Michigan Department of Community Health
Division of Chronic Disease and Injury Control
HIV Care Section (HCS)

CARE COORDINATION REQUEST FOR PROPOSAL

August 8, 2014

Applicants must meet submission requirements in this Request for Proposal (RFP) to be considered for a contract. Failure to comply with these requirements will disqualify applicants without further consideration. Each applicant is responsible for the preparation and submission of a proposal in accordance with instructions. A Letter of Intent to submit a proposal must be submitted no later than September 1, 2014. The form can be found in Appendix I. The Proposal Checklist (Appendix VI) and Service Category Definitions (Appendix VII) can be found at the end of this RPF for your reference.

READ ALL MATERIALS BEFORE PREPARING THE PROPOSAL

A. Introduction and Background

Over the last several years there have been some significant developments affecting HIV Care and Treatment:

- Scientific evidence that Anti-Retroviral Treatment (ART), which works to suppress the virus in people living with HIV, not only provides clinical benefit, but it can also significantly reduce the risk of HIV transmission.
- Passage of the Affordable Care Act (ACA) will dramatically expand health insurance coverage for millions of people in the U.S., including people living with HIV.
- The National HIV/AIDS Strategy (NHAS) established goals of reducing HIV incidence, increasing access to care, and reducing HIV related health disparities.

Understanding these changes has led to a new way to look at Ryan White funded HIV Care in Michigan. This RFP is the first in a series of steps that will support a transition to focus on the following strategies that will produce improved health outcomes for people living with HIV in Michigan.

- Support people with HIV at each stage of the treatment cascade from diagnosis to viral suppression.
- Build HIV Care Networks in underserved communities.
- Integrate HIV care expertise into the mainstream health care system.

The premise of coordinated care is that all HIV-infected persons, also referred to as Persons Living with HIV (PLWH), in Michigan should have access to:

- Comprehensive and holistic healthcare situated in a medical home as defined by the American College of Physicians, and
- Health promotion to promote self-sufficiency, optimal health and risk reduction.

As needed, PLWH should receive assistance:

- Navigating the healthcare and social services systems
- Coordinating logistics such as transportation and childcare to ensure that they have ready access to their care providers
- Reviewing their eligibility for government-funded benefits and programs to provide the best possible financial assistance, medical insurance and stable housing
- Receive training on the key principles of chronic disease management and client-self management
- Benefit from an effective flow of health information between their primary care providers, specialist and a care coordination team
- Overcoming personal and contextual barriers to antiretroviral treatment (ART) adherence

All PLWH should expect that critical health information is available to providers as needed, and that adequate security measures are in place to safeguard confidentiality.

The intent of this RFP is to put all of these program goals together in a Care Coordination Model of service delivery. Care coordination is the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services throughout the HIV continuum of care. In this definition, all providers working with a particular patient share important clinical information and have clear, shared expectations about their roles. Equally important, they work together to keep patients and their families informed and to ensure that effective referrals and transitions take place, clients are engaged and retained in care, health outcomes are improved and viral load is suppressed. This service delivery model has been tested and implemented in chronic disease programs throughout the country for a number of years, but it has only been in the last five years or so that it has been adapted to HIV Care. The following list of resources may be useful as you develop your program description for this RFP:

1. Unique People Services – Care Coordination Program
2. NYC Care Coordination Program Tools
3. Indiana HIV Care Coordination Program
4. Baton Rouge HIV Care Coordination
5. Kentucky HIV Care Coordination Program
6. Improving Chronic Illness Care – Care Coordination Model
7. Oregon HIV Care Coordination
8. Michigan State Innovation Model Design Proposal (SIM)

In Michigan, it is estimated that 18,591 persons are living with HIV infection, including 3,346 (18%) who are unaware of their infection. While advances in medical care for PLWH have been significant, disparities exist in health care access and health outcomes for PLWH. Factors associated with poorer health outcomes include belonging to a racial/ethnic minority group, being an injection drug user, having a mental illness, being of a lower socioeconomic status, and from other high-risk groups. Many of these factors coexist among persons belonging to racial/ethnic minority groups in Michigan and accordingly these groups are more likely to be out

of care and access care later. These factors make the facilitation of access to and maintenance in HIV primary care a priority.

In the past decade, advances in HIV/AIDS treatment have resulted in lower mortality and longer life expectancy for PLWH. Greater disease prevalence in turn places greater demands on the HIV care system. At the individual level HIV has evolved into a chronic illness; this requires a broad range of specialized services to meet patients' needs and the development of skills among patients to better facilitate self-management of HIV infection. Despite advances in treatment and increased life expectancy for PLWH, HIV treatment remains challenging. A high level of adherence to ART is needed to achieve viral load suppression. A suppressed viral load is associated with better health outcomes and reduced potential for HIV transmission per risk encounter. The high adherence requirements of ART and the lifelong nature of HIV treatment are difficult and best met by those in stable life situations or with strong support systems. The complexity of HIV -related services makes navigation of the system(s) and accessing services difficult for those who are unaccustomed to the system.

The development of a Michigan Care Coordination Program (hereafter referred to as the "Program") seeks to address HIV healthcare disparities by facilitating access to care and other services via medical case management, navigation, promotion of self-reliance and patient education. It aims to combine elements of the HIV Navigation Model and the Chronic Care Model to define and implement an HIV specific Care Coordination Model within the integrated HIV continuum of care. With increased treatment efficacy, early and continuous engagement in medical care is more important than ever for improving patient outcomes. To that end, factors associated with poor adherence to medical care plan and antiretroviral medications need to be addressed. These factors include: mental illness; substance abuse; inadequate housing; lack of transportation; legal difficulties; inadequate access to food; being of racial/ethnic minority; social stigma; lack of knowledge about HIV/AIDS; health care provider bias and miscommunication; health care provider lack of knowledge or adherence to HIV/AIDS clinical guidelines. Once barriers to treatment have been eliminated and the patient is receiving adequate care, vaccinations, screenings and treatment, she/he should experience a decrease in viral load (VL), an increase in CD4 counts, and advances in disease stage would be reduced with adherence to their prescribed ART medication. By reducing VL in individuals and periodic assessment of HIV transmission risk with harm reduction counseling and partner notification where needed, HIV transmission may ultimately be reduced in the community.

The Michigan Department of Community Health, HIV Care Section (MDCH/HCS) is issuing this competitive RFP to support efforts for HIV Care Coordination to provide services to medically underserved PLWH to improve health outcomes and ultimately achieve viral load suppression. Specifically, this Care Coordination RFP will fund a community network of services that will seek out and engage individuals who can benefit from an integrated approach to alleviate barriers to care and ongoing support to maintain a relationship with a patient centered medical home.

Funds for this RFP are to be used only where existing federal, state, and local funds are not adequate and will supplement and not supplant existing funds for services.

Applicants must demonstrate need based on epidemiological data specific to the area served and the network of providers in the care coordinated plan. HIV/AIDS surveillance reports that will be useful in preparing proposals include, the Michigan HIV Treatment Cascades Annual Indicator Reports, County Level Analysis, Unmet Needs Analysis, Special HIV/AIDS Data Analysis Reports, Annual Review of HIV Trends and Epidemiological Profiles respectively. Data from the MDCH HIV Surveillance program can be accessed at:
http://www.michigan.gov/mdch/0,4612,7-132-2944_5320_5331---,00.html

This competition is open to organizations that currently contract with the MDCH/HCS and organizations that do not currently have a contract with MDCH/HCS.

Health Equity

The RFP supports efforts to improve the health of populations disproportionately affected by HIV 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.

Applicants should use epidemiologic and social determinants data to identify communities disproportionately affected by HIV and related diseases and conditions within their community. 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 partner 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.

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. 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. 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. In addition, income was shown to be an important predictor of a lack of health insurance among persons with HIV and 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.

Details of the health equity strategy and approach are outlined in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Social Determinants of Health White Paper.

B. Available Funds

The MDCH/HCS expects to award grants totaling approximately $3 million for each year of a three year period. The expected number of awards is four-six. (pending State Administrative Board Approval)

Agreements will be issued to agencies that compete successfully under this RFP based on the State of Michigan Fiscal Year (October 1 – September 30). Year one agreements will start on January 1, 2015. Agreements will be reviewed on an annual basis for funding purposes and evaluation; subsequent allocations will depend on performance and evaluation.

The amount requested must correlate with the number of underserved HIV clients who will be enrolled in and receiving services from the applicant network, and the scope of the care coordination plan.

C. Components of Care Coordination

1. Planning and Development

The Applicant agency engages local providers and other interested parties to come together to identify and define needs, set priorities, establish goals, create a plan to facilitate coordination of care that will result in improved health outcomes for PLWH in a community, county or region. This initial phase can extend up to six months of the first year of the funding cycle.

2. Care Navigation

Care Navigation guides patients in knowing where, when, and how to access all health and related services, and increases access to appropriate resources. Care Navigation services include the coordination of:

- Primary medical care
- Specialty care
- Mental health care and substance abuse services
- Imaging and other diagnostic service
- Laboratory services
- Health insurance
- Housing
- Benefits/Entitlements/Public Assistance

3. Health Promotion and Improved Health Outcomes

The Program would ensure that persons infected with HIV will receive assistance from a Care Coordination plan that will:

- Promote health literacy for all patients, and care coordination team, on the biology of HIV, disease management, communication with providers, risk reduction and healthy behavior, and ART adherence via a structured curriculum.

- Have logistical support to facilitate access to and retention in care
- Benefit from an effective flow of health information between their primary care providers, specialists and care coordination team
- Provide medical case management and support services to improve health outcomes
- Improve oral health care
- Improve medication, immunizations and health screening compliance for patients and providers
- Promote treatment adherence and ultimately achieve viral suppression

4. **Benefits counseling and social support**

The Program is primarily responsible for assessing social services and benefits needs, in the event that no other clinic personnel have conducted such a review. The initial assessment of social services needs and benefits eligibility, (housing needs, health insurance, etc.) would occur within two weeks of enrollment into the Program.

There are certain factors that help with Care Coordination. The Program should ensure that patients have maximal access to support from their community peers.

Priority Populations

Proposals should target individuals who are at least 18 years of age and meet one or more of the following criteria:

1. Newly diagnosed with HIV
2. Lost to care as defined by having at least one primary care visit in the past two years and not having any primary care for the past nine month
3. Difficulty keeping appointments
4. Receive sporadic, irregular care
5. Never been in care
6. Have indications of ART challenges and have not achieved viral suppression

Duration of Enrollment in Program

Duration of enrollment should be considered on a case by case basis; targeted outcome should include suppression of viral load with viral load monitoring and improved health outcomes.

D. Applicant Eligibility

It is expected that the applicant agency will represent a network of agencies that is capable of providing the range of services required, rather than apply as an individual service provider. One entity will act as the fiscal agent for the network. This entity will be the sub-recipient to MDCH, and will enter into sub-contracts with the other entities in the network. MOUs, contracts or Letters of Agreement should be included in the application which demonstrates the relationship or a credible plan with evidence that the network development is underway.

Any Community Based Organization (CBO) or Non-Governmental Organization (NGO) applying under this RFP must have been certified by the Federal Internal Revenue Services (IRS) as a 501(c) (3) Organization prior to January 1, 2014. A Copy of the IRS certificate of non-profit status must be included as an attachment to the proposal. Proposals from CBOs which are

lacking documentation of tax exempt status will not be reviewed and will be ineligible to receive funding under this RFP.

All applicants must document both the Medicaid provider status within their network and the Essential Provider status within Qualified Health Plans. While each entity is not required to be a Medicaid and/or QHP provider, it is expected that all services that can be billed, will be billed. A service may be considered "not billable" because no insurance company includes it as a benefit or because the person served is uninsured (e.g., undocumented immigrant, or, despite all reasonable efforts, refuses to seek insurance).

All networks must include adequate providers to serve the target population and document that they are fully licensed to provide clinical services, as required by state and/or local jurisdiction. Medicaid provider status and licensure should be in place prior to submitting an application.

Proposals that do not provide clear and convincing evidence of strong community ties and experience in service of the proposed target population(s) will not be selected for awards. Collaboration with other relevant service providers, groups or organizations is strongly encouraged, particularly as it relates to facilitating the integration of services to improve health outcomes.

Eligible Applicants include:

1. Government Organizations
    a. Local public health departments
    b. Native American Tribal Governments (federally recognized and other than federally recognized).
2. Education Organizations
    a. Public, private and state institutions of higher education with demonstrated experience in providing services to persons infected with HIV/AIDS.
3. Medical Clinics
    a. Federally qualified health centers (FQHCs).
    b. Health facilities operated by or pursuant to a contract with the Indian Health Service.
    c. Clinics, hospitals, providers, and other health facilities.
4. Other
    a. Nonprofit private entities that provide comprehensive primary care services to populations at risk of HIV/AIDS including faith-based and community-based organizations.

Ineligible applicants include:

1. Organizations that do not have the capacity to treat and support individuals at risk for/or living with HIV/AIDS.

The eligible applicant will submit an application on behalf of a locally created network of providers that can ensure the delivery of the range of services which meets the expectations specified in this RFP.

E. Program Requirements

1. Eligibility for Ryan White services

To be eligible for MDCH-funded Ryan White services, an individual must meet the following criteria:

- Must be HIV-positive
- Must reside in the state of Michigan
- Must be low income, not to exceed 450% of the federal poverty level
- Must be underinsured or uninsured for applicable Ryan White services that are reimbursable through third party payers

Proof of eligibility criteria must be collected and documented in the client's health record and recertification of eligibility for individuals must be completed at a minimum every six months. In addition, MDCH-funded Ryan White agencies must develop agency-specific policies and procedures that outline how eligibility and recertification is conducted.

In compliance with Health Resources and Services Administration (HRSA) Universal and Program Monitoring Standards, additional eligibility criteria may be developed specific to a service category, especially to ensure that clients with the most complex and urgent needs are served.

For more information on Ryan White initial eligibility and recertification, refer to the MDCH Ryan White Program Guidance #14-01 (revised 7/25/2014) by following the link here or referring to Appendix IV.

2. Standards and Other Requirements

Funded agencies must adhere to all federal, state, and local laws, policies, and statues.

Development of a Care Coordination Plan within six months of receipt of funding.

Upon completion of the Care Coordination Plan, funded agencies will be required to implement services in accordance with the following established federal and state standards:

- HRSA, National Monitoring Standards for Ryan White Part A and part B Grantees; Universal-Part A and B. For more information, please click here.
- HRSA, National Monitoring Standards for Ryan White Part B Grantees: Program-Part B. For more information, please click here.
- HRSA, National Monitoring Standards for Ryan White Part B Grantees: Fiscal-Part B. For more information, please click here.
- MDCH, Universal Standards for Michigan Department of Community Health—Continuum of Care Funded Agencies in Michigan. For more information, please click here.
- MDCH, Standards of Service for HIV Case Management in Michigan Medical and Non-Medical. For more information, please click here.
- Cultural and Linguistically Appropriate Standards (CLAS). For more information, please click here.

NOTE: *The MDCH standards mentioned above are being updated with completion projected by December 31, 2014. MDCH will collaborate with funded agency to provide training and technical assistance to integrate updated standards.*

3. **Data Requirements**

Funded agencies will be required to ensure data is entered into CAREWare either through direct data entry (or development of interfaces to transfer data into CAREWare system) to document and report, at minimum, client-level uniform reporting service data, units of service per service category, and performance measurement data. For further information on CAREWare, please click here. MDCH will provide the definitions of units of service and sub-service categories by service category (i.e. MCM Assessment for medical case management) to help agencies code their service delivery into data input. In addition, all services provided in a given month must be entered and updated into CAREWare by the tenth of the next month.

Funded agencies are responsible for ensuring that only essential staff members at their organization have access to CAREWare. Essential staff members are those involved in the provision of direct service delivery, data entry, data transfer and/or data management. To activate a new staff member, funded agencies must follow MDCH-established protocol. When a staff member is no longer directly involved in MDCH-funded services or data management, the agencies must contact MDCH within two weeks to inactivate the username.

For more information on CAREWare follow this link:
http://hab.hrsa.gov/manageyourgrant/careware.html

4. **Meetings**

The applicant agency will be required to participate in quarterly conference calls and two mandatory grantees' meeting each contract year. At these meetings, agencies may present best practices, network with other funded agencies, discuss program evaluation, and/or receive technical assistance or contract guidance from MDCH.

5. **Needs Assessments and Statewide Planning**

Funded agencies are required to participate in ongoing needs assessments and statewide planning as needed by MDCH. This may include meetings, client surveys, focus groups, disseminating results and plans, etc. Agencies are expected to have a thorough understanding of gaps in their geographic area as well as the needs of their target population.

F. Monitoring, Evaluation and Quality Management

Agencies awarded funding under this RFP will be required to submit:

1. Ongoing client-level data via the CAREWare system.
2. Monthly financial status reports via the Electronic Grants Administration and Management System (EGrAMS).
3. Biannual progress reports according to a format and guidelines established by MDCH/HCS.

4. A quality management plan by the end of year one. Report progress within the biannual progress report.

MDCH/HCS will conduct annual programmatic and fiscal site visits to ensure compliance with standards, policies, and statues. Agencies awarded funding under this RFP will be required to establish a quality management infrastructure to provide continuous quality improvement as an aspect of care coordination and participate in an MDCH/HCS program evaluation.

G. Reimbursement

Agencies are reimbursed on a monthly (or quarterly for local health departments) basis for expenditures incurred. Grantees will be required to prepare, and submit monthly financial status reports (FSRs). All expenditures must be in compliance with HRSA standards and MDCH/HCS guidance.

H. Format Requirements

Proposals should follow these submission guidelines in order to be considered eligible for funding:

1. Sequentially number all pages, including attachments. Attachments do not count in the page limitation.
2. Include a table of contents and a list of attachments for the entire package submitted. These pages do not count in the page limitation.
3. Submit the entire document as a PDF document.
4. Use 12 point font, only, for the narrative documents, either Arial or Times New Roman. Budgets, figures, charts, tables, figure legends, and footnotes may be slightly smaller in size, but must be readily legible to be considered.
5. Use 1" margins (top and bottom, left and right)
6. Adhere to page limits for each section of the proposal narrative as indicated in Section I. Proposal Outline. Page limits specified in this RFP refer to single-spaced pages.

I. Proposal Outline

Agency Profile Form (not included in page limit)

This form provides a summary of your proposal and can be found in Appendix V.

Agency Capacity [Maximum two (2) pages]

This section addresses the expertise and experience of the applicant agency in providing or supporting the proposed services.

1. **Agency Mission:** What is the applicant agency's mission?
2. **Service Provision History:** What is the applicant agency's history and experience relevant to the provisions of proposed service? Experience and success of such efforts should be supported with quantitative and qualitative data, if available.

3. **History with Target Population:** What is the applicant agency's history and experience relevant to the provisions of services to target population(s)? Experience and success of such efforts should be supported with quantitative and qualitative data, if available.
4. **Collaboration:** Because proposed programming is to be carried out through collaboration between two or more agencies, provide a description for each collaborating agency that includes relevant qualifications and capacity, according to the criteria listed previously. Collaborative relationships must be supported with specific, detailed and current MOUs, MOAs, Letters of Agreement or contracts.
5. **Required Attachments from the applicant agency (not included in page limit):**
    - 501(c)(3) certification, if applicable. (Attachment I)
    - Board of Directors description including names, position on Board, professional affiliations and expertise represented. (Attachment II)
    - Organizational chart which clearly identifies positions in the organization and reporting relationships relevant to this proposal. (Attachment III)
    - Most recent independent financial audit or financial statements if audit is unavailable. (Attachment IV)
    - A description of other programs within the agency and sources of support. This attachment should describe total agency budget, by program. HIV services must be described by **type of service**. Forms available in the List of Attachments section. (Attachment V)
    - Memoranda of Agreement, Memoranda of Understanding, Letters of Agreement or Contracts. (Attachment VI)
    - Letters of Support. (Attachment VII)
    - Certificate of Liability Insurance. (Attachment VIII)
    - Federally Approved Indirect Cost Rate, if applicable (Attachment IX)
    - Program Narrative (Attachment X)

Program Description [Maximum ten (10) pages]

Describe how your network proposes to implement the care coordination model. This should include efforts to bring more people who are "out of care, into care," linkages with other systems, new and expanded services to be offered, and innovative changes in the service delivery system. The program plan should identify the services intended to serve the target population. Describe the network's intended service area, both in terms of geography and demographics.

1. Describe the network's plan to reach these areas. The network is encouraged to develop innovative activities or approaches that improve the service delivery system.
2. Describe, specifically, why these areas were selected for services.
3. Describe service(s) for target population within the Care Coordination Network for this application. Refer to Appendix V. Describe the operational structure of the Care Coordination Network: communication strategies, accountability within the network, data sharing, etc.

Statement of Need [Maximum six (6) pages]

This section should include detailed information about the target population, and the unmet needs for services. Provide support for identified HIV care needs, preferably through the use of

local or agency data. Although you may refer to information from the State of Michigan HIV/AIDS data, Statewide Needs Assessments or Statewide Prevention Plan in this section, it is **not** necessary to restate this information in detail.

1. Describe the proposed target population and geographic area to be served.
2. Describe this population's unique care challenges.
3. Describe the specific behaviors which placed this population at risk.
4. Describe how your network knows this information, how you came to the conclusions that you did, and how the network will meet the needs of your targeted population.
5. Describe the network's experience and strategies for identifying and linking to services, those individuals that know they are HIV+ but are not receiving HIV primary medical care, as well as those who do not know their HIV status or risks for HIV, and how you propose to reach those individuals and link them to care. Additionally, describe the network's plan to keep these individuals linked to care once they are in care, and how this will be documented.
6. Identify methods used to assess target population needs, and target population input in the development of the proposed program. What process and data did the network use to assess these needs? Describe the specific services used, including the number of participants included in each service.
7. Identify gaps in service and what other programs currently address the identified needs of the proposed target population in your community, and how your proposed program addresses these gaps in service, or complements existing services. Ensure the cultural, linguistic and developmental competence of interventions and materials.

Service Delivery Plan [Maximum ten (10) pages]

1. **Geographic Service Area:** What are the specific geographical service area(s) which will be served, and why was/were the area(s) chosen? Applicants can propose to serve a community, a county, or a region. If proposing a regional service provision, list what percent of services will be conducted in each community, city or county.

2. **Recruitment:** Describe how clients will be recruited; include venue-based or electronic outreach, internal or external referrals or other program promotion strategies. Describe the role of community providers and partners that will be instrumental in reaching the target population, their role should be clearly stated, and letters of commitment from these partners should be included as attachments.

3. **Start-Up Period:** When will services begin? Networks awarded funding under this RFP will be expected to have programs staffed and a Care Coordination plan within six months of receipt of award.

4. **Process Objectives:** State measurable process objectives related to providing the proposed services and the operational structure of the network for each of the three years of the project

period. Objectives for Year 1 include development of an operational care coordination plan and should include indication of when you anticipate service delivery will start. Objectives should specify both the number of services proposed as well as the anticipated number of target population members participating in each service.

5. **Outcome Objectives**: Describe the expected outcomes of the project for each of the three years. Use the implementation plan to complete this section (See Appendix II or click here)

Implementation Plan (not included in page limit)

Implementation Plan template can be found in Appendix II. Complete and submit a separate template for each Ryan White Service selected.

Budget Documents (no page limit)

Listed below are the required budget forms for submission. All budget documents are contained within one linked spreadsheet, the Budget Tool. A separate attachment provides detailed instructions on completing the budget documents within the Budget Tool (See Appendix III).

1. **Funding-Year 1:** Applicants are to complete the Funding-Year 1 form, which will reflect the total agency request for funding the first year. The financial details are automatically drawn from the details provided in the Budget Justification.
2. **Staffing Plan:** Applicants are to prepare a detailed Staffing Plan for each agency in the network.
3. **Budget Justification:** Applicants are to develop a single budget justification for the proposal for Year 1 (Jan. 1, 2015- Sept. 30, 2015). Provide detailed descriptions of planned expenditures, including justification and rationale. All budget line items must be described in the budget justification. Years 2 and 3 will be required at a later date, if funded.
4. **Service Description Form:** Applicants are to complete the Service Description Form by summarizing the service(s) they are proposing in this RFP.
5. **Three Year Summary Funding:** Applicants are to complete a high-level overview of their budgets for Years 2 and 3 of the project. Year 1 information will be automatically populated into this form when other budget documents are completed.

All budget forms submitted with your application package (excluding the Three Year Summary Funding form) should only reflect the funding for Year 1. A new set of these forms will be required at a later date for Years 2 and 3.

J. Review and Evaluation of Proposals

All proposals that are submitted on time will undergo a preliminary evaluation for completeness by the Grants and Contracts Technician. Applicants who fail to include all required elements of the proposal package, as described in the proposal checklist, will be ineligible to receive funding under this RFP, and proposals will not be evaluated further.

The complete proposal submitted in response to this RFP will be evaluated by the review panel and scored by the established criteria:

Section I Care Coordination: 35%

Components of Care Coordination
Priority Populations

Section II Agency Capacity: 25%
Agency Mission
History with Target Population
Service Provision History and Collaboration
Attachments

Section III Program Plan: 30%
Description of the Program
Statement of Need
Proposed Service(s)
Service Delivery Plan

Section IV Program Budget: 10%
Funding – Year 1
Staffing Plan
Budget Justification
Service Description Form
Three Year Summary Funding

MDCH/HCS reserves the right to consider criteria in addition to reviewer's scores in making final decisions regarding programming and awards. These criteria include but are not limited to: resource availability, gaps in services, agency capacity, and other factors relevant to addressing changing needs and priorities. MDCH/HCS has the final authority for decisions related to the allocation of funding and resources available through this RFP.

K. Technical Assistance

HIV Care Section staff will provide technical assistance to agencies applying for this RFP. A Technical Assistance Conference Call will be held on Friday, August 15, 2104 at 10:00-11:30 am. The call in number is 888.251.2909, access code: 3290334.

Questions concerning the RFP are to be submitted electronically before 5:00 pm by September 4, 2014 to:

Hope McElhone, Grants and Contracts Technician, at **mcelhoneh@michigan.gov** between August 8 and September 4, 2014.

All questions must be submitted in writing and sent electronically as an attachment in Microsoft Word or Rich Text Format (RTF). Changes to the RFP and answers to questions will be prepared as an addendum and posted on MDCH's web site. The posted addendum officially revises and supersedes the original RFP. The questions and answers addendum will be posted approximately September 19, 2014. Answers and guidance related to each question will be either answered at the Technical Assistance Conference Call and/or posted on the website.

The Letter of Intent is due September 1, 2014 and should be submitted as an attachment to an email to Hope McElhone (see above). The proposal timeline is as follows:

- **Proposals are due on October 15, 2014 by 11:59 pm Eastern Daylight Time**.
- **Agencies will be notified of award on November 7, 2014.**
- **Proposals will be implemented January 1, 2015.**

L. List of Appendices

I. Letter of Intent Template
II. Implementation Plan-Service Categories with Objectives
III. Budget Tool Instructions
IV. Ryan White Program Guidance #14-01
V. Evaluation Tool
VI. Agency Profile
VII. Proposal Checklist
VIII. Service Category Definitions

Exhibits:

A. Budget Forms: Excel Workbook
B. MDCH Standard Agreement Boiler Plate Language
C. FY14-15 Standard Agreement Exhibit C (Reporting Requirements)

APPENDIX I:

LETTER OF INTENT FORM

Care Coordination RFP

Must be sent to mcelhoneh@michigan.gov by **5 PM EST on September 1, 2014**

Lead Agency:		
Contact Person:	**Name:**	
	Title:	
	Email Address:	
	Phone Number:	
Geographic Area to be Served:		
Name of Agencies in the Network		**Type of Agency (e.g. local health department, community based organization, hospital, federally qualified health center, medical clinic, etc.)**

APPENDIX II

CARE COORDINATION IMPLEMENTATION PLAN

Complete one page for each service category to be provided. Include the page number out of the total pages in the Implementation Plan. Specify the requested funds for each service. Develop a Specific, Measurable, Achievable, Realistic and Time Scaled (SMART) goal for each service and SMART objectives to implement the goal. If you have more than one goal, use a second page for the second goal for the same service. Estimate the funds needed for each objective.

Agency: _____

Service:					**Total Allocation: $ _____**
Service Goal:					
1. Objectives: List quantifiable time-limited objectives related to the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to each objective listed.	**5. Funds:** Provide the approximate amount of funds to be used for each objective.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
6. From the Objectives above, list one or more planned outcome measures to be tracked, and include benchmarks for each outcome measure:					

APPENDIX III:

Sub-Recipient Budget Instructions for Care Coordination RFP

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I. INTRODUCTION TO BUDGET PACKAGE

This budget package is to be used for all awards issued and administered by the Michigan Department of Community Health (MDCH) Division of Chronic Disease and Injury Control for HIV Care Section. The package has been prepared to provide complete budget information as required under Federal Cost Principles and all other requirements of Federal, State, and Local grantors.

The budget summary and justification forms should be completed carefully in accordance with the instructions provided below. Please be aware that you must provide justification for all costs at the level of detail requested in these instructions.

II. GUIDELINES FOR DETERMINING TYPES OF COSTS

There are two types of costs: program and administrative costs. For the purposes of this RFP, all costs, both program and administrative, must be accounted for as direct costs.

a. Program costs are defined as the costs incurred for direct service delivery. These costs are normally only incurred as a direct result of providing a specific service to a client or his or her family members.

   Examples of program costs are:

   - Salaries and related employee benefits for staff who provide direct services to clients, their clinical supervisors and other staff who directly assist these individuals in the provision of services
   - Consultants who provide direct services to clients, develop program materials, or perform other program functions
   - Program supplies such as educational materials, medical supplies and other supplies that are used specifically for this program
   - Office supplies that directly support program activities such as folders for client charts
   - Travel costs for program staff
   - Printing and photocopying of medical forms, program materials and other materials used by or for program participants
   - Equipment used for direct service delivery
   - Maintenance of client records, including client and service data entry

b. Administrative costs are defined as the costs incurred for usual and recognized overhead, including established indirect rates for agencies; management and oversight of specific programs; and other types of program support such as quality assurance, quality control and related activities.

   Examples of administrative costs are:

- Salaries and related employee benefits for accounting, secretarial and management staff, including those individuals who produce, review and sign monthly reports and invoices
- Consultants who perform administrative, non-service delivery functions
- General office supplies
- Travel costs for administrative and management staff
- General office printing and photocopying
- General liability insurance associated with administrative staff or space
- Audit fees

As mentioned above, administrative costs can be direct or indirect. Both program and administrative costs, as defined above, can be direct costs if they are directly attributable to the program.

c. Direct costs are costs that can be directly charged to the program and which are incurred in the provision of direct services.

Examples of direct costs are:

- Salaries and related employee benefits for staff who charge their time directly, on the basis of actual time worked, to the program or project for which they work
- Expenses related to staff that are direct-charged, including recruitment costs and travel expense
- Telephone expenses related to a unique telephone number or an extension for which expenses can be determined and substantiated on an actual or allocated basis
- Space costs and related expenses for facility space that is used only for funded activities, for which expenses can be determined and substantiated on an actual or allocated basis
- All program supplies, as defined above
- Other expenses that are both directly attributable to the program and consistently treated, on an agency-wide basis, as direct costs

III. SUMMARY OF UNALLOWABLE COSTS

Below is a summary of unallowable costs; it is not intended to be a complete or definitive listing. Agencies are responsible for referring to the documents referenced below for complete guidelines.

The following costs are not permitted under the Public Health Service Grants Policy Statement and *OMB Circular A-122*:

- Bad debts
- Capital improvements
- Contingency provisions

- Contributions and/or donations to others
- Depreciation expenses as a direct cost and as related to federally-funded equipment
- Entertainment costs
- Fines and penalties
- Interest expense, unless the expense meets the specific criteria outlined in the regulations
- Land or building acquisition (includes mortgage payments)
- Lobbying costs
- Refreshments
- Stipends
- Taxes for which exemptions are available to the organization

IV. DESCRIPTION OF BUDGET FORMS

1) **Form 1, FUNDING-YEAR 1**: This form prepares a categorical line item budget detail for the total funding amount for Year 1 based on information entered in the other workbook tabs.
2) **Form 2, STAFFING PLAN**: This form requires listing personnel information including employee name, position title, a brief position description, and total annual salary.
3) **Form 3, BUDGET JUSTIFICATION**: Provides written justification for budget requests. The MDCH requires all of the information requested on this form. Provision of this data is **MANDATORY**. Listed expenses may be excluded from the total award amount if adequate narrative is not provided for each budgeted expense.
4) **Form 4, SERVICE DESCRIPTION FORM**: This form requires a description of services provided for all program costs (INCLUDES administrative costs).
5) **Form 5, THREE YEAR FUNDING SUMMARY**: This form provides a high level overview of the funding requested over the three year project duration by object class. On this form you will also detail the source of funds over the project period.

The MDCH requires information concerning the purpose and necessity of each cost on your award budget. The budget document must be self-explanatory, outlining the service(s) to be provided and the contribution of **every** expense to provision of the service. This is required for large and small dollar amounts. This Budget Tool will help ensure the level of detail requested from agencies is provided to the MDCH.

V. BUDGET FORM INSTRUCTIONS

For a description of acronyms used in the drop-down lists, please reference the Data Dictionary within the workbook to ensure appropriate choices are selected for proposed activities performed.

Keep in mind that Year 1 is only a 9 month budget (Jan 1. Through Sept 30, 2015). Requested budget information for Year 2 and Year 3 are for 12 month periods (Oct. 1 through Sept. 30).

1) **Form 1, FUNDING-YEAR 1**:

Enter the agency name, total amount requested, and RFP number. This information is cell referenced to all forms. The Funding-Year 1 form will show a categorical line item budget in the "Total Costs," "Program Funding" and "Administrative Funding" columns that are cell referenced to other tabs in the workbook.

- If your agency has a Federally Approved Indirect Rate, please enter it in cell C:34 and it will be assessed by the MDCH. Please itemize associated administrative costs in the Budget Justification that are not included in the indirect rate.
- In the Source of Funds-Year 1 table, input the projected dollar amounts for each funding category.
-

NOTE: *Source of Funds refers to the various funding sources that are used to support the program. Funds used to support the program should be recorded in this section for Year 1 according to the following categories:*

Fees and Collections: Enter the total fees and collections estimated. The total fees and collections represent funds that the program earns through its operation and retains for operation purposes. This includes fees for services, payments by third parties (insurance, patient collections, Medicaid, etc.) and any other collections.

State Agreement: Enter the amount of MDCH funding allocated for support of this program. This amount includes all state and federal funds received by the Department that are to be awarded to the Contractor through the agreement.

Local: Enter the amount of Contractor funds utilized for support of this program. In-kind and donated services from other agencies/sources should not be included on this line.

Federal: Enter the amount of any Federal grants received directly by the Contractor in support of this program and identify the type of grant received in the space provided.

Other: Enter and identify the amount of any other funding received. Other funding could consist of foundation grants, United Way grants, private donations, fund-raising, charitable contributions, etc. In-kind and donated services should not be included unless specifically requested by MDCH.

Total Source of Funds: The total funding amount is the amount from all sources that will be input into the program.

2) **Form 2, STAFFING PLAN**: Summarize the personnel, salaries, FTE's, etc. associated with this budget for the Applicant agency.
NOTE: *Other personnel are generally defined as per diem, non-salaried and or short-term employees working in or for your organization. These are subcontractors and should not be listed on this form. Subcontractors are to be listed on Form 3, Budget Justification.*
NOTE: *The Staffing Plan form for Year 1 must be included in your application package. Years 2 and 3 will require the same form to be submitted at a later date.*

- Column 1: Enter name or TBD (to be determined and the date), as well as the credentials held by the employee or the TBD employee. Employee name should be listed using the first initial of the first name, period, space, and last name (example: J. Doe)
- Column 2: Enter the job title of employee.
- Column 3: Provide a brief position description for the named individual. Generic job descriptions are unacceptable. Use only ONE line per employee, even if they are going to work across different categories in the grant. Make sure you describe all activity types the employee will perform related to Administrative and Direct Services.
- Column 4: Enter the TOTAL salary paid to employee on a yearly basis.
- Column 5: **You do not need to enter data in this column.** The form automatically calculates the funded FTE once the Budget Justification form has been filled out.

3) **Form 3, BUDGET JUSTIFICATION**: This form contains calculations for subtotals. If entered properly, the form will calculate subtotals and totals. You **MUST** enter the standard bi-weekly hours for your agency in the header in the orange box (cell N:8).
Enter narrative detail for each proposed activity and/or cost. You will exclude a narrative for salaries on the Budget Justification, as this information has been captured on the Staffing Plan Form.
This form (Form 3, Budget Justification) must also be completed for EACH proposed subcontractor agency. Subcontractor's forms should be attached to the agency budget and must agree to the amount listed for that subcontractor.
All costs listed must be allowable under Federal Cost Principles.

NOTE: *The Budget Justification form for Year 1 must be included in your application package.*

Personnel

- Select the employee name from the drop-down list (the drop-down list is a pre-populated list based on your entries in the Staffing Plan.

- Enter the number of hours that will be worked by this employee bi-weekly (Column 2) in the specified categorical area (Column 3).

- In Column 3, you must select whether the activities allocated relate to Administrative (ADMIN), or Program (PROG). Use separate lines for each employee, and use separate lines if the employee will be working on more than one activity.

- Complete the proposed months each employee will be on this budget (Column 4).

- **You do not need to enter data in the Full-Time Salary column, the FTE Column, or the Amount Requested Column**. Salary information is automatically linked to the Budget Justification from the Staffing Plan. The FTE

and Amount Requested columns will populate with the correct information once an employee is selected from the drop-down list and columns 2 and 4 are populated.

NOTE: *If an employee will be working in more than one service category, they must be listed on new lines with the appropriated FTE for each specified category in Column 3.*

Fringe Benefits

Check the box (es) for the fringe benefit types that are included in the Agency Fringe Rate. Input the proposed benefit percentage rate to be applied to employees in the box provided and the form will calculate the benefit amount.

Travel

A narrative of both proposed local and proposed out of town travel must be provided. Describe who, what, where, when and why travel is proposed for this activity/service category. Travel must be directly beneficial in accomplishing the objectives of the activity/service category. In the Out of Town Travel Category, make sure to enter a formula in section (5) Hotel (=Number of Days*Rate Per Day) and (6) Meals (=Number of Days*Rate Per Day) so we are able to determine how you arrived at the amount for that category.

Equipment

Provide the detail of all specific proposed equipment purchases. Proposed equipment leases will go under "Other" below. Provide a narrative of program purpose for each piece of proposed equipment and justify the benefit of purchase versus lease, if a large expenditure. It is not adequate to list "office equipment - $10,000".

Equipment is defined as any single item with a useful life of more than one year and an acquisition cost that equals or exceeds the lesser of (a) the capitalization level established by your agency for financial statement purposes, or (b) $5,000. The justification should list each specific item of equipment with purchase price and indicate the purpose of the equipment and who will use it.

Supplies

The narrative must be specific for proposed program supplies and proposed office supplies, as well as describe in detail the type, cost and purpose of purchases. The narrative must justify why these costs are required to carry out your program.

Subcontract

There are two different types of agreements that can be proposed in this section:

1. Consultant Agreements:

   A consultant agreement is defined as an agreement with an individual to provide a service. In this budget section, you will need to include brief, proposed scopes of work for all consultants and state how each assists the agency in meeting the

program's service delivery objectives. The following must also be included for each consultant agreement:

- The generic type of service to be provided (i.e. direct client service delivery, staff training, etc.)
- The total proposed service units and/or hours
- The hourly rate to be paid for the services to be provided
- The time frame for the consultant agreement
- The total amount requested for each consultant/title

2. Contractual Agreements:

   A subcontract is defined as an agreement with an organization or firm to deliver any direct services. If you are proposing to subcontract with another organization, you must state the name of the subcontractor and the purpose of the subcontract. Please be aware that all subcontractors are subject to the same federal, state and local regulations as your agency.
   Proposed subcontractor agencies must be listed in the second section of Subcontract. Include the name and a narrative describing services and service units to be provided. **Form 3, BUDGET JUSTIFICATION** must be prepared for each proposed subcontractor listed and must agree to the amount listed.

Other

The categories under "other" include rent, utilities, communications, leased equipment, insurance, printing, repairs and maintenance and "miscellaneous" other. Provide a complete narrative proposing "who", "what", "where", "when" and "why" for each item listed. All costs based on allocations must show the allocation and method.

Total Direct Costs

You do not need to enter data in the amount column. The form calculates all the costs above as direct costs. Please note that the amount requested in the summary at the top of the page may differ from the Service Category Funding-Year 1 sheet. You are REQUIRED to enter the Amount Requested at the top of the Service Category Funding-Year 1 form, which in addition should reflect indirect costs, if applicable.

3) **Form 4, SERVICE DESCRIPTION FORM**: Summarize the service(s) proposed in this RFP.

   For a description of acronyms used in the drop-down lists, please reference the Data Dictionary within the workbook to ensure appropriate choices are selected for proposed activities performed.
   NOTE: *The Budget Justification form for Year 1 must be included in your application package. Years 2 and 3 will require the same form to be submitted at a later date.*

- Column 1: Enter the Service Category for the services being proposed. This is a drop-down selection menu.
- Column 2: Enter percentage of total funds for this, including associated administrative costs. This column total must equal 100%.
- Column 3: **You do not need to enter data in this column**. The form calculates the dollar amount of the funding for this activity: (total activity award * percentage in Column-2).
- Column 4: Enter the Component of Care Coordination that corresponds with the item selected in Column 1. This is a drop-down selection menu.
- Column 5: Enter the number of clients with unmet need proposed to be served during the award period.
- Column 6: **You do not need to enter data in this column**. The form calculates the proposed cost per client by dividing Column 3 by Column 5.

4) **Form 5, THREE YEAR FUNDING SUMMARY**: Provide an overview of the requested funding for the project duration by year. Complete the Source of Funds section for years two and three.

NOTE: *Make sure you update the effective dates in the heading to be inclusive of all dates in this RFP.*
NOTE: *For years two and three, no additional budget information is needed at this time, except for the high level detail given in this form. You will be required to submit the same budget forms for years two and three at a later date if you are selected for an award.*

- Year 1: Year One totals will be automatically populated from the Funding-Year 1 form.
- Year 2: Enter the amount to be requested for year two for each budget line item in the Year Two Column.
- Year 3: Enter the amount to be requested for year three for each budget line item in the Year Three Column.
- Total: All totals will automatically populate when information for all three years has been input.

Complete the Source of Funds section. Year One Source of Funds information will be carried over from the Funding sheet. You must input the information for Years 2 and 3.

NOTE: *Source of Funds refers to the various funding sources that are used to support the program. Input is not required for Year 1, as information is carried over from the Funding tab. Funds used to support the program should be recorded in this section for Years 2 and 3 according to the following categories:*

Fees and Collections: Enter the total fees and collections estimated. The total fees and collections represent funds that the program earns through its operation and retains for operation purposes. This includes fees for services, payments by third parties (insurance, patient collections, Medicaid, etc.) and any other collections.

State Agreement: Enter the amount of MDCH funding allocated for support of this program. This amount includes all state and federal funds received by the Department that are to be awarded to the Contractor through the agreement.

Local: Enter the amount of Contractor funds utilized for support of this program. In-kind and donated services from other agencies/sources should not be included on this line.

Federal: Enter the amount of any Federal grants received directly by the Contractor in support of this program and identify the type of grant received in the space provided
.

Other: Enter and identify the amount of any other funding received. Other funding could consist of foundation grants, United Way grants, private donations, fund-raising, charitable contributions, etc. In-kind and donated services should not be included unless specifically requested by MDCH.

Total Source of Funds: The total funding amount is the amount from all sources that will be input into the program.

BUDGET CHECKLIST

The following budget forms are completed and returned to MDCH:

- ❑ Form 1 (Funding-Year 1)
- ❑ Form 2 (Staffing Plan)
- ❑ Form 3 (Budget Justification)
- ❑ Form 4 (Service Description Form)
- ❑ Form 5 (Three Year Funding Summary)

APPENDIX IV:

Michigan Department of Community Health
Division of Chronic Disease and Injury Control
HIV Care Section

Ryan White Program Guidance #14-01

PURPOSE
This guidance sets forth requirements related to eligibility and recertification for clients served by Michigan Department of Community Health (MDCH)-funded Ryan White sub-grantees.

BACKGROUND
Ryan White funds are used only where existing federal, state, and local funds are not adequate. It will supplement and not supplant existing funds. MDCH must assure that sub-grantees make reasonable efforts to secure non-Ryan White funds whenever possible for services to individual clients. MDCH and their sub-grantees are expected to vigorously pursue insurance coverage, including Medicaid enrollment, for individuals who are likely eligible for coverage and rigorously document their attempts to enroll their clients in an insurance plan or Medicaid if the client is non-compliant or the attempts are not successful. Documentation of proof must be included in the individual's health record at initial enrollment and at recertification to establish eligibility for criteria.

INSTRUCTIONS
1. *An individual is eligible for MDCH-funded Ryan White services if he/she meets the following criteria:*

- Must be HIV-positive
- Must reside in Michigan
- Must be low income (not to exceed 450% of Federal Poverty Level)
- Must be underinsured or uninsured for applicable Ryan White services that are reimbursable through third party payers

2. *Proof of eligibility criteria include:*

Eligibility Criteria	Accepted Proof/Documentation
HIV Status	• Eligible laboratory documentation confirming HIV diagnosis test results include: Western Blot, viral load, viral culture, genotype, Nucleic Acid Amplification Test (NAAT), Multi-spot, or Immunoassay (IA) results positive for HIV. • Documentation from eligible Physician or his/her designee: As allowed under Michigan law verifying that the individual is HIV positive.

	• Other documentation: 2 Dual Immunoassay (IA) results positive for HIV (assays must be from different manufacturers).
Residency	• Current State of Michigan identification card or Driver's License • Utility bill in individual's name showing address • Benefits award letter (Department of Human Services (DHS)/Social Security Administration(SSA)) with individual's name and address • Lease or mortgage in individual's name showing address • Voter registration
Income	• Benefits award letter (DHS/SSA) • DHS Client Benefits Assessment • Most recent months' pay stubs • Tax forms from previous year • Unemployment benefits award • Corrections release papers within 30 days of release • Declaration of no income • Declaration of support • Notarized statement from an employer showing gross pay for 30 days
Insurance Status	• Insurance cards • Department of Human Services CBE • Denials from DHS/SSA

3. MDCH-funded Ryan White sub-grantees must complete recertification of eligibility for individuals at **a minimum of every six months**. The recertification process must include collection and update of more in-depth documentation of proof at **a minimum once a year**.

   Guidelines for completing recertification:

Eligibility Criteria	Initial Eligibility	6 Months Recertification	12 month Recertification
HIV Status	Collect and document acceptable proof in individual's health record	No recertification required	No recertification required
Residency Income	Collect and document acceptable proof in	Talk to the individual about eligibility status	Collect and update acceptable proof in

Insurance Status	individual's health record	If individual reports no change, document in the individuals health record If individual reports change, collect and update acceptable proof in individual's health record	individual's health record (same information collected at initial eligibility)

APPENDIX V:

APPLICANT AGENCY PROFILE & SERVICE DELIVERY SUMMARY

1. Agency Name	
2. Executive/Director/Health Officer Name (whoever will be signing contract)	**3. Phone Number**
4. Address	
5. List of Agencies in the Network	
6. Services: *Complete the table below for all service(s) for which you are applying.*	

SERVICE	Total Years of Experience Providing this Service to HIV or Seriously Chronically Ill Clients (whichever agency in the network will be provide this service component	FY14/15			
		Anticipated # of Clients to be Served	Anticipated # of Units of Service	Anticipated # of Clients with Insurance	Total $

7. Applicant Agency: In the table below, enter the number and percent of management, employees and Board members (or other governing body) by race/ethnicity. ***NOTE: Each COLUMN should total 100%. Also, the TOTALS for race and for ethnicity in each column should be the same.***

RACE	**Management**		**Employees**		**Board Members**	
	#	%	#	%	#	%
White						
African American						
Asian/Pac Islander						
American Indian						
Arab/Chaldean American						
Multi-Racial						
Other/ Unknown						
TOTAL		100%		100%		100%
ETHNICITY						
Hispanic						
Non-Hispanic						
Unknown						
TOTAL		100%		100%		100%

APPENDIX VI:

Care Coordination Proposal Checklist

__ Letter of Intent, date submitted:

__ Proposal Checklist

__ Proposal Package

- Agency Profile Form
- Agency Capacity
- Program Description
- Statement of Need
- Service Delivery Plan
- Implementation Plan
- Budget (In Excel)
    - Service Category Funding-Year 1
    - Staffing Plan
    - Budget Justification
    - Service Description Form
    - Three Year Summary Funding

Agency Attachments:

__ I. Non-Profit Status (IRS) letter, if applicable

__ II. List of Current Board Members with affiliations

__ III. Organizational Chart

__ IV. Most Recent Single or Financial Audit Report

__ V. Current Agency Operating Budget

__ VI. Memoranda of Understanding (MOU)/Memoranda of Agreement (MOA)

__ VII. Letters of Support

__ VIII. Certificate of Liability Insurance

__ IX. Federally Approved Indirect Cost Rate if applicable

APPENDIX VII:

Service Category Definitions

CORE SERVICES

Outpatient/Ambulatory Medical Care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Oral Health Care *includes dia*gnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary c*are providers*.

Early Intervention Services (EIS) include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Mental Health Services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Medical Nutrition Therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Medical Case Management Services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other

key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Substance Abuse Services Outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

SUPPORT SERVICES

Case Management (Non-Medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Emergency Financial Assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

Food Bank/Home-Delivered Meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

Health Education/Risk Reduction is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Housing Services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

Linguistics Services include the provision of interpretation and translation services.

Medical Transportation Services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

***Outreach* Services** are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Psychosocial Support Services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Rehabilitation Services are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Treatment Adherence Counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

HRSA Standards

HRSA Universal Monitoring Standards – Part B:
http://hab.hrsa.gov/manageyourgrant/files/universalmonitoringpartab.pdf

HRSA Program Monitoring Standards – Part B:
http://hab.hrsa.gov/manageyourgrant/files/programmonitoringpartb.pdf

HRSA Fiscal Monitoring Standards – Part B:
http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringpartb.pdf