

**Funding Opportunity Announcement (FOA)**  
***PS17-1704: Comprehensive High-Impact HIV Prevention Projects for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color***

**Attachment B: Health Department Targeted HIV Testing and Partner Services Letter of Agreement**

Date: \_\_\_\_\_

Karen Zion, Grants Management Specialist Office  
of Grants Services  
Centers for Disease Control and Prevention  
2920 Brandywine Road, Mailstop E15  
Atlanta, GA 30341

Dear Ms. Zion:

This letter confirms that [Health Department Name] \_\_\_\_\_ staff have reviewed and discussed [CBO Name] \_\_\_\_\_'s plan for testing under CDC Funding Opportunity Announcement PS17-1704: *Comprehensive High-Impact HIV Prevention Projects for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color*.

[Health Department Name] \_\_\_\_\_ confirms that they have discussed state and local laws and regulations pertaining to HIV testing with staff of [CBO Name] \_\_\_\_\_. During these discussions, [CBO Name] \_\_\_\_\_ has expressed their understanding of the need for complete compliance with all state and local laws and regulations pertaining to HIV Testing and Partner Services (PS). Please see CBO Statement Of Understanding on page 2.

This letter also serves as an acknowledgement between [Health Department Name] \_\_\_\_\_ and [CBO Name] \_\_\_\_\_ that the following items have been discussed in detail:

Select all that apply.

<input type="checkbox"/> Anonymous versus confidential testing	<input type="checkbox"/> Follow-up for results
<input type="checkbox"/> Informed consent	<input type="checkbox"/> Early intervention services
<input type="checkbox"/> CLIA certificate of waiver	<input type="checkbox"/> Data collection and reporting
<input type="checkbox"/> Training of counselors	<input type="checkbox"/> Quality assurance of counselors
<input type="checkbox"/> Confidentiality	<input type="checkbox"/> Linkages with partner notification
<input type="checkbox"/> Surveillance reporting	<input type="checkbox"/> Local laws and regulations
<input type="checkbox"/> Laboratory processing	<input type="checkbox"/> Target population to be served
<input type="checkbox"/> Type of test(s) to be used	<input type="checkbox"/> Referral networks

<input type="checkbox"/> Physician orders	<input type="checkbox"/> Ways to address barriers related to Partner Services
<input type="checkbox"/> Training of staff on the importance of Partner Services	<input type="checkbox"/> Other:
HIV Testing Reporting	
<input type="checkbox"/> CBO will use EvaluationWeb for direct data entry of HIV test reporting	

Under state and/or local guidelines, [CBO Name] \_\_\_\_\_, in conjunction with guidance and assistance from [Health Department Name] \_\_\_\_\_ is allowed to provide the following services related to Partner Services:

<input type="checkbox"/> Partner Solicitation	<input type="checkbox"/> Partner Notification
<input type="checkbox"/> Other:	

Lastly, physician oversight of the CBO's HIV testing program  is **OR**  is not required by the health department jurisdiction.

**Note: If physician oversight is required, the CBO must complete and submit Attachment C (Letter of Intent from a Physician for State Regulations and HIV Testing Activities).**

Please provide [Health Department Name] \_\_\_\_\_'s Point of Contact for HIV Testing and PS who will liaise with [CBO Name] \_\_\_\_\_.

[HD HIV TESTING/PS POINT OF CONTACT NAME] \_\_\_\_\_  
 [TITLE] \_\_\_\_\_  
 [EMAIL] \_\_\_\_\_  
 [PHONE] \_\_\_\_\_

Sincerely,

[NAME] \_\_\_\_\_  
 [TITLE] \_\_\_\_\_  
 [HEALTH DEPARTMENT NAME] \_\_\_\_\_

### STATEMENT OF UNDERSTANDING

[CBO Name] \_\_\_\_\_ confirms that they understand all state and local laws pertaining to HIV testing and, furthermore, will comply with all state and local laws and regulations pertaining to Partner Services.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date