and other surveillance data to assess and reduce HIV transmission risk.

The narrative must address how the health department will implement activities over the proposed project period with more detailed information for activities conducted during the first year of funding. It must include the following items in the order listed:

A. Background and Need:

1. Provide the rationale for proposing the project within the focus area(s) (e.g., identified need, epidemiologic data, or other data).
2. Describe the methods and the data sources that were used to identify areas and facilities to implement project.

3. Provide evidence that the health department has experience and capacity to implement the demonstration project.
4. Describe how the demonstration project addresses the NHAS goals of reducing new HIV infections, increasing access to care and reducing HIV-related disparities and/or health inequities and expected outcomes for the jurisdiction.

B. Program Description

1. Provide a detailed description of your proposed demonstration project and related activities, including:
    a. Scope of program
    b. Target population
    c. Strategies to be used
    d. Names, roles and responsibilities of collaborators and partners
    e. Reach and impact
    f. Training and technical assistance
    g. Dissemination of findings throughout the jurisdiction

C. Program Planning and Monitoring and Evaluation Plan

For purposes of this application, the following draft information should be provided:

1. Program Description
    a. Annual program goals and SMART objectives for each activity, to include program performance targets.
    b. Activities that will be conducted to meet the objectives.
    c. Capacity building needs.
    d. Timeline for implementation of interventions and strategies for selected focus area(s). Timeline should include planning, implementation and evaluation phases.
2. M&E Description
    a. A plan for evaluating progress and outcomes of the project and for identifying lessons learned.

b. The plan should identify evaluation questions for program plan objectives, describe when and how data will be collected and analyzed, indicate who is responsible, and describe how the results will be utilized and shared.
c. Include a logic model addressing program objectives and expected outcomes.
d. Details of systems in place for:
    (1) Data collection and management, entry, submission, and data analysis.
    (2) Data usage: how, by whom, and when data will be used to support program planning, resource allocation, and evaluation; measure progress toward meeting objectives; and improve program performance, quality, and accountability.
    (3) Data dissemination and sharing with participating healthcare/non-healthcare facilities, CBOs or other service organizations, and key stakeholders.
e. Local monitoring and evaluation activities to answer M&E questions.
f. A description of procedures in place for data security and confidentiality. These procedures must be in accordance with the CDC HIV data security and confidentiality guidelines.
g. Plans to collaborate with CDC or other technical assistance providers to provide ongoing training, technical assistance, and consultation to all staff conducting the demonstration project.

D. Staffing and Management

Submit a staffing and management description for the proposed demonstration project that includes:

1. Proposed staffing, staff experience and background, and job descriptions for both proposed and current budgeted staff to support and carry out the activities of the program including evaluation. Submit curriculum vitae for each staff member named in the proposal.
2. Describe how the applicant will manage, monitor, and maintain collaborations with other programs, service providers and/or stakeholders.

E. Budget and Budget Justification

The budget justification **will not be counted** in the 10 page limit. Applicants should submit one budget and budget narrative for Category C outlining the focus area(s) for each proposal. In accordance with Form CDC 0.1246 (E) , applicants are required to provide a line item budget and narrative justification for all requested costs that are consistent with the purpose, objectives, and proposed program activities. The budget and budget justification should be placed in the application's attachments and named *Budget and Budget Justification.* Within the budget, include the following:

1. A detailed, line-item budget and justification (also known as a budget narrative.
2. A line-item breakdown and justification for all personnel that includes name, position title, actual annual salary, percentage of time and effort, and amount requested.
3. A line-item breakdown and justification for all consultants, including:
    a. Name of consultant
    b. Organizational affiliation (if applicable)
    c. Nature of services to be rendered
    d. Relevance of service to the project
    e. The number of days of consultation (basis for fee) or period of performance (dates)
    f. The expected rate of compensation (travel, per diem, other related expenses) - list a subtotal for each consultant in this category.
4. A line-item breakdown and justification for all contractor(s), including:
    a. Name of contractor
    b. Method of selection
    c. Period of performance
    d. Scope of work
    e. Method of accountability
    f. Itemized budget and justification.

If the above information is unknown for any contractor/consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget if the applicant is selected for funding.

5. Allocated funds must be included for two to three persons to attend at least two CDC-sponsored conferences or meetings each year. This includes events such as the grantee orientation meeting, the National HIV Prevention Conference, the HIV Prevention Leadership Summit (HPLS), etc.

Additional information may be included in the application appendices. The appendices will not be counted toward the narrative page limit. This additional information includes:

- Curriculum Vitas, Resumes, Job Descriptions, Organizational Charts, Logic Models, Letters of Support, Letters of Agreement, etc. Additional information submitted via Grants.gov should be uploaded in a PDF file format and should be named:
- Appendix-Organizational Chart
- Appendix-Resumes
- Appendix-Letters of Support

Each section and appendix of the application submitted to Grants.gov should clearly identify the category of funding for which it is submitted. Applicants may label each file with the state abbreviation and the title of document (e.g., AL for Alabama, DP Logic Model for Demonstration Project Logic Model).

Additional information submitted via www.Grants.gov should be uploaded in a PDF file format. Please list the additional items in the Appendix (as indicated above) in the application's Table of Contents and include page numbers for each item.

No more than 50 electronic attachments and 100 additional pages should be uploaded for each application.

Additional requirements for additional documentation with the application are listed in the Section VII Award Administration Information; subsection entitled "Administrative and National Policy Requirements."

Submission Dates and Times

This announcement is the definitive guide on LOI and application content, submission, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline published herein, it will not be eligible for review and the applicant will be notified the application did not meet the submission requirements.

(Sign-up to receive notification of any changes at the "Send Me Change Notification Emails" link on the CDC-RFA-PS12-1201 synopsis page at www.grants.gov).

Application Deadlines:

Categories A, B, and C: **September 14, 2011**, 5:00pm, U.S. Eastern Standard Time

Category C, Cycle 2: June 1, 2013, 5:00pm, U.S. Eastern Standard Time

Category C, Cycle 3: June 1, 2014, 5:00pm, U.S. Eastern Standard Time

Letters of Intent (LOI) Deadline Date:

Submission of a LOI is **only** applicable to Category C: Demonstration Project funding.

Category C, Cycle 1: **July 21, 2011**, 5:00pm, U.S. Eastern Standard Time

Category C, Cycle 2: April 15, 2013, 5:00pm, U.S. Eastern Standard Time

Category C, Cycle 3: April 15, 2014, 5:00pm, U.S. Eastern Standard Time

Intergovernmental Review

Executive order 12372 does not apply to this program.

Funding Restrictions

Restrictions, which must be taken into account while writing the budget, are as follows:

- Grantees may not use funds for research.

- Grantees may not use funds for clinical care.
- Grantees may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- Awardees may not generally use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. Any such proposed spending must be identified in the budget.
- The direct and primary grantees in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- Reimbursement of pre-award costs is not allowed.
- Grantees may not use funds for the purchase of medications, treatment vaccinations, or other medicines.
- Projects that involve the collection of information from 10 or more individuals and are funded by a grant/cooperative agreement will be subject to review and approval by the Office of Management and Budget (OMB) under the Paperwork Reduction Act.

Other Submission Requirements

Application Submission

Submit the application electronically by using the forms and instructions posted for this funding opportunity on www.Grants.gov. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms on-line, contact the HHS/CDC Procurement and Grant Office Technical Information Management Section staff at (770) 488-2700 for further instruction.

Note: Application submission is not concluded until successful completion of the validation process. After submission of an application package, applicants will receive a "submission receipt" email generated by Grants.gov. Grants.gov will then generate a second email message to applicants which will either validate or reject their submitted

application package. This validation process may take as long as two (2) business days. Applicants are strongly encouraged to check the status of their application to ensure submission of their application package is complete and no submission errors exists. To guarantee that an applicant has complied with the application deadline published in the Funding Opportunity Announcement, applicants are strongly encouraged to allocate additional days prior to the published deadline to file their application. Non-validated applications will not be accepted after the published application deadline date.

In the event that an applicant does not receive a "validation" email within two (2) business days of application submission, please contact Grants.gov. Refer to the email message generated at the time of application submission for instructions on how to track the application or the Application User Guide, Version 3.0, page 57.

Electronic Submission

Applications must be submitted electronically at www.Grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully made available to CDC for processing from Grants.gov on the deadline date. The application package must be downloaded from www.Grants.gov. Applicants complete the application package off-line, upload attachments, then submit the application via Grants.gov. The applicant must submit all application attachments using a PDF file format when submitting via Grants.gov. Directions for creating PDF files can be found on the Grants.gov website. Use of file formats other than PDF may result in the file being unreadable by staff.

Applications submitted through Grants.gov (http://www.grants.gov), are electronically time/date stamped and assigned a tracking number. The AOR will receive an e-mail notice of receipt when Grants.gov receives the application. The tracking number serves to document submission and initiate the electronic validation process before the application is made available to CDC for processing.

If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov customer service. The Grants.gov Contact Center is available 24 hours a day, 7 days a week, with the exception of all federal holidays. The Contact Center provides customer service to the applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service is received any time it's needed. Grants.gov Support Center can be reached at 1-800-518-4726 or by email at support@grants.gov. Submissions sent by e-mail, fax, CD's or thumb drives of applications will not be accepted.

Organizations that encounter technical difficulties in using www.Grants.gov to submit their application must attempt to overcome those difficulties by contacting the Grants.gov Support Center (1-800-518-4726, support@grants.gov). After consulting with the Grants.gov Support Center, if the technical difficulties remain unresolved and electronic submission is not possible to meet the established deadline, organizations may submit a request prior to the application deadline by email to GMO/GMS for permission to submit a paper application. An organization's request for permission must: (a) include the Grants.gov case number assigned to the inquiry, (b) describe the difficulties that prevent electronic submission and the efforts taken with the Grants.gov Support Center, and (c) be submitted to the GMO/GMS at least 3 calendar days prior to the application deadline. Paper applications submitted without prior approval will not be considered.

If a paper application is authorized, the applicant will receive instructions from PGO TIMS to submit the original and two hard copies of the application by mail or express delivery service.

V. APPLICATION REVIEW INFORMATION

Eligible applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of CDC-RFA-PS12-1201, Comprehensive HIV Prevention Programs for Health Departments. Measures of

effectiveness must relate to the performance goals stated in the "Purpose" section of this announcement. Measures of effectiveness must be objective, quantitative and measure the intended outcome of the proposed program. The measures of effectiveness must be included in the application and will be an element of the evaluation of the submitted application.

Criteria

Eligible applications will be evaluated against the following criteria:

Category A: HIV Prevention Programs for Health Departments

A. Background and Need

This section will be reviewed for comprehensiveness and relevance of describing the background and need, as it relates to the jurisdictional HIV epidemic.

1. The extent to which the applicant provides a description of the overall HIV epidemic within the jurisdiction.
2. The extent to which the applicant specifies the MSA or Metropolitan Divisions within the jurisdiction that have at least 30% of persons living with HIV.
3. The extent to which the applicant specifies the highest-risk populations in the target area; summarizes the epidemiologic data that quantifies these populations as representing the highest proportion of cases in the jurisdiction; and describes the behaviors, social determinants, and contexts that put each of these populations at risk.
4. The extent to which the applicant summarizes the current situation and gaps in scope, reach, coordination, and services.
5. The quality of experience, expertise, and existing capacity to provide services that address the HIV epidemic within the jurisdiction.

B. Program Description

This section will be reviewed for feasibility, comprehensiveness, and relevance as it relates to achieving the NHAS goals of reducing new HIV infections, increasing access to

care, improving health outcomes for people living with HIV, and promoting health equity.

1. HIV Testing

a. The extent to which the applicant adequately addresses implementing and/or coordinating routine, opt-out testing for HIV in healthcare settings of patients ages 13-64.
b. The extent to which the applicant adequately addresses implementing and/or coordinating HIV testing in non-healthcare settings to identify undiagnosed HIV infection.
c. The extent to which the applicant adequately addresses supporting HIV testing activities in venues which reach persons with undiagnosed HIV infections.
d. The extent to which the applicant adequately addresses ensuring the provision of test results, particularly to clients testing positive.
e. The extent to which the applicant adequately addresses promoting early HIV testing for all pregnant women according to current CDC recommendations.
f. The extent to which the applicant adequately addresses increasing the number of persons diagnosed with HIV through strengthening current HIV testing efforts or creating new services.
g. The extent to which the applicant adequately addresses facilitating voluntary testing for other STDs (e.g., syphilis, gonorrhea, chlamydial infection), HBV, HCV, and TB, in conjunction with HIV testing, including referral and linkage to appropriate services, where feasible and appropriate and in accordance with current CDC guidelines and recommendations.
h. The extent to which the applicant adequately addresses ensuring that testing laboratories provide tests of adequate quality, report findings promptly, and participate in a laboratory performance evaluation program for testing.
i. The extent to which the applicant adequately addresses incorporating new testing technologies, where feasible and appropriate.

j. The adequacy of the applicant's proposed methods and the data sources that will be used to identify settings in areas with high HIV incidence and/or prevalence.
k. The extent to which the applicant identifies the proposed number of settings and types of settings in which HIV testing activities will be supported.
l. The extent to which the applicant provides a rationale for selection of healthcare or non-healthcare facilities.
m. If healthcare facilities that will be recruited for this program have already been identified, extent to which the applicant included information about their experience with HIV testing. Provided copies of MOUs or MOAs, if available.
n. The extent to which the applicant adequately details how it will ensure that the selected providers promote HIV testing to target populations including pregnant women; guarantee that testing laboratories provide tests of adequate quality, report findings promptly, and participate in a laboratory performance evaluation program for testing; utilize test technologies and strategies that will maximize the proportion of persons tested who receive their results; and deliver services in a culturally and linguistically appropriate manner and in accordance with CDC guidelines and recommendations.
o. The extent to which applicant describes type(s) of consent procedure(s) that will be used and the rationale for this approach, including state or local laws or regulations regarding consent for HIV screening and testing.
p. The extent to which the applicant adequately describes expected outcomes for each proposed HIV testing service.
q. The extent to which the applicant adequately describes how test results will be provided to patients/clients, especially those who test positive for HIV including how individuals with reactive rapid tests receive confirmatory tests.
r. The extent to which the applicant adequately details how services will be provided to persons who test positive for HIV, including prevention counseling, linkage to care, treatment and prevention services, and initiation of Partner Services as soon as possible after diagnosis.

2. Comprehensive Prevention with Positives

a. The extent to which the applicant adequately addresses linkage to HIV care, treatment, and prevention services for those persons testing HIV-positive or currently living with HIV/AIDS.

b. The extent to which the applicant adequately addresses provision of interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons.

c. The extent to which the applicant adequately addresses referral and linkage to other medical and social services such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and others for HIV-positive persons and persons at highest risk of acquiring HIV infection.

d. The extent to which the applicant adequately addresses provision of ongoing Partner Services for HIV-positive persons and their partners.

   (1) The extent to which the applicant adequately addresses collaboration and coordination with STD programs, HIV and/or STD surveillance programs to utilize data to maximize the number of persons identified as candidates for Partner Services.

   (2) The extent to which the applicant adequately addresses partnership(s) with non-health department providers, including CBOs and private medical treatment providers, to identify more opportunities to provide Partner Services.

e. The extent to which the applicant adequately addresses ensuring that HIV-positive pregnant women receive the necessary interventions for the prevention of perinatal transmission.

f. The extent to which the applicant adequately addresses sentinel event case review and community action to address local systems issues that lead to missed perinatal HIV prevention opportunities by utilizing the FIMR-HIV Prevention Methodology, if applicable.

g. The extent to which the applicant adequately addresses implementation of behavioral and clinical risk screening followed by risk reduction interventions for HIV-positive persons (including those for serodiscordant couples) at risk of transmitting HIV.
h. The extent to which the applicant adequately addresses implementation of behavioral, structural, and/or biomedical interventions (including interventions focused on treatment adherence) for HIV infected persons.
i. The extent to which the applicant adequately addresses plans to support and/or coordinate integrated of hepatitis, TB, and STD screening, and Partner Services, for HIV-infected persons, according to existing guidelines.
j. The extent to which the applicant adequately addresses plans to support reporting of CD4 and viral load results to health departments and use of these data for estimating linkage and retention in care, community viral load, quality of care, and providing feedback of results to providers and patients, as deemed appropriate.
k. The extent to which the applicant adequately addresses provision of ART and treatment adherence in accordance with current treatment guidelines.
l. Adequacy of the described linkage network/system to ensure that clients have easy access to medical care, treatment, prevention services and other medical and social services, to include tracking linkage activities and outcomes, promoting retention or re-engagement in care for HIV-positive persons, and collaboration strategies. Provided copies of MOAs or MOUs, if available.
m. The extent to which the applicant describes expected Partner Services outcomes.
n. The extent to which the applicant describes strategies for assuring that HIV-positive pregnant women receive the necessary interventions and treatment for the prevention of perinatal transmission and conducting sentinel event case review and community action to address local systems issues that lead to missed perinatal HIV prevention opportunities.
o. The extent to which the applicant identifies the interventions to be used within the jurisdiction.

p. The extent to which the applicant describes expected behavioral, biomedical, or structural intervention outcomes.
q. The extent to which the applicant describes process for tracking reductions in community viral load through CD4 and viral load testing, as deemed appropriate.
r. The extent to which the applicant describes strategies to promote antiretroviral therapy in accordance with current treatment guidelines.
s. The extent to which the applicant identifies interventions to be used within the jurisdiction and strategies to ensure that the providers address each of the following: promoting and completing linkage to care; treatment and prevention services; providing behavioral risk screening and risk-reduction interventions; implementing behavioral, biomedical or structural interventions; supporting and/or coordinating integrated hepatitis, TB, and STD testing, and Partner Services; and delivering all services in a culturally and linguistically appropriate manner, in accordance with CDC guidelines and recommendations.

3. Condom Distribution

a. The extent to which the applicant adequately describes how it will prioritize and conduct condom distribution to target HIV-positive persons and persons at highest risk of acquiring HIV infection.
b. The adequacy of the applicant's proposed methods and data sources that will be used to identify settings that serves high risk populations and healthcare or non-healthcare facilities it will recruit for condom distribution.
c. The extent to which the applicant adequately identifies number of settings and types of settings in which condom distribution activities will be supported. The extent to which the applicant provides a rationale for selection of healthcare or non-healthcare facilities, including state or local laws or regulations regarding condom distribution.

d. The extent to which the applicant adequately describes expected condom distribution outcomes and how the proposed condom distribution effort aligns with NHAS.

4. Policy Initiatives

a. The extent to which the applicant adequately addresses efforts to align structures, policies, and regulations in the jurisdiction with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts, where applicable, subject to lobbying restrictions under federal law.
b. The extent to which the applicant identifies existing structures, policies, and regulations that can be changed or enhanced to create an enabling environment for optimal HIV prevention, care, and treatment.
c. The extent to which the applicant details proposed strategies and collaborators/partners that will address the proposed change or enhancement to existing structures, policies, and regulations. Includes expected policy outcome.

*For those applicants proposing to implement a **recommended HIV program component**, the criteria below will be used.*

1. Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk of Acquiring HIV

a. The extent to which the applicant adequately addresses the following:
   (1) Provision of behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV particularly those in an HIV-serodiscordant relationship.
   (2) Implementation of evidence-based community interventions that reduce HIV risk.

(3) Support syringe services program, where allowable, and according to HHS and CDC guidelines.

b. Adequacy of applicant's strategies to provide behavioral risk screening followed by individual and group-level evidence-based interventions to high-risk negative persons and serodiscordant couples including rationale for selected interventions and target populations.

(1) Adequacy of rationale for selected evidence-based community interventions that reduce HIV risk, including target populations and areas to be served by these interventions.

(2) The extent to which the applicant details strategies and activities to support syringe services program, where allowable and according to HHS and CDC guidelines.

(3) Provided documentation of existing agreements with providers and other agencies where target population will be served.

(4) Adequacy of the applicant's strategies to identify populations and communities at greatest risk for acquiring HIV in order to conduct outreach and condom distribution.

(5) The extent to which the applicant describes expected interventions outcomes.

(6) The extent to which the applicant outlines how it plans to ensure that providers deliver services in a culturally and linguistically appropriate manner consistent with CDC guidelines and recommendations.

2. Social Marketing, Media, and Mobilization

a. The extent to which the applicant adequately addresses supporting and promoting social marketing campaigns targeted to relevant audiences including the use of campaign materials developed and tested by CDC.

b. The extent to which the applicant adequately addresses supporting and promoting educational and informational programs for the general population based on local needs and linked to other funded HIV prevention activities.

c. The extent to which the applicant adequately addresses supporting and promoting the use of media technology (e.g., Internet, texting, and web applications) for HIV prevention messaging to targeted populations and communities.
d. The extent to which the applicant adequately addresses encouraging community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors.
e. The extent to which the applicant adequately details the health issue(s) addressed in the social marketing campaign(s), message(s) to be promoted, proposed target populations, and the media and/or methodology to be used.
f. Adequacy of the applicant's community mobilization strategies, message(s) to be promoted, proposed target populations, and the methodology to be used.
g. The extent to which the applicant adequately describes how the social marketing campaign, media messages, and/or community mobilization strategies will be evaluated.

3. Pre-Exposure Prophylaxis and Non-Occupational Post-Exposure Prophylaxis Services

a. The extent to which the applicant adequately describes the provision of pre-exposure prophylaxis services to MSM populations at high risk for HIV.
b. The extent to which the applicant adequately describes the provision of non-occupational post-exposure prophylaxis to populations at greatest risk.
c. The extent to which the applicant describes how PrEP and/or nPEP services will be made available within the jurisdiction; services to be provided; how populations at greatest risk will be served; communication activities related to PrEP; and how PrEP- and nPEP-related activities will be evaluated.

*The criteria below will be used to evaluate the **required program activities**.*

1. Jurisdictional HIV Planning

a. The extent to which the applicant describes proposed plans to develop a jurisdictional HIV prevention plan that aligns with NHAS. For directly funded cities, the city jurisdictional plan is reflective of the state jurisdictional plan.
b. The extent to which the applicant describes proposed plans to facilitate a collaborative HIV prevention planning process that contributes to the reduction of HIV infection in the jurisdiction.
c. The extent to which the applicant describes the group composition of the HIV prevention planning group.
d. The extent to which the applicant describes proposed strategies that will increase coordination of HIV programs across the state, jurisdiction, tribal and local government (in alignment with NHAS).
e. The extent to which the applicant describes plans to ensure that the HIV Prevention Planning Group participates in the development of the **Engagement Process**.

2. Capacity Building and Technical Assistance

a. If applicable, the extent to which the applicant describes how it plans to conduct or update the capacity building needs assessment of the health department, HIV prevention service providers, and other prevention agencies/partners, including CBOs.
b. The extent to which the applicant plans to provide or collaborate with partners within or external to the health department to offer capacity building assistance to HIV prevention service providers and other prevention agencies and partners.
c. The extent to which the applicant adequately describes how it will ensure that all health department staff are appropriately trained for their respective job responsibilities.

d. The extent to which the applicant adequately describes how training and technical assistance for staff (health department, participating healthcare facilities, CBOs, or other service organizations) will be identified, provided, and tracked.
e. The extent to which the applicant adequately describes its plan to facilitate exchange of information, and promote peer-to-peer consultation and technical assistance among service providers.

C. Program Planning, Monitoring and Evaluation, and Quality Assurance

1. The extent to which the applicant describes how the most current epidemiologic and surveillance data will be used to assist in program planning and evaluation. A current copy of the Epi Profile is submitted to CDC.
   a. The applicant identifies cities/MSAs with at least 30% of the HIV epidemic within the jurisdiction and explains how it proposes to ensure that funding and prevention resources will be allocated to the local areas within the jurisdiction with the greatest burden of HIV disease.
   b. Proposed plans to coordinate with state and local surveillance programs to collect data needed for HIV incidence and surveillance efforts.
   c. Proposed plans to collaborate with local NHBS staff to assess exposure to, utilization of, and effect of HIV prevention programs.
2. Quality of the applicant's proposed program goals and SMART objectives, and activities for each required and recommended core components. A timeline is included.
3. The extent to which the applicant adequately describe systems in place for data collection, entry, management, and submission. The extent to which the applicant adequately describes procedures in place for data security and confidentiality in accordance with the CDC HIV data security and confidentiality guidelines. The extent to which the applicant outlines its ability to collect and submit performance measures for HIV prevention components and activities and test-level data in accordance with CDC National HIV Monitoring and Evaluation requirements.

D. Staffing and Management

1. The extent to which the applicant describes how all aspects of the program will be planned, managed, and overseen.
2. Quality of the applicant's management plan that describes proposed staff, staff experience and background, and job descriptions for both proposed and current budgeted staff to support and carry out the activities of the program including evaluation. Submits curricula vitae or resume for each professional staff member named in the proposal.
3. The extent to which the applicant describes the process for managing, monitoring, and maintaining collaboration with other programs (e.g., surveillance, STD, laboratory).
4. Submits an organizational chart of the health department's HIV prevention program.

E. Budget and Budget Justification

The extent to which the budget appears reasonable and consistent with the proposed activities and purpose of the program.

Category B: Expanded HIV Testing for Disproportionately Affected Populations

Applicants applying for funding under Category B can propose to implement services only in healthcare settings or in both healthcare and non-healthcare settings. Applicants cannot solely apply for funding of non-healthcare settings. Service integration is an optional component.

A. Background and Need This section will be reviewed for comprehensiveness and relevance of describing the background and need, as it relates to the jurisdictional HIV epidemic.

1. Healthcare Settings

a. The extent to which the applicant describes its experience with routine HIV testing programs in healthcare settings, including experience providing or

supporting similar programs in the past or currently and the length of time. The extent to which the applicant describes the yield of these programs in terms of number of tests done and number of persons with newly diagnosed HIV infection. Describes experience with training and technical assistance needs associated with such programs.

b. The extent to which the applicant adequately describes the target population(s) that the applicant plans to reach through the proposed program for routine HIV testing in healthcare settings (e.g., demographic and risk behavior characteristics, geographic location). Includes an explanation of the rationale behind the selection of the target population(s). Includes a description of current collaboration(s) to plan, develop, and implement integrated screening activities for STDs, TB, or hepatitis (if applicable).

2. Non-Healthcare Settings *(if applicable)*

a. Quality of the applicant's experience with HIV testing programs in non-healthcare settings, including experience providing or supporting similar programs in the past or currently, and for what length of time. The extent to which the applicant describes the types of venues and settings where such programs have been provided or supported. Describes the yield of these programs in terms of number of tests done and number of persons newly diagnosed with HIV infection.

b. The extent to which the applicant adequately describes the target population(s) it plans to reach through the proposed program for HIV testing in non-healthcare settings (e.g., demographic and risk behavior characteristics, geographic location). Includes an explanation of the rationale behind the selection of the target population(s). Includes a description of current collaboration(s) to plan, develop, and implement integrated screening activities for STDs, TB, or hepatitis (if applicable).

B. Program Description

This section will be reviewed for feasibility, comprehensiveness, and relevance as it relates to achieving the goals of expanded HIV testing efforts for populations disproportionately affected by HIV.

1. Healthcare Settings

a. The adequacy of the applicant's proposed methods and data sources that will be used to identify areas with high HIV incidence or prevalence and candidate healthcare facilities that serve the target population(s). The description includes the following information:
   (1) The proposed number of healthcare facilities and types of healthcare settings (e.g., emergency departments, primary care clinics, STD clinics, correctional facility clinics) in which routine HIV testing activities will be supported.
   (2) How the applicant decides which candidate healthcare facilities to recruit for this program. MOU is provided.

b. The extent to which the applicant describes how routine HIV testing will be promoted to administrators, managers, and clinical service directors at candidate healthcare facilities and how they will be engaged to support, develop, implement, and maintain routine HIV testing programs in their facilities.

c. The extent to which the applicant describes how it will work with administrators, managers, and clinical directors of healthcare facilities that agree to participate in the program to develop and implement detailed plans for conducting routine HIV testing programs.

d. The extent to which the applicant adequately describes:
   (1) Promoting the program to staff, educating providers and other appropriate staff about routine HIV testing, and gaining their support for the program.
   (2) Promoting and providing HIV testing to patients/clients.
   (3) Using test technologies and strategies that will maximize the proportion of persons tested who receive their results.

(4) Delivering all services in a culturally and linguistically appropriate manner.

(5) Delivering all services in a manner consistent with applicable CDC guidelines and recommendations.

e. The extent to which the applicant describes the type(s) of consent procedure(s) that will be used for testing in healthcare settings and the rationale for this approach. Includes a description of any state or local laws or regulations regarding consent for HIV screening and testing.

f. The extent to which the applicant describes how test results will be provided to patients/clients, especially those who test positive for HIV. If using rapid HIV testing, ensures that individuals with reactive rapid tests receive confirmatory tests according to state or local requirements.

g. The extent to which the applicant adequately describes how the following services will be provided to persons who test positive for HIV (including persons newly diagnosed with HIV and, when appropriate, persons previously diagnosed): prevention counseling, linkage to medical care as soon as possible after diagnosis, and initiation of Partner Services as soon as possible after diagnosis. If implementing this program in correctional facility clinics, describes how inmates who test positive for HIV will be linked to medical care at the time of release.

h. The extent to which the applicant describes opportunities for improving timely linkage to care, particularly among priority populations and populations experiencing HIV-related health disparities, and develop strategies for taking advantage of those opportunities that can be implemented throughout the duration of the program.

i. The extent to which the applicant adequately describes how it will maximize the likelihood that the programs developed will be sustainable. In the response, the following is included:

(1) A plan on how to obtain reimbursement for HIV testing from third party payers. How the applicant will use funds received from reimbursement by third party payers to sustain or expand this program.

(2) How and under what circumstances the applicant plans to use funds from this FOA to cover the cost of HIV testing.

j. The extent to which the applicant describes how opportunities will be explored to integrate HIV testing and screening into other screening programs conducted at participating facilities (e.g., screening programs for blood pressure, diabetes, and cholesterol).

k. The adequacy of the applicant's proposed methods and data sources that will be used to assess the potential value and feasibility of integrating screening and testing for other STDs, HBV, HCV, and TB into the HIV testing programs funded under this FOA.

l. The extent to which the applicant adequately describes which strategies will be explored to promote routine HIV testing at other healthcare facilities (i.e., facilities other than those with which the applicant will be directly collaborating on this program).

2. Non-Healthcare Settings *(if applicable)*

a. Extent to which the applicant describes process for identifying and funding CBOs or other service organizations that have experience providing HIV testing services in non-healthcare settings and experience working with the target populations. Describes how the applicant will work with the participating CBOs or other service organizations to conduct formative work to do the following:

(1) Identify specific settings or venues in which high-risk members of the target population(s) can be accessed.

(2) Work with gatekeepers to gain access to targeted settings and venues.

(3) Promote the program to members of the target population(s), key stakeholders, and other potential supporters.

(4) Recruit high-risk members of the target population(s) who do not know their HIV status.

(5) Obtain informed consent for testing, using appropriate consent procedures that adhere to all state and local requirements.

(6) Provide HIV tests to clients who give informed consent.

(7) Use test technologies (e.g., rapid tests) and strategies (e.g., use of incentives) that will maximize the proportion of persons tested that receive their results.

(8) Achieve at least a 2% rate of newly identified positive tests when the program is fully implemented (i.e., all contracts with participating CBOs or other service organizations have been executed, health department and subcontractor staff have been hired and trained, all necessary policies and procedures have been developed and implemented, all necessary supplies and materials have been procured, and necessary technical assistance has been provided).

(9) Take corrective actions if the rate of newly diagnosed positive tests is below 2%.

(10) Deliver all services in a manner consistent with current CDC guidelines and recommendations.

(11) Educate program staff about Partner Services and gain their support for these services.

(12) Deliver all services in a culturally and linguistically appropriate manner.

b. If the CBOs or other service organizations that the applicant will contract with for this program have already been identified, the extent to which the applicant included that information, along with the rationale for selecting them and information about their experience with providing HIV testing in non-healthcare settings, including rates of new HIV diagnoses, and experience working with the target population(s). Copies of MOUs or MOAs provided, if available.

c. Extent to which the applicant describes how the applicant will work with participating CBOs or other service organizations to develop and implement detailed plans for providing HIV testing services, based on the formative work previously conducted.

d. Extent to which the applicant describes how test results will be provided to clients, especially those who test positive for HIV. If rapid HIV tests will be used, describe the following:
   (1) How individuals with reactive rapid tests will receive confirmatory tests.
   (2) State or local requirements for providing confirmatory testing.
e. Extent to which the applicant describes how the following services will be provided to persons who test positive for HIV (including persons newly diagnosed with HIV and, when appropriate, persons previously diagnosed):
   (1) Prevention counseling and, if needed, referral to other prevention services.
   (2) Linkage to medical care as soon as possible after diagnosis.
   (3) Initiation of Partner Services as soon as possible after diagnosis.
   (4) Referral to other services (e.g., housing, legal services, partner violence services), as needed.
f. Extent to which the applicant describes how prevention counseling (and referral to other prevention services, if needed) will be provided to persons who test negative for HIV, but are at high risk for becoming infected.
g. Extent to which the applicant describes the methods and the data sources that will be used to assess the potential value and feasibility of integrating screening and testing for other STDs, HBV, HCV, and TB infection into the HIV testing in non-healthcare settings programs funded under this FOA.

3. Service Integration *(optional)*

If the applicant plans to implement integrated screening activities under Category B of this funding opportunity announcement, the extent to which the applicant adequately describes how each of the following will be addressed:

a. Collaboration with key staff of the participating facilities to plan, develop and implement integrated screening activities for STDs, TB or hepatitis, in accordance with CDC guidelines and recommendations.
b. Collaboration with STD, hepatitis, and TB programs to design, develop, and implement activities, including referral and linkage to appropriate evaluation, treatment and vaccination (e.g., hepatitis A and B vaccination).

c. Reimbursement for integrated testing activities from third party payers (applicable to healthcare settings only).
d. Assurance that patients/clients receive their test results, especially those who test positive.
e. Assurance that patients/clients who test positive for other STDs are linked to medical care and receive timely and appropriate evaluation and treatment.
f. For patients/clients who test positive for other STDs, assurance that Partner Services are initiated as soon as possible after diagnosis, in accordance with CDC recommendations and state and local requirements.
g. Periodic review of monitoring data with the participating facilities to assess the value of continuing screening for other STDs, viral hepatitis, and TB.

C. Capacity Building and Technical Assistance

1. The extent to which the applicant describes any anticipated capacity-building needs for implementing routine HIV testing in healthcare settings and HIV testing in non-healthcare settings.
2. The extent to which the applicant describes plans to provide or collaborate with partners within or external to the health department to offer capacity building assistance to HIV prevention service providers and other prevention agencies and partners.
3. The extent to which the applicant describes plans to ensure that all health department staff are appropriately trained for their respective job responsibilities under this program.
4. The extent to which the applicant describes plans to provide or coordinate training and technical assistance (e.g., interventions, organizational infrastructure, HIV testing efforts, policies for data reporting to surveillance) for staff of participating healthcare facilities and CBOs or other service organizations.
5. The extent to which the applicant describes plans to document and track the provision of training and technical assistance to health department staff, staff of participating healthcare facilities and CBOs or other service organizations.

6. The extent to which the applicant describes plans to facilitate exchange of information and peer-to-peer consultation and technical assistance among sites (e.g., convening jurisdiction-level workshops, development of collaborations, referral networks).

D. Program Planning, Monitoring and Evaluation, and Quality Assurance

1. The extent to which the applicant describes how the most current epidemiologic and surveillance data and other available data sources will be used to assist in program planning and evaluation. Included a current copy of the Epi Profile, if available.
2. Quality of the applicant's proposed program goals and SMART objectives and activities for expanded HIV testing. The extent to which the applicant provides a brief description for data collection, entry, management, and submission; procedures in place for data security and confidentiality in accordance with the CDC HIV data security and confidentiality guidelines; and ability to collect and submit data for performance measures.

E. Staffing and Management

1. The extent to which the applicant describes how all aspects of the program will be planned, managed, and overseen.
2. Submits a management plan that describes proposed staff, staff experience and background, and job descriptions for both proposed and current budgeted staff to support and carry out the activities of the program including evaluation. Submits curricula vitae or resume (limited to two pages per person) for each professional staff member named in the proposal.
3. The extent to which the applicant describes the process for managing, monitoring, and maintaining collaborations with other programs (e.g., surveillance, STD, laboratory).

F. Budget and Budget Justification

The extent to which the budget appears reasonable and consistent with the proposed activities and purpose of the program.

Category C: Demonstration Projects (500 points)

A. Background and Need (50 points)

This section will be reviewed for comprehensiveness and relevance of describing the background and need, as it relates to the jurisdictional HIV epidemic.

1. The extent to which the applicant provides a rationale for proposing the project within the focus area(s) (e.g., identified need, epidemiologic data or other data).
2. The adequacy of the methods and the data sources used to identify the areas and facilities to implement the project.
3. Quality of the health department's experience and capacity to implement the demonstration project.
4. The extent to which the applicant adequately describes how the demonstration project addresses the NHAS goals of reducing new HIV infections, increasing access to care and reducing HIV-related disparities and health inequities and expected outcomes for the jurisdiction.

B. Program Description (200 points)

This section will be reviewed for feasibility, comprehensiveness, and relevance as it relates to achieving the NHAS goals of reducing new HIV infections, increasing access to care, improving health outcomes for people living with HIV, and promoting health equity.

1. The extent to which the applicant provides a detailed description of the proposed demonstration project and related activities to include:
    a. Scope of program
    b. Target population
    c. Strategies to be used
    d. Collaborators and partners
    e. Reach and impact

f. Training and technical assistance

g. Dissemination of findings throughout the jurisdiction

C. Program Planning and Monitoring and Evaluation (200 points)

1. The extent to which the following draft information is provided:
   a. Program Description
      (1) Annual program goals and SMART objectives for each activity, to include program performance targets.
      (2) Activities that will be conducted to meet the objectives.
      (3) Capacity building needs.
      (4) Timeline for the project period that shows the implementation of interventions and strategies for selected focus area(s). Timeline includes planning, implementation and evaluation phases.
   b. M&E Description
      (1) A plan for evaluating progress and outcomes of the project and for identifying lessons learned.
         (a) The plan identifies evaluation questions for program plan objectives, describes when and how data will be collected and analyzed, indicates who is responsible, and describes how the results will be utilized and shared.
         (b) Includes a logic model addressing program objectives and expected outcomes.
      (2) Details of systems in place for:
         (a) Data collection and management, entry, submission, and data analysis.
         (b) Data usage: how, by whom, and when data will be used to support program planning, resource allocation, and evaluation; measure progress toward meeting objectives; and to improve program performance, quality, and accountability.
         (c) Data dissemination and sharing with participating healthcare/non-healthcare facilities, CBOs or other service organizations, and key stakeholders.

(3) Local monitoring and evaluation activities to answer M&E questions.

(4) A description of procedures in place for data security and confidentiality. These procedures must be in accordance with the CDC HIV data security and confidentiality guidelines.

c. Plans to collaborate with CDC or other technical assistance providers to provide ongoing training, technical assistance, and consultation to all staff conducting the demonstration project.

D. Staffing and Management (50 points)

1. Submits a staffing and management description for the proposed demonstration project that includes staff experience and background, and job descriptions for both proposed and current budgeted staff to support and carry out the activities of the program including evaluation. Submits curriculum vitae or resume for each staff member named in the proposal.
2. Describes how it will manage, monitor, and maintain collaborations with other programs, service providers and/or stakeholders.

E. Budget and Budget Justification (Not scored)

The extent to which the budget appears reasonable and consistent with the proposed activities and purpose of the program.

Additional Budget Information

Budget (SF 424A) and Budget Narrative (Reviewed, but not scored). Although the budget is not scored, applicants should consider the following in development of their budget. Is the itemized budget for conducting the project and justification reasonable and consistent with stated objectives and planned project activities?

If the applicants requests indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with “Other Attachment Forms” when submitting via Grants.gov.

Review and Selection Process

Review

Applications will be reviewed for completeness by the Procurement and Grants Office (PGO) staff, and for responsiveness jointly by NCHHSTP and PGO. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified if the application did not meet submission requirements.

A CDC Objective Review Panel will be conducted in conjunction with a Structured Review by the Prevention Program Branch based on the evaluation criteria listed in Section V of the FOA. **All eligible applicants submitting complete and responsive applications for Category A and Category B will be funded.** Funding for Category C is competitive and based on application strengths. **Applications for Category C will be reviewed by an Objective Review Panel.**

Selection

All eligible and technically acceptable applications for **Category A and Category B** will be funded.

For Category C, all applications deemed eligible and technically acceptable by the review panel will be funded in order of score and rank **within their funding tier**.

In addition, the following factors may affect the funding decision: availability of funds, geographic diversity, and relevance to DHAP program priorities.

CDC will provide justification for any decision to fund out of rank order.

VI. AWARD ADMINISTRATION INFORMATION

Award Notices

Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between the recipient and CDC. The NoA will be signed by an authorized Grants Management Officer and e-mailed to the program director. A hard copy of the NoA will be mailed to the recipient fiscal officer identified in the application.

Any application awarded in response to this FOA will be subject to the DUNS, CCR Registration, and Transparency Act requirements.

Unsuccessful applicants will receive notification of the results of the application review by mail.

Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 74 or Part 92, as appropriate. The following additional requirements apply to this project:

- 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 2020
- AR-12 Lobbying Restrictions
- AR-14 Accounting System Requirements
- AR-15 Proof of Non-Profit Status
- AR-16 Security Clearance Requirement
- AR-20 Conference Support
- AR-21 Small, Minority, and Women-Owned Business
- AR-23 States and Faith-Based Organizations

- AR-24 Health Insurance Portability and Accountability Act Requirements
- AR-25 Release and Sharing of Data
- AR-26 National Historic Preservation Act of 1966 (Public Law 89-665, 80 Stat. 915)
- AR-27 Conference Disclaimer and Use of Logos
- AR-29 Compliance with E.O. 13513 Federal Leadership on Reducing Text Messaging While Driving, October 1, 2009.
- AR-30 Information Letter 10-006. – Compliance with Section 508 of the Rehabilitation Act of 1973
- AR-31 Research Definition

Additional information on the requirements can be found on the CDC website at the following Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm.

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: http://www.access.gpo.gov/nara/cfr/cfr-table-search.html

Reporting

Federal Funding Accountability And Transparency Act Of 2006 (FFATA): Public Law 109-282, the Federal Funding Accountability and Transparency Act of 2006 as amended (FFATA), requires full disclosure of all entities and organizations receiving Federal funds including grants, contracts, loans and other assistance and payments through a single publicly accessible website, www.USASpending.gov. The website includes information on each federal financial assistance award and contract over $25,000, including such information as:

1. The name of the entity receiving the award.
2. The amount of the award.
3. Information on the award including transaction type, funding agency, etc.
4. The location of the entity receiving the award.
5. A unique identifier of the entity receiving the award.
6. Names and compensation of highly-compensated officers (as applicable).

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 recipients: 1) information on executive compensation when not already reported through the Central Contractor Registry and 2) similar information on all /subcontracts/consortiums over $25,000.00.

For the full text of the requirements under the Federal Funding Accountability and Transparency Act of 2006, please review the following website: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s2590enr.txt.pdf

Each funded applicant must provide CDC with an annual Interim Progress Report submitted via www.grants.gov:

1. The interim progress report (IPR) is due no less than 90 days before the end of the budget. The IPR will serve as the non-competing continuation application, and must contain the following elements:
    a. Standard Form ("SF") 424S Form.
    b. SF-424A Budget Information-Non-Construction Programs.
    c. Budget Narrative.
    d. Indirect Cost Rate Agreement.
    e. Project Narrative.

Additionally, funded applicants must provide CDC with an original, plus two hard copies of the following reports:

2. Annual progress report (APR), due 90 days after the end of the budget period. Additional guidance on what to include in this report may be provided by CDC well in advance of the due date. It must include:
    a. Progress the grantee has made toward achieving the target levels and goals of performance for each objective.
    b. Current budget period financial progress.

c. Additional requested information.

3. Financial Status Report* (SF 269) and annual progress report, no more than 90 days after the end of the budget period.
4. Final performance and Financial Status Reports*, no more than 90 days after the end of the project period.

*Disclaimer: As of February 1, 2011, current Financial Status Report (FSR) requirements will be obsolete. Existing practices will be updated to reflect changes for implementation of the new Federal Financial Reporting (FFR) requirements.

These reports must be submitted to the attention of the Grants Management Specialist listed in the Section VII below entitled "Agency Contacts".

VII. Agency Contacts

CDC encourages inquiries concerning this announcement.

For **programmatic technical assistance**, contact:

Erica Dunbar, Program Leader
Department of Health and Human Services
Centers for Disease Control and Prevention
1600 Clifton Road NE, Mailstop E-58
Telephone: 404-639-8330
E-mail: HDFOA@cdc.gov

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

Angie Tuttle, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS E-14

Atlanta, GA 30341

Telephone: 770-488-2863

E-mail: atuttle@cdc.gov

For assistance with **submission difficulties,** contact:

Grants.gov Contact Center Phone: 1-800-518-4726

Email: support@grants.gov

Hours of Operation: 24 hours a day, 7 days a week. Closed on Federal holidays.

For application **submission** questions, contact:

Technical Information Management Section

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS E-14

Atlanta, GA 30341

Telephone: 770-488-2700

Email: pgotim@cdc.gov

CDC Telecommunications for the hearing impaired or disabled is available at:
TTY 1-888-232-6348

VIII. Other Information

1. National HIV/AIDS Strategy (NHAS): http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/what-is-the-nhas/strategy.html

2. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention's (NCHHSTP) Strategic Plan:

http://www.nchhstp.cdc.gov/docs/10_NCHHSTP%20strategic%20plan%20Book_semi%20final508.pdf

3. CDC Health Disparities and Inequalities Report — United States, 2011: http://www.cdc.gov/mmwr/pdf/other/su6001.pdf

4. NCHHSTP's Social Determinants of Health White Paper**:** http://www.cdc.gov/socialdeterminants/docs/SDH-White-Paper-2010.pdf

5. PCSI White Paper: http://www.cdc.gov/nchhstp/programintegration/docs/207181-C_NCHHSTP_PCSI%20WhitePaper-508c.pdf

6. HIV Surveillance Report, Volume21: Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas, 2009 www.cdc.gov/hiv/surveillance/resources/reports/2009report/index.htm

7. Healthy People 2020 – HIV Topic Area: http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=22

8. Department of Health and Human Services Implementation Guidance for Syringe Services Programs, July 2010: http://www.cdc.gov/hiv/resources/guidelines/PDF/SSP-guidanceacc.pdf

9. Integrated Guidelines for Developing Epidemiologic Profiles: HIV Prevention and Ryan White CARE Act Community Planning: http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/epi-guideline/index.htm

10. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, 2006:

http://www.cdc.gov/mmwr/pdf/rr/rr5514.pdf

11. Revised Guidelines for HIV Counseling, Testing, and Referral, 2001: http://www.cdc.gov/mmwr/pdf/rr/rr5019.pdf

12. Quality Assurance Standards for HIV Counseling, Testing, and Referral Data, 2009: http://www.cdc.gov/hiv/testing/resources/guidelines/qas/

13. Quality Assurance Guidelines for Testing Using Rapid HIV Antibody Tests Waived Under the Clinical Laboratory Improvement Amendments of 1988 | Rapid HIV Testing | Testing | Topics | CDC HIV/AIDS: http://www.cdc.gov/hiv/topics/testing/resources/guidelines/qa_guide.htm

14. HIV Testing Implementation Guidance in Correctional Settings, January 2009: http://www.cdc.gov/hiv/topics/testing/resources/guidelines/correctional-settings/pdf/Correctional_Settings_Guidelines.pdf

15. Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr57e1030a1.htm

16. Guidelines for Internet-based Partner Services: http://www.ncsddc.org/upload/wysiwyg/documents/IGPS.pdf

17. Sexually Transmitted Diseases Treatment Guidelines, 2010: http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf

18. Interim Guidance: Preexposure Prophylaxis for the Prevention of HIV Infection in Men Who Have Sex with Men: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6003a1.htm?s_cid=mm6003a1_w

19. Non-Occupational Post-Exposure Prophylaxis: http://www.cdc.gov/mmwr/PDF/rr/rr5402.pdf

20. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm

21. Compendium of HIV Prevention Interventions with Evidence of Effectiveness: http://www.cdc.gov/HIV/topics/research/prs/evidence-based-interventions.htm

22. Diffusion of Effective Behavioral Interventions: www.effectiveinterventions.org

23. Act Against AIDS Communication Campaign: http://www.cdc.gov/hiv/aaa/

24. Antiretroviral Treatment Access Study (ARTAS) Linkage to Care Intervention: Craw JA, Gardner LI, Marks G, Rapp RC, Bosshart J, Duffus WA, Rossman A, Coughlin SL, Gruber D, Safford LA, Overton, J, Schmitt K. Brief strengths-based case management promotes entry into HIV medical care: results of the Antiretroviral Treatment Access Study-II (ARTAS-II). *JAIDS*, 2008; 47:597-606. http://www.ncbi.nlm.nih.gov/pubmed/18285714

25. National Standards for Culturally and Linguistically Appropriate Services in Health Care: http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

26. Distinguishing Public Health Research and Public Health Nonresearch" Policy: http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf

27. Guidelines for Budget Preparation:
http://www.cdc.gov/od/pgo/funding/budgetguide.htm

28. Contract Clause for Safeguards for Individuals and Establishments against Invasions of Privacy and with Subsection (m) of the Privacy Act of 1974 (5 U.S.C. 552a) and Section 308(d) of the Public Health Service Act (42 U.S.C. 242m):
http://www.justice.gov/opcl/privstat.htm

References

1. Waite KR, Paasche-Orlow M, Rintamaki LS, Davis TC, Wolf MS. Literacy, social stigma, and HIV Medication Adherence. J Gen Intern Med 2008; 23:1367-1372.

2. Osborn CY, Paasche-Orlow M, Rintamaki LS, Davis TC, Wolf MS. Health literacy: An overlooked factor in understanding HIV health disparities. Am J Prev Med 2007 33:374-378.

3. Peterson JL, Coates TJ, Catania JA, Middleton L, Hilliard B, Hearst N. High-risk sexual behavior and condom use among gay and bisexual African-American men. Am J Public Health 1996;82:1490-1494.

4. Mays VM and Cochran SD. High risk HIV-related sexual behaviors in a national sample of U.S. black gay and bisexual men. Abstract WS-C07-2. IX International Conference on AIDS. Berlin, Germany, June 6-11,1993.

5. Denning P, DiNenno E. Communities in crisis: Is there a generalized HIV epidemic in impoverished urban areas of the United States? Abstract WEPDD101. *XVIII International AIDS Conference*, Vienna, Austria, July 18-23, 2010.

6. Diaz T, Chu SY, Conti L, Nahlen BL, Whyte B, et al. Health insurance among persons with AIDS: Results from a multistate surveillance project. Am J Public Health;1994;84:1015-1018.

7. Kidder DP, Wolitski RJ, Campsmith ML, Nakamura GV. Health status, health care use, medication use, and medication adherence among homeless and housed people living with HIV/AIDS. Am J Public Health. 2007; 97:2238-2245.

8. Marks SM, Taylor Z, Ríos Burrows N, Qayad M, Miller B. Hospitalization of homeless persons with tuberculosis. Am J Public Health. 2000; 90(3):435-438.

9. HIV Surveillance - United States 2001-2008. MMWR Weekly. June 3, 2011 / 60(21); 659-693-1076. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6021a1.htm.

CDC-RFA-PS12-1201 List of Attachments

Attachments are located at http://www.cdc.gov/hiv/topics/funding/PS12-1201/.

1. Attachment I: Glossary of Terms
2. Attachment II: Recommended HIV Testing Definitions and Examples
3. Attachment III: Examples of Perinatal HIV Prevention Activities
4. Attachment IV: Sample of Letter of Concurrence
5. Attachment V: Request for an Assurance of Confidentiality for the National HIV Prevention Program Monitoring and Evaluation (NHME) for HIV/AIDS Prevention Program Data
6. Attachment VI: MOU between the Centers for Disease Control and Prevention and Directly Funded Agencies for use of CDC-Licensed or Owned Data Systems
    a) Attachment VI.a: MOU between the Centers for Disease Control and Prevention and Directly Funded Agencies for use of Non CDC-Licensed or Privately Owned Data Systems
7. Attachment VII: Rules of Behavior for use of CDC-Licensed or Owned Data Systems Agency System Administrators
    a) Attachment VII.a.: Rules of Behavior for Non CDC-Licensed or Privately Owned Data Systems Agency Administrators

8. Attachment VIII: Rules of Behavior for use of CDC-Licensed or Owned Data Systems Agency Users
    a) Attachment VIII.a: Rules of Behavior for use of Non CDC-Licensed or Privately Owned Data Systems Agency Users
9. Attachment IX: CDC PrEP Program Guidance for HIV Prevention Health Department Grantees
10. Attachment X: Funding Tables
11. Attachment XI: Sample Letter of Agreement between Local and State Health Departments
12. Attachment XII: CDC Form 0.1113 Assurance of Compliance with the Requirements for Contents of AIDS-Related Written Materials (**Must be downloaded from Grants.gov**)
13. Attachment XIII: Application Checklist

For additional information on reporting requirements, visit the CDC website at: http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm.

Other CDC funding opportunity announcements can be found at www.grants.gov.

Attachment X: Funding Tables

Anticipated award levels for Category A (core prevention) are based on the relative share of the unadjusted number of people living with HIV through 2008 attributable to each eligible jurisdiction. Awards to the states, U.S. territories, and the District of Columbia were calculated first by multiplying their epidemiological proportion by the total amount available to support Category A activities. The maximum funding for which each city was eligible was calculated using each city's relative share of its state HIV epidemic. CDC then examined the distribution of draft funding allocations to identify jurisdictions which, under a strict, epidemiologically proportionate funding approach, would receive less than the established floor ($250,000 for Pacific Island territories and $750,000 for states, Puerto Rico, the Virgin Islands, and D.C.) The award for any jurisdiction falling below the floor was raised up to its pre-specified floor.

Anticipated awards for Category B (expanded testing) were determined in the same fashion, but with a different metric because this funding is specifically focused on reaching Hispanic and African American persons. CDC determined the total unadjusted number of Hispanic and African American people living with HIV at the end of 2008 in the eligible jurisdictions and then calculated each jurisdiction's proportionate share of the total disease burden. These epidemiological proportions were applied to the total amount of funding available to support expanded testing activities. Consistent with the approach used to allocate core prevention dollars, the funding level for the directly funded cities was calculated after the overall state allocations had been determined.

Anticipated funding levels for Category B are listed by eligible jurisdiction in the tables below. Estimated annual Category A funding levels for FY 2012 through FY 2016 can be found at: http://www.cdc.gov/hiv/topics/funding/PS12-1201/pdf/Attachment-X.pdf. These amounts are estimates based on current resources and are subject to change depending on the annual availability of funds. Applicants may request funding in an amount that falls outside of the ranges presented.

Estimated Individual Award Ranges for Category B:

Jurisdiction	Floor of Individual Award Range	Ceiling of Individual Award Range
Alabama	$702,800	$776,800
Arizona	$424,700	$469,500
Atlanta	$1,629,200	$1,800,600
Baltimore	$1,490,000	$1,646,800
California*	$2,227,600	$2,462,000/$5,614,800
Chicago	$1,802,200	$1,991,900
Colorado	$342,800	$378,800
Connecticut	$675,500	$746,600
D.C.	$1,195,500	$1,321,300
Florida*	$3,223,000	$3,562,200/$7,024,700
Fort Lauderdale	$2,146,800	$2,372,800
Georgia*	$877,500	$969,900/$2,770,500
Houston	$1,446,900	$1,599,300
Illinois*	$315,000	$348,200/$2,340,100
Indiana	$343,800	$380,000
Los Angeles	$2,335,600	$2,581,400
Louisiana	$1,174,100	$1,297,700
Maryland*	$878,100	$970,500/$2,617,300
Massachusetts	$756,900	$836,500
Miami	$985,900	$1,089,700
Michigan	$883,000	$976,000
Mississippi	$609,100	$673,300
Missouri	$537,800	$594,400
New Jersey	$2,681,800	$2,964,000
New York*	**$1,496,300**	**$1,654,000/$10,780,700**
New York City	**$8,258,000**	**$9,127,000**
North Carolina	$1,660,700	$1,835,500
Ohio	$783,800	$866,400
Pennsylvania*	$522,800	$577,800/$2,282,600
Philadelphia	$1,542,400	$1,704,800
Puerto Rico	$1,815,500	$2,006,600
San Francisco	$517,000	$571,400
South Carolina	$1,055,800	$1,167,000
Tennessee	$892,000	$985,800
Texas*	$2,515,000	$2,779,800/$4,379,100
Virginia	$1,343,900	$1,485,300

* The first amount in the "Ceiling of Individual Award Range" column reflects the maximum amount a state with eligible cities could receive if the cities are funded at a level within the range presented in the table. The second figure reflects the maximum a state could receive if their eligible city(ies) did not apply for or receive funding for expanded testing activities.

Attachment XIII: Application Checklist
Funding Opportunity Announcement (FOA) CDC-RFA-PS12-1201: Comprehensive HIV Prevention Programs for Health Departments

The following items should be submitted with the application:

1. Table of Contents ☐
2. Cover Letter ☐
3. Application Form (with DUNS number included) ☐
4. Project Abstract (one condensed abstract that address each requested category) ☐
5. Project Narrative (as outlined in the FOA for each requested category) ☐
6. City/State Letter of Agreement ☐
7. Jurisdiction HIV/AIDS Epidemiology Profile (if available) ☐
8. Management Plan (for each requested category) ☐
   - Curriculum Vitae or resume ☐
9. Budget and Budget Justification (for each requested category)
   - Detailed line item budget ☐
   - Budget justification ☐
   - Standard form 424A ☐
10. CDC Form 0.1113 Assurance of Compliance ☐
    (Located at http://www.cdc.gov/od/pgo/forms/hivpanel.htm)

The following items should be submitted within six-month after the start of the project period:

1. Jurisdictional HIV Prevention Plan ☐
2. Results of Prevention Planning Group (PPG) Engagement Process ☐
3. Letter of Concurrence ☐
4. Capacity Building Needs Assessment (if applicable) ☐
5. Comprehensive Program Plan ☐
6. Data Security and Confidentiality
   - Memorandum of Understanding – CPEMS System Administrator ☐
   - Memorandum of Understanding – Non-CPEMS System Administrator ☐
7. Rules of Behavior for Data Systems
   - CPEMS System Administrator ☐
   - Non-CPEMS System Administrator ☐
   - CPEMS Users ☐
   - Non-CPEMS Users ☐

The following items should be submitted annually

1. Rules of Behavior for Data Systems
   - CPEMS System Administrator ☐
   - Non-CPEMS System Administrator ☐
   - CPEMS Users ☐
   - Non-CPEMS Users ☐
2. Completed Syringe Services Programs (SSPs) Annual Certification Statement ☐