

## Notice of Funding Opportunity (NOFO)

### PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States

#### General Asked Questions (GAQs)

Updated April 2, 2020

*This GAQ document is developed based on the questions received from potential applicants and stakeholders via the mailbox and/or informational webinar. Please view the question and answers (Q&As) under each respective heading/section for responses to submitted questions.*

#### Sections:

- Eligibility
- Submission Requirements
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#### Eligibility

##### **Q: Which agencies/types of organizations are eligible for this notice of funding opportunity?**

A: Eligible applicants include state, local, and territorial health departments or their Bona Fide Agents identified in Phase 1 of the Ending the HIV Epidemic (EHE) Initiative and that have a current direct funding relationship with CDC. Eligibility for funding to implement the program described in the NOFO PS20-2010 is contingent upon the existence of a comprehensive EHE plan. Refer to the Eligibility Information section of the NOFO for additional information.

The Ending the HIV Epidemic: A Plan for America is a new initiative announced by the President in February 2019. The Phase 1 jurisdictions represent more than 50% of new HIV diagnoses only 48 counties, Washington, DC, and San Juan Puerto Rico. In addition, seven (7) states have a substantial rural burden with over 75 cases and 10% or more of the diagnoses in rural areas.

#### Submission Requirements

##### **Q: Are jurisdictions allowed to submit their PS20-2010 applications early?**

A: Yes, jurisdictions are encouraged to submit their completed applications as early as possible.



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**Q: What is the page limit for the project narrative and any other text requirements?**

A: The project narrative (description) is limited to 15 pages for the base program (Component A) and up to 4 additional pages per component (Components B and C). This is a total of 23 pages, if the eligible health department is applying for all three components. If the eligible health department is applying for two of the three components, please make sure that the total number of pages for your application does not exceed 23 pages.

The project narrative (description) must include the following headings: Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. The work plan can be uploaded in “Other Attachments” and will not count towards the page limit described above. The applicant may include *Refer to Attachment X or Other Attachments* under the Applicant Evaluation and Performance Measurement Plan and the Work Plan sections.

**Q: Where are the CDC Assurance of Compliance forms located on [www.grants.gov](http://www.grants.gov)?**

A: For the CDC Assurance of Compliance form, please visit [CDC Grants Assurances webpage](http://www.grants.gov).

**Budget and Funding Requirements**

**Q: Is there a minimum percentage of the total award that should be allocated to the mandatory program requirement of strengthening our surveillance system?**

A: No, there is no specified minimum percentage that should be allocated to the mandatory program requirement of strengthening your surveillance system.

**Q: The NOFO states the “70% of the total resources received are to be directed to the local EHE jurisdictions.” Can the 70% of the total award be used for any purpose, as long as the funds are spent in the jurisdiction, or is the 70% specifically for direct services in the jurisdiction?**

A: The 70% may be used for purposes directly related to the oversight/management, program implementation, evaluation, etc. of the EHE program in the EHE identified jurisdictions. Funds should be allocated in a manner that best supports the jurisdictions’ EHE efforts.

**Q: How many budgets and 424A forms do we need to submit?**

A: Please submit one line item budget for Component A (Core Component) program. If applying for Components B and/or C, please include a separate budget narrative and 424A form each component for which you are applying. There will be one Notice of Award (NOA). There will be one notice of award (NOA).

**Q: Can we request more than the award ceiling? How much should we request?**

A: The award ceiling for Component A is included in the individual funding ranges included in Attachment C: Funding Range Tables. Jurisdictions may apply for more than the ceiling amount listed in Attachment C. However, CDC strongly encourages health departments to develop their proposed program based on the



funding ranges listed in Attachment C to ensure better alignment of your proposed program with available funding.

**Q: How many years of budgets and budget narratives should we include in the application? Just year 1? Is this the same for the core and demonstration project?**

A: The budgets and budget narrative should be developed for Year 1 only.

**Q: Should applicants budget for a required all-grantee meeting in Year 1 of the project period for Component A? What about for the other Components?**

A: Yes, recipients should budget for a Recipient meeting during Year 1 for Components A and C. Although we have not finalized the logistics for the Recipient meeting, we anticipate that there will be one meeting inclusive of both components. Additional information will be provided once awards are made. Furthermore, based on an applicants' training needs and available resources, please include training/TA needs within the budget.

**Q: Is Direct Assistance (DA) available through this notice of funding opportunity (NOFO)?**

A: DA is available through this NOFO. Applicants may request federal personnel, equipment, or supplies, including SAS licenses, as Direct Assistance (DA) to support HIV surveillance and prevention activities, in lieu of a portion of financial assistance (FA). To address staffing and/or program expertise deficits, applicant may convert FA to DA to recruit staff with the requisite training, experience, expertise (e.g., Public Health Associate Program [PHAP]). For information on Direct Assistance for Assigning CDC Staff to State, Tribal, Local, and Territorial Health Agencies, refer to:

[https://www.cdc.gov/stltpublichealth/GrantsFunding/direct\\_assistance.html](https://www.cdc.gov/stltpublichealth/GrantsFunding/direct_assistance.html).

**Q. Who should the budget letter be addressed to?**

A. A budget letter is not required.

## **Component A-specific Questions**

### **Required Strategies**

**Q: Do we have to implement all activities listed under each of the four strategies? Can we opt out of any of the activities?**

A: Implementation of all strategies is required. However, the activities listed under each strategy were strategically selected to maximize the ability of all jurisdictions to reach the goals of the EHE initiative and to focus efforts and facilitate transfer of knowledge, best practices, and lessons learned.

- Applicants can request to opt out of some activities (e.g., implementation is not currently feasible due to local or state laws).
  - A justification requesting to opt-out is required and must be submitted with the application for funding. Approval will be made after review of the application.



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**Q: How can the new HHS Ready, Set, PrEP program be integrated into a jurisdiction’s comprehensive activities for Strategy 3 (Prevent new HIV transmission by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs); aka the Prevent Pillar of EHE)?**

A: The new Ready, Set, PrEP program, which provides pre-exposure prophylaxis (PrEP) medications at no cost to thousands of individuals who qualify, is an example of one of the other EHE components that can be integrated into a jurisdiction’s activities to help achieve the desired Strategy 3/Prevent pillar outcomes.

For example:

- Information about Ready, Set, PrEP can be integrated into provider training about PrEP and the Ready, Set, PrEP provider fact sheet <<https://protect2.fireeye.com/url?k=3492867d-68c69f01-3492b742-0cc47adc5fa2-62ee78a2cacfaa76&u=http://files.hiv.gov/s3fs-public/RSP-HCPFactsheet-PRINT.pdf>> can be shared during such trainings.
- Health departments, health centers, CBOs and other can educate and inform locally-developed peer leaders and networks of PrEP users about Ready, Set, PrEP to ensure awareness of it and other available programs to address cost barriers to accessing or continuing use of PrEP experienced by some individuals. Factsheets, information cards, posters, and social media posts that can be used are available at <https://protect2.fireeye.com/url?k=9fa31945-c3f70039-9fa3287a-0cc47adc5fa2-32b2fa9854474f6e&u=https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/prep-program-resources>

Health departments can integrate information about Ready, Set, PrEP into any locally developed cost-assistance navigation protocols for PrEP patients. Information about Ready, Set, PrEP eligibility, enrollment, and more is available at <https://protect2.fireeye.com/url?k=7facc453-23f8dd2f-7facf56c-0cc47adc5fa2-0b3b1d96de551575&u=https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/prep-program>

**Q: Will jurisdictions be required to participate in Component A Cluster Detection and Response, and use PS20-2010 to do so? We are having internal discussions and disagreements between surveillance and prevention on the need of this funding, and if this activity is required and a “proven” activity.**

A: Yes, jurisdictions are required to implement Strategy 4. Cluster and outbreak detection and response are relatively new activities that have not yet been widely implemented. Through our recent past and ongoing experience, CDC feels that successful cluster response depends on strong partnerships, processes, data systems, and policies. The strategies and activities in the Response section are intended to develop and strengthen response capabilities of jurisdictions in similar ways to provide a foundation for future work to yield:

- Efforts designed to more rapidly identify and be ready to respond to outbreaks of HIV; and
- Efforts designed to use data in a more timely manner to inform where and in which populations we should target prevention interventions most urgently.

All jurisdictions are required to support activities in all EHE pillar areas, including response. Response activities are important for identifying hotspots of HIV transmission and to help focus prevention interventions in areas where they are most needed. All jurisdictions need to have a plan to detect and be prepared to deal with outbreaks should they occur; outbreaks can occur in unexpected areas and an effective response can mitigate the magnitude of the problem. Each jurisdiction will need to decide the level of support to allocate across the four pillars. The EHE plans (funded through PS19-1906) should help support the prioritization exercise.



## Staffing

**Q: The NOFO requires recipients to designate, at a minimum, a specific individual at 100% effort to coordinate all EHE activities funded under this NOFO. Is it permissible to reduce the percentage of time to enable this individual to work across multiple EHE grants from various organizations?**

A: This NOFO, as does other funding opportunities, involves multiple activities over several program areas. To fully execute and ensure coordination, at least one individual must be designated at 100% effort to coordinate activities funded under the PS20-2010.

- Part of the coordination duties may include work across other funding opportunities to ensure consistency and integration, but the primary purpose of the work must be to coordinate PS20-2010 activities.
- In addition to the PS20-2010 Coordinator, recipients may wish to designate someone to oversee all EHE funding opportunities and activities within the jurisdiction. In this case, CDC supports having the additional individual devote partial effort to PS20-2010 in order to ensure that activities are appropriately integrated and successfully implemented across funding opportunities and program areas.

**Q: Is it permissible to reduce the percentage of time and effort (less than the 50% stated in the NOFO) for existing staff (programmatic and scientific) funded to implement EHE activities under this NOFO?**

A: CDC intends that existing key programmatic and scientific staff working on EHE activities funded under PS20-2010 should devote a significant amount of their time to implementing the jurisdiction's EHE activities to ensure that they are successful.

- Key programmatic and scientific staff are, as defined by the Office of Grant Services, "the PD/PI and other individuals who contribute to the programmatic development or execution of a project or program in a substantive, measurable way, whether or not they receive salaries or compensation under the grant." One of the goals of this funding is to increase staffing levels to support EHE activities (refer to page. 39). Therefore, recipients may need to hire additional staff to support program activities funded under this announcement.

## Evaluation and Performance Management Plan (EPMP) and Work Plan

**Q: Is there is a fillable copy or a word document available for the PS20-2010 Component A Evaluation and Performance Measurement Plan (EPMP)?**

A: A fillable copy of the *PS20-2010 Component A Evaluation and Performance Measurement Plan (EPMP)* template was forwarded to applicants on February 7, 2020 via the [EHENOFO@CDC.GOV](mailto:EHENOFO@CDC.GOV) mailbox. In addition, the document is available in the attachments section of the [PS20-2010 website](#).

**Q: How should I include my PS20-2010 Component A EPMP and Work Plan with my application submission?**

A: In the "Applicant Evaluation and Performance Measurement Plan" section of the project narrative, applicants can describe their jurisdictional EPMP or indicate that their jurisdictional EPMP is described in an uploaded attachment. The Component A EPMP and Work Plan is an acceptable attachment and will be reviewed by CDC. The jurisdictional EPMP is required as part of the application process, however, the template provided is **optional**.



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**Q: If jurisdictions are conducting activities associated with each of the required strategies with non-CDC PS20-2010 funding, do we need to include these activities in Table 7? Are jurisdictions required to submit data for non-CDC PS20-2010 funded activities?**

A: The PS20-2010 EPMP is designed to monitor recipient performance, to provide information to assist in guiding program planning and performance, and to diffuse lessons learned and promising practices from this CDC-funded program. Only activities that are funded by PS20-2010 should be included in the EPMP for this program. Similarly, program data are not required for EHE activities that are not funded under PS20-2010.

### **Component B-specific Questions**

**Q: Is a letter of intent (LOI) required for Component B? What information should be included in the LOI?**

A: Yes, a letter of intent should be submitted as an attachment with the PS20-2010 application. The LOI does not count toward the page limit. The LOI can be a basic statement that you intend to apply for Component B funding at a later date following receipt of additional guidance from CDC. The LOI should include a brief summary of your proposed Component B project, including any perceived facilitators and challenges to implementation.

**Q: Are applicants required to respond to the Component B requirements in the PS20-2010 application due on May 1, 2020?**

A: No, applicants are not required to respond to the Component B requirements in their PS20-2010 applications. CDC will provide additional guidance at a later date. However, applicants should include a letter of intent stating that they will be applying for Component B in their PS20-2010 application packet.

**Q: How was eligibility determined?**

A: Jurisdictional eligibility was based on the following criteria: previous experience conducting incidence surveillance activities, having reliable CD4-based incidence estimates, and having a phase 1 EHE jurisdiction. For eligibility, CDC considered criteria at the state level using CDC published data.

(<https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-24-1.pdf>).

**Q: Will there be funding for shipping? Will funds be able to be used to pay laboratories for specimen handling/processing?**

A: It is suggested that jurisdictions include funding for these activities in the budget for Component B.

**Q: What is meant by engaging stakeholders?**

A: A strong foundation of community engagement is critical to the success of incidence surveillance. Applicants shall propose to engage a diverse group of key partners and stakeholders, including community groups, HIV testing providers, and laboratories, about health department activities surrounding HIV incidence surveillance activities and use of incidence data to support efforts of the Ending the HIV Epidemic initiative. Community engagement shall be conducted prior to implementing incidence surveillance activities and continue as an ongoing process that responds to community needs and concerns. Stakeholders will be made



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aware of any changes in incidence procedures and can discuss questions and concerns to ensure responsible implementation and support for the program.

**Q: Will CDC be working with commercial laboratories for this project in order to gain broader access to remnant viral load specimens?**

A: This comment/question was noted by CDC and consideration will be given as part of the review process.

**Q: Are we doing real time incidence analysis?**

A: The process will be expedited. We aim to produce annual reports of the analyses and are open to suggestions on frequency and timeliness of reporting.

**Q: Are state HDs that are not in phase 1 able to apply for component B since public health law requires reporting to the state HD and not local HDs?**

A: State HDs that don't have a phase 1 EHE jurisdiction are not eligible; they must be eligible for component A.

**Q: What are the requirements?**

A: Contingent on application for component A, eligibility was based on previous experience conducting incidence surveillance activities, having reliable CD4 based incidence estimates (published), and having a phase 1 EHE jurisdiction.

**Q: Is Component B linked to HIV clusters and outbreaks?**

A: Component B looks at broader geographic areas to estimate HIV incidence at a population level. During cluster and outbreak investigations recency assays may be used to inform recency of infection within a transmission cluster.

**Q: Could we enhance laboratory reporting under component A in year one to be ready for component B in year two?**

A: Yes, this is appropriate.

**Q: Has CDC thought of working with FDA for approval of the recency assay?**

A: Yes, but there is no FDA guidance for assessment of HIV recency assays.

**Q: Can we describe the most ideal or feasible way to stand up recency testing in the application?**

A: Yes, application should reflect the best approach for your jurisdiction.

**Q: Can we have subsequent calls to exchange proposals with other jurisdictions?**



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A: CDC does not have control over applicant discussions and cannot participate in them. Applicants may speak to whomever they wish throughout the application process.

**Q: What formative work does CDC recommend we do in year one with component A funding?**

A: No formative work for Component B is expected in year 1 of NOFO PS20 2010.

**Q: Should laboratory activities be done in the first year of Component B (NOFO year 2) or should formative work be done in the first year of component B (NOFO year 2) with lab reporting in years 3,4, and 5 of the NOFO?**

A: All Component B activities including formative and operational work should start in year two of NOFO PS20 2010 after Component B funds are awarded. The start of specimen submission will be determined by CDC based on the results of the formative work and availability of samples from participating jurisdictions.

**Q: Does CDC have a long-term plan for incidence beyond the NOFO years?**

A: Long-term plans will be assessed during the development of Component B.

**Q: What are the maximum allowed number of pages?**

A: Multi-component NOFOs may have a maximum of 15 pages for the “base” (subsections of the Project Description that the components share with each other, which may include target population, inclusion, collaboration, etc.); and up to four additional pages per component for Project Narrative subsections that are specific to each component (e.g., Component B). Attachments don’t count toward the page limit.

**Q: What is the situation with the CDC designated laboratory?**

A: No information can be shared on the CDC designated laboratory at this time.

**Q: Is the expectation to collect specimens in 2021?**

A: The start of specimen submission will be determined by CDC based on the results of the formative work and availability of samples from participating jurisdictions.

**Q: Will EPMP plans be separate?**

A: Yes, a template will be provided.

**Q: Could we plan to enhance our electronic laboratory reporting capacity in Year 1 under Component A?**

A: Yes, this is appropriate.

**Q: How is RITA related to HIV clusters and outbreaks as prioritized in Pillar 4 of Component A?**

A: Component B is a separate component of NOFO PS20 2010 which would employ a recent infection testing algorithm (RITA) to assess incidence using recency testing results along with clinical data from persons with newly diagnosed HIV collected through surveillance. During cluster and outbreak investigations, recency assays may be used to inform recency of infection within a transmission cluster.



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## **Component C-specific Questions**

### **Q: Can funding be used to open or reopen STD clinics that closed due to financial challenges?**

A: The purpose of Component C is to enhance and scale up quality HIV prevention services in an existing STD specialty clinic, not to open/reopen a clinic. CDC's funding strategy is to support STD clinics that can demonstrate their capacity to scale up HIV prevention services within a year to achieve the goals of this NOFO and support EHE. Future funding to expand this activity may depend on how well awardees document their ability to: serve populations who are vulnerable to acquire or transmit HIV; implement the proposed staffing plan to provide all the required HIV and STD prevention services in a timely manner; establish appropriate referral and linkage agreements with HIV providers in the community; and report required data for monitoring and evaluation purposes. By funding sites that are more likely to succeed with the funding currently available, CDC will be able to provide a strong rationale for funding additional STD clinics if additional funds become available in the future.

### **Q: Will there be assistance in accessing the free Gilead medication program to access PrEP medication for use with Component C?**

A: Ready, Set, PrEP should be considered as resource for EHE jurisdictions working to expand the provision of PrEP to persons in their communities at risk of HIV. Recipients are encouraged to provide information about the Ready, Set, PrEP program to both healthcare providers and their uninsured and underinsured patients. Ready, Set, PrEP is an HHS-led program. Below are some resources for PrEP and Ready, Set PrEP.

- To enroll in Ready, Set, PrEP, patients must first have a prescription for PrEP. PrEP prescribers can be found through [www.locator.hiv.gov](http://www.locator.hiv.gov).
- Once a PrEP prescription has been acquired, patients can visit [www.GetYourPrEP.com](http://www.GetYourPrEP.com) or call 855-447-8410 to qualify and enroll.

### **Q: How was the total funding amount for Component C determined?**

A: STDs are associated with a higher risk of acquiring HIV, therefore CDC prioritized support for addressing STDs through PS20-2010. This work began in late 2019 with an STD PCHD supplement that awarded three pilot sites a total of \$1.3M to jump start their efforts to scale up HIV prevention services in STD specialty clinics. In addition to the STD PCHD supplement and to Component C funds, CDC has made a significant investment in STD prevention through Component A.

Depending on the local/community needs, funds available through Component A of this NOFO can support STD prevention via multiple paths:

- Up to 10% of the approved total funding amount can be used to:
  - Enhance and expand integrated screening activities conducted in conjunction with HIV testing, with accompanying referral for prevention and care services (in previous NOFOs, this had been capped at 5%); and/or
  - Diagnose and treat STDs for uninsured or underinsured people receiving care in not-for-profit or governmental clinics when conducted in conjunction with HIV testing. These facilities must



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document their ability to provide safety-net STD clinical preventive services as per CDC guidance – at a minimum, clinics receiving assistance should have the capacity to rapidly diagnose and treat bacterial STDs.

- At least 25% of the total funds directed to the local EHE jurisdictions must support community organizations, including STD clinics that meet the NOFO’s definition of a community organization.
  - Community organizations include non-profit or private organizations, American Indian/Alaska Native tribally designated organizations (e.g. tribal health programs, tribal organizations, urban Indian health programs, etc.), community-based organizations, faith-based organizations, hospitals, and health centers, including federally qualified health centers.
- Strategy 3A of Component A notes that CDC funds may be used for laboratory costs for screening or monitoring PrEP per CDC Guidelines for uninsured or underinsured people receiving PrEP in non-for-profit or governmental clinics.
  - CDC Guidelines recommend the following both at screening and semi-annual visits:
    - Tests to screen for syphilis for all adults prescribed PrEP;
    - Tests to screen for gonorrhea for all sexually active adults prescribed PrEP; and
    - Tests to screen for chlamydia for all sexually active MSM prescribed PrEP.

Should additional resources become available, CDC anticipates scaling up Component A and Component C activities.

**Q: Are health departments jurisdictions limited to applying for one clinic or multiple clinics?**

A: More than one STD specialty clinic can be considered for Component C funding in a jurisdiction. Each jurisdiction can submit one application that includes the core component (Component A) and the optional components that they wish to apply for (Component B and/or C). If a jurisdiction contains multiple eligible STD specialty clinics, a Component C application for each eligible clinic should be included within the one application the jurisdiction submits for PS20-2010. For example, if a jurisdiction is applying for Component C funds for four eligible STD specialty clinics in their PS20-2010 application, each clinic will need a separate project and budget narrative so that each clinic can be evaluated separately during the three-phase review process. If CDC cannot identify separate project and budget narratives for each eligible clinic within the Component C portion of a jurisdiction’s application, the jurisdiction’s STD specialty clinics will not be considered eligible for funding. The Component C funding ceiling provided per jurisdiction should be considered the total ceiling for each clinic.

**Q: Will the funding require tracking of prescription savings accumulated from 340b purchased medications?**

A: No, CDC will not require recipients to track these purchases under Component C.

**Q: How will the STD specialty clinics receiving Component C funds be selected? What metrics will be used to determine funding?**

A: Applications will be reviewed in three phases. In Phase I, applications will be reviewed for eligibility and completeness by the Office of Grants Services. Complete applications will be reviewed for responsiveness by Grants Management Officials and Program Officials. In Phase II, an objective review panel will evaluate complete, eligible applications in accordance with the criteria and scoring breakdown included in the application package. In Phase III, a technical review process will be conducted by CDC to provide feedback to



all applicants on the proposed program. Component C applications will be funded in order by score and rank determined by the review panel; geographic distribution and morbidity may also be considered in the final funding decisions.

**Q: Do the STD specialty clinic eligibility requirements for Component C also limit a clinic's ability to receive funds that would strengthen infrastructure, and ultimately limit the benefit to the jurisdiction?**

A: CDC's funding strategy is to support STD clinics that can demonstrate their capacity to scale up HIV prevention services within a year to achieve the goals of this NOFO and support EHE. Future funding to expand this activity may depend on how well awardees document their ability to: serve populations who are vulnerable to acquire or transmit HIV; implement the proposed staffing plan to provide all the required HIV and STD prevention services in a timely manner; establish appropriate referral and linkage agreements with HIV providers in the community; and report required data for monitoring and evaluation purposes. By funding sites that are more likely to succeed with the funding currently available, we will be able to provide a strong rationale for funding additional STD clinics if additional funds become available in the future.

Please remember that STD clinics who do not currently offer all required services listed in the NOFO can still apply and be considered for funding. The applicant will need to include detailed plans in their application outlining how they will make these services available onsite within the first 12 months of the project.

**Q: How are "STD specialty clinics" defined? How are specialty clinics different from the traditional STD clinics?**

A: A functional STD specialty clinic is one that has the following services available onsite (or can provide detailed plans to have these services available onsite within the first 12 months of the project):

- STAT syphilis test
- Microscope for STAT Gram stain/Methylene Blue/Gentian Violet and wet mount
- Gonorrhea culture capacity
- Medications on site including Benzathine Penicillin LA and ceftriaxone

CDC's [Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020](#) (or STD QCS) outline the services that healthcare facilities can offer to provide the highest-quality STD care. If by "traditional STD clinic" you are referring to a primary care setting (including HIV care and family planning) that also offers STD services, that is not the same as an STD specialty clinic. STD QCS highlights CDC's recommendations based on clinical setting type – primary care or STD specialty care. We encourage you to view the report for additional details.

**Q: Where can I find additional information about the *Ready, Set, PrEP* program?**

A: <https://www.getyourprep.com/>

**Q: Does Component C require any funded staff to be at 50% or more level of effort (LOE) as Component**

A: No, this is not a requirement in Component C.



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**Q: If each STD specialty clinic will be evaluated separately, should the funding ceiling provided per jurisdiction be considered a total ceiling for each clinic?**

A: Yes – the Component C funding ceiling provided per jurisdiction should be considered the total ceiling for each clinic.

Each jurisdiction can submit one application that includes the core component (Component A) and the optional components that they wish to apply for (Component B and/or C). If a jurisdiction contains multiple eligible STD specialty clinics, a Component C application for each eligible clinic should be included within the one application the jurisdiction submits for PS20-2010. For example, if a jurisdiction is applying for Component C funds for four eligible STD specialty clinics in their PS20-2010 application, each clinic will need a separate project and budget narrative so that each clinic can be evaluated separately during the three-phase review process. If CDC cannot identify separate project and budget narratives for each eligible clinic within the Component C portion of a jurisdiction’s application, the jurisdiction’s STD specialty clinics will not be considered eligible for funding.

**Q: Will a work plan template be provided for Component C?**

A: Yes, a sample work plan for Component C is available and can be found on the PS20-2010 [Attachments and Important Resources page](#). The use of this template is optional.

**Q: If a jurisdiction’s STD clinic does not meet the eligibility requirements in the NOFO, should they still apply for Component C funds and why?**

A: CDC is encouraging all jurisdictions with an STD clinic to apply for Component C. Please remember that STD clinics who do not currently offer all required services listed in the NOFO can still apply and be considered for funding. The applicant will need to include detailed plans in their application outlining how they will make these services available onsite within the first 12 months of the project.

Component C will fund 5-8 STD specialty clinics during the first year of award. The total number of applications received will indicate interest and need for this project and will strengthen the rationale for funding additional STD clinics if additional funds become available in the future.

**Q: Should jurisdictions with clinics that do not currently have any experience providing STD screening and treatment apply for Component C funds?**

A: The purpose of Component C is to enhance and scale up quality HIV prevention services in an existing STD specialty clinic, not to introduce STD services to a public health clinic. While STD clinics who do not currently offer all required services listed in the NOFO can still apply and be considered for funding, the applicant will need to include detailed plans in their application outlining how they will make these services available onsite within the first 12 months of the project.

CDC’s funding strategy is to support STD clinics that can demonstrate their capacity to scale up HIV prevention services within a year to achieve the goals of this NOFO and support EHE. Future funding to expand this



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activity may depend on how well awardees document their ability to: serve populations who are vulnerable to acquire or transmit HIV; implement the proposed staffing plan to provide all the required HIV and STD prevention services in a timely manner; establish appropriate referral and linkage agreements with HIV providers in the community; and report required data for monitoring and evaluation purposes. By funding sites that are more likely to succeed with the funding currently available, CDC will be able to provide a strong rationale for funding additional STD clinics if additional funds become available in the future.

### **Additional Questions**

**Q: How many Principal Investigator(s) may we include on the integrated NOFO application?**

A: With the submission of your application, please include 1 Principal Investigator (PI) and 1 Business Official. After the NOFO has been awarded, grantees may complete a “new user form” to add an additional PI, if needed.

**Q: In the MMWR vital signs article published in December 2019 (vol 68, no. 48), PrEP coverage was presented by state for 2018. Are data available for PrEP coverage from the prior 4 years (2014 to 2017)?**

A: At this time, PrEP coverage data are only available by state for 2018 and are presented in the MMWR Vital Signs published Dec 2019 (vol 68, no. 48).

