MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Health, Wellness & Disease Control

HIV Care Section

Request for Proposal for Ryan White HIV/AIDS Program Part B

Application Due Date: June 1, 2015

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Respondents must meet submission requirements in this Request for Proposal (RFP) to be considered for a contract. Failure to comply with these requirements will disqualify respondents without further consideration. Each respondent is responsible for the preparation and submission of a proposal in accordance with instructions. **A Letter of Intent must be submitted no later than 5:00 p.m. EST, Monday, May 11, 2015 via email to mcelhoneh@michigan.gov**.

READ ALL MATERIALS BEFORE PREPARING THE PROPOSAL

Introduction and Background

Michigan Department of Health and Human Services (MDHHS), HIV Care Section (HCS) is the Michigan grantee of the federal Ryan White Part B funds issued by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). These funds, disbursed to all US states, territories, and associated jurisdictions, aim to provide funding to people living with HIV (PLWH) "who have no health insurance (public or private), have insufficient health care coverage, or lack financial resources to get the care they need for their HIV disease."[1] Ryan White funding fills gaps left by other funding sources and addresses the social determinants of health that contribute to HIV-related health disparities.

MDHHS/HCS activities are aligned with the National HIV/AIDS Strategy (NHAS) developed by the White House Office of National AIDS Policy in 2010.[2] In accordance with NHAS goals and HRSA/HAB guidelines, MDHHS/HCS programs aim to keep patients and their families informed; to engage and retain clients in care; to ensure that effective referrals and transitions take place throughout the HIV treatment cascade. More specifically, MDHHS/HCS works towards improved health outcomes and viral load suppression by:

- Identifying people who were previously unaware of their HIV status and linking them to medical care
- Reengaging PLWH who are lost to medical care
- Supporting PLWH in maintaining ongoing HIV medical care and treatment
- Providing resources to address social determinants and reducing HIV-related health disparities
- Supporting people with HIV at each stage of the treatment cascade from diagnosis to viral load suppression

MDHHS/HCS is issuing this competitive Request for Proposal to fund Ryan White Part B programs throughout Michigan that demonstrate proficiency working with PLWH to achieve positive health outcomes. The suppression of HIV viral load is a desirable health outcome for PLWH, especially as this contributes to reduced mortality/morbidity and improved disease prognosis. As the Michigan HIV Treatment Cascade illustrates, the path to viral load suppression starts with the individual learning his/her HIV status,

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1 Health Resources and Services Administration, HIV/AIDS Bureau, www.hab.hrsa.gov/.

2 National HIV/AIDS Strategy, www.aids.gov/federal-resources/national-hiv-aids-strategy/overview/.

then being connected to an HIV medical home, receiving anti-retrovirals and treatment, and, finally, having access to resources that reduce barriers to ongoing medical adherence.[3]

As part of this RFP process, MDHHS/HCS will fund culturally-competent programs offering an array of Ryan White core medical and support services that directly address the needs of Michigan citizens disproportionately infected by HIV. These programs will exist within a statewide continuum of care network that provides services in a consistent, cost-effective manner; coordinates effectively with other service providers; and minimizes duplication of effort. Funding will be directed to specific geographic areas and target populations that exhibit need based on epidemiological data.[4]

Finally, the implementation of the Patient Protection and Affordable Care Act (ACA) in early 2014 is dramatically changing the landscape of Ryan White programs. ACA expanded insurance coverage to PLWH in Michigan through the creation of a federally-facilitated insurance marketplace, the Healthy Michigan program, as well as a list of general provisions that eliminates restrictive practices and expands coverage. This continues to facilitate the transition of hundreds of uninsured PLWH from Ryan White funded programs into insurance coverage that offer comprehensive medical care, life-saving medications, and other services. Identifying and covering gaps left by ACA will be an ongoing collaborative effort; at the same time, this also affords Ryan White programs the opportunity to assess existing service delivery models to determine how to best adapt to the changes resulting from ACA.

Agencies submitting a proposal under this RFP are encouraged to look at HIV demographics, local service needs, and the changing healthcare landscape to develop a model of service delivery that moves a client from initial diagnosis to viral load suppression and improved quality of life.

Technical Requirements

Funding Scope

This competitive RFP will fund an array of service categories along a continuum of comprehensive and coordinated HIV care services through Ryan White Part B and other State of Michigan funds. Ryan White funds must be used to supplement, but not supplant, existing funds for services currently. The amount requested must correlate with the number of underserved PLWH who will be enrolled in and receiving services from the applicant network as well as the scope of the proposal/project.

MDHHS/HCS expects to award grants over the next three years for the period October 1, 2015 - September 30, 2018. MDHHS/HCS expects to award grants totaling approximately seven million for the period October 1, 2015 - September 30, 2016.

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3 See Michigan HIV Care Continuum, 2013 Care Cascades by Metropolitan Statistical Area, March 2015, www.michigan.gov/mdch/0,4612,7-132-2940_2955_2982_46000_46003-293090--,00.html

4 See Michigan HIV Statistics, www.michigan.gov/mdch/0,4612,7-132-2940_2955_2982_46000_46003---,00.html

Annual awards are expected to range from $250,000 to $600,000 annually. Notices of Award are expected to be made in writing by June 30, 2015. This notice is an announcement of selection, and the receipt of the notice is not legally binding until there is a fully-executed contract. Applicants not selected will also receive written notification.

Funding under this RFP is awarded for three years to agencies that successfully compete. Contracts will be issued based on the State of Michigan Fiscal Year (October 1 – September 30). As needed, funded agencies may be asked to revise the budget, service categories and/or service levels of proposals. Contracts will be reviewed on an annual basis for future funding purposes; subsequent allocations will depend on performance, evaluation, and availability of federal funds.

Minority AIDS Initiative Funding

In addition to Ryan White Part B funding, MDHHS/HCS is also issuing this RFP to fund Minority AIDS Initiative (MAI) projects in Michigan. Under the MAI award, MDHHS/HCS will only fund education and outreach to increase participation in the AIDS Drug Assistance Program (ADAP) for minority PLWH being released from the Michigan Department of Corrections (MDOC).

MDHHS expects to fund a maximum of two MAI projects for a total of $185,000. To be successful with an MAI proposal, MDHHS would expect the applicant agency's budget to be a minimum of $85,000 up to the maximum of $185,000 and meet MDHHS' intent for MAI to focus on recently released incarcerated PLWH.

If preparing to request MAI funding, agencies are encouraged to identify services that are innovative and effective at engaging the re-entry population at or before the point of release to help them gain access to Ryan White resources. Also, MDHHS/HCS is looking for creative strategies that bridge the gap between MDOC and community resources. MAI funding, if requested, will be scored independently from the Part B proposal.

Applicant Eligibility

Eligible agencies include

- Government organizations:
  - State, local, city, or township governments and their agencies.
  - Special district governments
  - Local health departments
  - Native American Tribal Governments (federally recognized and other than federally recognized)
- Educational organizations:
  - Independent school districts
  - Public and state institutions of higher education
  - Private institutions of higher education
- Medical Clinics:
  - Federally qualified health centers (FQHCs)

- Health facilities operated by or pursuant to a contract with the Indian Health Service.
- Clinics, hospitals, and other health facilities

- Other:
  - Private non-profit entities with a 501(c)(3) status

Applicants must be located within the state of Michigan.

Any non-profit agency applying under this RFP must have been certified by the federal Internal Revenue Service (IRS) as a 501(c)(3) organization prior to January 1, 2015. A copy of the IRS certificate of non-profit status must be included as an attachment to this proposal. Proposals from non-profit organizations that are lacking documentation of tax exempt status will not be reviewed and will be ineligible to receive funding under this RFP.

Eligible Service Categories

MDHHS/HCS will fund Ryan White service categories outlined in the table below. Agencies are encouraged to request funds for multiple service categories and to develop a coordinated continuum of core medical and support services that meet the needs of the clients served.

Please refer to HRSA's *National Monitoring Standards for Ryan White Part B Grantees: Program-Part B* for the full list of service category definitions, allowable services, and restrictions.[5] MDHHS/HCS also issues *Ryan White Standards of Care* and should also be consulted for a full understanding of the expectations for the HIV care of PLWHA in Michigan.[6] Additional information specified by MDHHS/HCS for certain service categories are provided in the summaries below.

MDHHS/HCS Ryan White Part B Service Categories	
Core Medical Services	
Outpatient/Ambulatory Medical Care	Hospice Services
Early Intervention Services	Mental Health Services
Health Insurance Premium and Cost-Sharing Assistance	Medical Nutrition Therapy
Home Health Care	Medical Case Management, including Treatment Adherence
Home And Community-Based Health Services	Substance Abuse Services (Outpatient)
Support Services	
Case Management (Non-Medical)	Linguistic Services
Child Care Services	Medical Transportation Services

[5] HRSA/HAB National Monitoring Standards for Ryan White Part B Grantees - http://hab.hrsa.gov/manageyourgrant/granteebasics.html. Note there are three sets of standards, Universal, Fiscal, and Program.

[6] MDHHS, Ryan White Standards of Care. www.michigan.gov/mdch/0,4612,7-132-2940_2955_2982_46000_46001---,00.html, March 2015.

Emergency Financial Assistance	Psychosocial Support
Food Bank/Home-Delivered Meals	Rehabilitation Services
Health Education/Risk Reduction	Respite Care
Housing Services	Substance Abuse Services (Residential)
Legal Services	Treatment Adherence Counseling
Minority AIDS Initiative	
Michigan Department of Corrections (MDOC) Outreach	

Core Medical Services Eligible for Third-Party Reimbursement
These requirements apply to the following service categories: Outpatient/Ambulatory Medical Care, Home Health Care, Home and Community-Based Health Services, Hospice Services, Mental Health Services, Medical Nutrition Therapy, Substance Abuse Services-Outpatient. MDHHS/HCS will fund the full range of these services for uninsured and the gaps for insured clients.

If a client is insured or underinsured, MDHHS/HCS will fund services allowed by HRSA that are not reimbursable by third-party reimbursement. Agencies must have a sliding fee scale if clients are billed for services, although no charges are to be imposed on clients with incomes below 100 percent of the Federal Poverty Level (FPL). Charges to clients with incomes greater than 100 percent of poverty are based on a discounted fee schedule and a sliding fee scale. In addition, income made from charges to clients or to insurance companies for services performed is considered program income and must be re-invested in the Ryan White program. Please see the HRSA/HAB Part B Manual for more information on Charges, Caps on Charges, and Program Income.[7]

Agencies must outline these specific services and how they fill gaps in coverage for managing chronically ill clients. Agencies must also clearly demonstrate their process for evaluating a client's insurance status and its documentation. See HRSA/HAB Policy Notice #13-04 for details about serving Ryan White clients with insurance.

Heath Insurance Premium and Cost-Sharing Assistance (HIPCA)
MDHHS/HCS will only fund services that cover cost-sharing assistance related to insurance deductibles, co-insurances, co-pays, and other costs associated with accessing medical, dental, vision, and mental health care. Agencies interested in assisting clients with HIPCA-related payments should apply for funding under this category.

Medical Nutrition Therapy
Per HRSA standards, medical nutrition therapy services that provide nutritional supplements must include a licensed registered dietitian who completes a nutritional plan with the client. Provision of nutritional supplements without consultation with a dietitian is not permissible as a core service.

[7] HRSA/HAB. *Ryan White HIV/AIDS Program Part B Manual*, Chapter 4. Client Charges and Program Income. http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf

Medical Case Management and Non-Medical Case Management
Medical Case Management (MCM) consists of an array of services provided by trained professionals with the purpose of ensuring improved engagement and retention in HIV medical care. MCM involves the coordination and follow-up of medical care and the provision of treatment adherence counseling on an ongoing basis. MCM also includes an outlined process - initial assessment of needs, determination of client level acuity, development of an individualized care plan, coordination of services to implement the plan, monitoring the progress of the plan, and periodic reassessment of needs.

The amount and intensity of MCM service provision will be determined by the client acuity, which is completed at minimum after each (re)assessment. Client level acuity and service provision will be organized as the following:

- Episodic (Low Acuity):
  - Identified barriers minimally impact client's ability to remain engaged in HIV medical care and to meet social service needs
  - Client requires sporadic and time-limited assistance
  - Contact with client is, at minimum, once every 3 months unless client contacts MCM with a concern in between
  - Reassessments are completed once every 6 months; when appropriate, client is graduated into non-medical case management
- Standard (Mid-level Acuity):
  - Identified barriers moderately impact client's ability to remain engaged in HIV medical care and to meet social service needs
  - Client requires ongoing and regular assistance
  - Contact with client is, at minimum, once every month unless client contacts MCM with a concern in between
  - Reassessments are completed once every 6 months
- Intensive (High Acuity):
  - Identified barriers severely impact client's ability to remain engaged in HIV medical care and to meet social service needs
  - Client requires ongoing and intensive assistance
  - Contact with client is, at minimum, twice a month unless client contacts MCM with a concern in between
  - Reassessments are completed, at minimum, once every 6 months; programs may also choose to complete reassessments once every 3 months for these clients

Non-Medical Case Management (NMCM) is the provision of advice and assistance to clients in accessing needed services and does not include the coordination and follow-up of medical care. In service delivery, NMCM involves working with a client who does not fit into any MCM client acuity level and, for the most part, self-manages their HIV and related needs. This client may contact the agency occasionally and may need one-time assistance.

Despite the name, both MCM and NMCM may be provided at clinic-based and community-based settings. Though MCM is a Ryan White core medical service and

NMCM is a Ryan White support service, both service categories may be utilized by agencies to provide a continuum of care coordination services that address health care and social service needs. NMCM may be utilized to manage stable and otherwise medically adherent clients without precluding them from accessing other support services at the agency (e.g., psychosocial support groups, emergency financial assistance). If at any time a NMCM client is deemed more appropriate for MCM, he/she may be appropriately moved into the correct service category.

In preparing this RFP, agencies applying for MCM/NMCM services are encouraged to identify a service delivery model that:

- Incorporates both MCM and NMCM services, with MCM services determined by client acuity
- Defines their care coordination services as either clinic-based or community-based MCM/NMCM and outlines the unique nature of each type of care coordination
- Incorporates the use of care coordination teams that include medically trained professionals (e.g., nurses), professionals trained in behavioral health and/or psychosocial needs (e.g., social workers), benefits specialists, and/or community health workers. These teams complement and coordinate services provided to the Ryan White client.

Emergency Financial Assistance
MDHHS/HCS will fund Emergency Financial Assistance to support only utilities, housing, food, or medications. Resources must be provided to clients with limited frequency and for limited periods of time, as defined by agency policy and procedures.

Health Education/Risk Reduction, Treatment Adherence Counseling
Health Education/Risk Reduction and Treatment Adherence Counseling services as a support service cannot be conducted by a medical professional, MCM, or other relevant staff as part of a core medical service (e.g., outpatient/ambulatory medical care, MCM). Agencies must demonstrate how these support service categories are unique from that provided within the core medical service categories. This may include a group intervention, a peer-facilitated intervention, a curriculum-based intervention, etc.

Program Requirements

Start-Up
Funded agencies (sub-recipients) will be expected to have programs fully staffed and trained within three months of receipt of funding. The projected start-up phase should be described in detail including steps and timeline required to have the program fully operational and delivering services. Failure to make reasonable progress in program development may result in revocation or reduction of award.

Eligibility for Ryan White Services
To be eligible to receive MDHHS/HCS-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, MDHHS/HCS-funded Ryan White sub-recipients must develop agency-specific policies and procedures that outline how eligibility and recertification is conducted onsite.

In compliance with HRSA standards, additional eligibility criteria may be developed by the sub-recipient specific to a service category, especially to ensure service of the clients with the most complex and urgent needs.

For more information on Ryan White initial eligibility and recertification, refer to the MDHHS/HCS Ryan White Program Guidance #14-01 (See Appendix V).

Allowable Costs

HRSA outlines specific items for which Ryan White funds can be used. For a detailed description of allowable costs, refer to HRSA Policy Notice 10-02.[8]

Ryan White cannot be used to support needle exchange programs, to make direct payments of cash to clients, alternative or complimentary therapies such as massage and acupuncture, fundraising expenses, lobbying activities, purchase of land or construction, international travel, and clinical trials. Ryan White funds cannot be used for HIV testing, unless there is evidence that the need for testing is not being met in the specified geographic area. Sub-recipients are required to have prior approval from MDHHS/HCS to utilize Ryan White funds for HIV testing. Sub-recipients are responsible for adhering to Ryan White allowable use of funds.

Ryan White funding must be the payer of last resort. Services funded by this RFP cannot be billable by third party reimbursements, including Medicaid, Medicare, Healthy Michigan, qualified health plans through the federal insurance marketplace, private insurance, and/or other state or local insurance programs. Sub-recipients are also required to vigorously pursue all other available funding sources before Ryan White funds are utilized. Ryan White funding may be used to complete coverage where there are gaps in insurance. Agencies must clearly outline these gaps and how they meet the needs of clients served. For more details about allowable costs and vigorously pursuing other insurance and funding sources, please see HRSA/HAB Policy Notice #13-04.

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8 HRSA/HAB, Eligible Individuals & Allowable Uses of Funds for Discretely Defined Categories of Services Policy Notice 10-02, http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html. Note that where Policy Notice 10-02 and the HRSA *National Monitoring Standards* differ, applicants should refer to the *National Monitoring Standards* for final resolution.

Standards and Other Requirements

Sub-recipients must adhere to all federal, state, and local laws, policies, and statues.

Sub-recipients will be required to implement services in accordance with the following established federal and state standards.[9]

- HRSA/HAB, *Ryan White HIV/AIDS Program Monitoring Standards – Fiscal Monitoring Standards Part B*
- HRSA/HAB, *Ryan White HIV/AIDS Program Monitoring Standards – Program Monitoring Standards Part B*
- HRSA/HAB, *Ryan White HIV/AIDS Program Monitoring Standards – Universal Monitoring Standards Part A & B*
- MDHHS/HCS, *Ryan White Programs Standards of Care*

Sub-recipients are required to follow all MDHHS/HCS Ryan White Program Guidance. Currently, this includes:

- MDHHS/HCS Ryan White Program Guidance #14-01: Eligibility and Recertification
- MDHHS/HCS Ryan White Program Guidance #14-02: Administration Expense Cap
- MDHHS/HCS Ryan White Program Guidance #14-03: Incentives

All program guidance may be found in Appendix V.

Scope of Services and Quality Management

As mentioned above, the goals of MDHHS/HCS-funded Ryan White services are to:

- Identifying people who were previously unaware of their HIV status and linking them to medical care
- Reengaging PLWH who are lost to medical care
- Supporting PLWH in maintaining ongoing HIV medical care and treatment
- Providing resources to address social determinants and reducing HIV-related health disparities
- Supporting people with HIV at each stage of the treatment cascade from diagnosis to viral load suppression

Sub-recipients exist within a network of services that include HIV prevention providers, local health departments, medical clinics, community-based organizations, etc. MDHHS/HCS expects agencies to collaborate across the HIV continuum of care to provide quality services for PLWH. This may include formalized coordination of service delivery, effective referral and communication mechanisms, out-posting of program staff, multidisciplinary case conferencing, and/or other practices that ensure effective and efficient service delivery. Due to the array of services provided by Ryan White,

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[9] HRSA/HAB National Monitoring Standards for Ryan White Part B Grantees - http://hab.hrsa.gov/manageyourgrant/granteebasics.html. Note there are three sets of standards, Universal, Fiscal, and Program. Please see Appendix V for the MDHHS Standards of Care.

MDHHS encourages such partnerships in order to improve overall health outcomes, and achieve and sustain viral load suppression, and to minimize duplication of services.

Sub-recipients must demonstrate experience and proficiency working with underserved individuals, especially those who are disproportionately impacted by HIV. This includes people who live in poverty, lesbian, gay, bisexual, and transgendered (LGBT) individuals, racial/ethnic minorities, people of all ages, and women. Agencies are expected to provide culturally-competent services, to recruit/retain culturally diverse staff members who are reflective of the population served, and to involve a diverse group of individuals in the planning, design, and implementation of services.

In coordination with MDHHS/HCS, sub-recipients will develop an annual work plan for the contract year that includes, at minimum, the following:

- Number of clients served and number of new clients served per service category
- Number of units of service provided per service category
- Standardized performance measures per service category
- Objectives related to enrolling Ryan White clients into the Affordable Care Act insurances and identifying gaps

Due to the ever changing healthcare environment and the Affordable Care Act, the scope of work outlined by this RFP may change over the course of the grant year. MDHHS/HCS reserves the right to make changes to work plans and other requirements to meet identified needs or requirements.

Sub-recipients are required to develop and implement a quality management program in accordance with HRSA guidelines within six months of receipt of funding . This will include developing an internal quality management structure, identifying annual goals, collecting standardized performance measures, and conducting ongoing quality improvement activities. MDHHS/HCS programs are aligned with HRSA/HAB core measures which were updated in 2013.[10] MDHHS/HCS will provide guidance and technical assistance, as needed, to help agencies implement a quality management program.

Data Requirements

Funded sub-recipients will be required to use CAREWare to document and report, at minimum, client-level demographic data, units of service per service category, and performance measurement data. MDHHS/HCS will provide the definitions of units of service and sub-service categories by service category (e.g., MCM Assessment for medical case management) to help sub-recipients code their service delivery into data input (see MDHHS/HCS *Ryan White Standards of Care*). **In addition, all services provided in a given month must be entered and updated into CAREWare by the tenth of the following month.**

[10] HIV/AIDS Bureau's Revised Performance Measure Portfolio, www.hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html.

Funded sub-recipients 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, and/or data management. To activate a new staff member, sub-recipients must follow MDHHS/HCS established protocol. When a staff member is no longer directly involved in MDHHS/HCS funded services or data management, the sub-recipient must contact MDHHS/HCS within fourteen days to inactivate the username.

Funded sub-recipients will be required to complete any required data reporting as mandated by HRSA, including the annual Ryan White Service Report.

Program Monitoring and Evaluation

Sub-recipients agree to comply with MDHHS/HCS required program monitoring and evaluation activities which are used to assess compliance with established standards as well as quality of services. MDHHS/HCS will review CAREWare data on an ongoing basis to assess number of clients served, type and units of services provided, and performance measures. Sub-recipients are required to keep CAREWare data updated to ensure the completion of program monitoring and evaluation activities.

Sub-recipients are required to submit the following reports:

- Monthly financial status reports via Electronic Grants Administration and Management System (EGrAMS) (Local health departments report quarterly.)
- Quarterly program reports according to the format and guidelines established by MDHHS/HCS.

MDHHS/HCS will conduct at least one site visit per year to ensure compliance with federal and state standards, policies, and statutes. During site visits, sub-recipients must make available applicable financial, administrative, program, and client records for review. As needed and in a timely manner, sub-recipients are also required to work with MDHHS/HCS to implement corrective action plans based on site visit findings and recommendations.

Failure to follow through on required program monitoring and evaluation activities may impact an agency's funding during the current contract year as well as eligibility for future funding.

MDHHS Activities

Sub-recipients will be required to participate in MDHHS related activities, such as technical assistance calls and face-to-face sub-recipients meeting, MDHHS committees (Quality Management, CAREWare, ADAP Formulary, etc.), and other activities that work towards the overall goals of the Ryan White Program.

Reimbursement

Sub-recipients are reimbursed on a monthly basis for expenditures incurred. Agencies will be required to prepare, and submit monthly financial status reports through the State of Michigan Electronic Grants Administration & Management System (EGrAMS).

Needs Assessments and Statewide Planning

Sub-recipients are required to participate in ongoing needs assessments and statewide planning as needed by MDHHS/HCS. 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.

Minority AIDS Initiative/MDOC Outreach

Under the Minority AIDS Initiative, MDHHS/HCS will only fund education and outreach to increase participation in the AIDS Drug Assistance Program (ADAP) for minority PLWH being released from MDOC. In applying for MAI funding, agencies are encouraged to identify services that are innovative and effective at engaging the re-entry population at or before the point of release to help them gain access to Ryan White resources. Also, MDHHS/HCS is looking for creative strategies that bridge the gap between MDOC and community resources. The service delivery method must include outreach, benefits counseling, and enrollment services into eligible insurances and ADAP which allow access to needed HIV medications.

MDHHS receives a total of $185,000 to fund Minority AIDS Initiative projects in Michigan. To be successful with an MAI proposal, MDHHS would expect the applicant agency's budget to be a minimum of $85,000 up to the maximum of $185,000 and meet MDHHS' intent for MAI to focus on recently released incarcerated PLWH. MDHHS expects to fund a maximum of two projects (i.e., one agency at $185,000; or two agencies at approximately $85,000).

Applying for MAI Funding

Agencies are able to apply for MAI funding as part of their Part B proposal or as a single-funded project. MAI applicant agencies must follow the same guidelines set forth in the Part B portion of this RFP and fulfill all contract related expectations (e.g., quality management, data submission, etc.). If applying as a single-funded project, MAI applicant agencies should ensure that all elements of the proposal - Letter of Intent, Agency Profile, and Proposal Narrative Outline - are included in their MAI proposal; responding to the MAI questions located in the Ryan White Service Categories section of this RFP.

Technical Assistance

MDHHS/HCS will provide technical assistance to agencies applying for this RFP. Technical assistance will consist of an opportunity for questions to be submitted, with responses within a week. All questions should be emailed to Hope McElhone, mcelhoneh@michigan.gov by 5:00 pm EST, May, 20, 2015. Responses will be posted on the MDHHS website, by Friday, May 22 2015.

Letter of Intent Due Date:	May 11, 2015 Submit via email to mcelhoneh@michigan.gov
Deadline for Email Questions:	May 20, 2015 Submit via email to mcelhoneh@michigan.gov
Proposal Due Date:	3:00 PM EST, June 1, 2015 Submit via email to mcelhoneh@michigan.gov
Notice of Award:	June 30, 2015
Program Start Date:	October 1, 2015

Proposal

Letter of Intent

See Appendix I for the Letter of Intent Form. The Letter of Intent is due by 5:00 p.m. EST on Monday, May 11, 2015. It must be emailed to Hope McElhone at mcelhoneh@michigan.gov.

Agency Profile

See Appendix II for the Agency Profile Form.

Proposal Narrative Outline

Agency Capacity

1. Agency Mission: What is the agency's mission?
2. Service Provision History: What is the agency's history and experience relevant to the provision of proposed services? Specify experience working with people with chronic diseases, especially HIV. Experience and success of such efforts should be supported with quantitative and qualitative data, if available.
3. Geographic Area of Focus: What are the specific geographical service areas (e.g., counties) served by the agency? Why were these areas chosen?
4. History with Target Population: What is the agency's target population? What is the agency's history and experience relevant to the provision of proposed services with the target population? Specify history and experience working

with people who are disproportionately impacted by HIV, including people who live in poverty, the LGBT community, racial/ethnic minorities, and women. Experience and success of such efforts should be supported with quantitative and qualitative data.

5. Program Management: What is the agency's experience in effectively administering programs, grants, or contracts? How will the applicant agency ensure that Ryan White Part B program requirements will be completed satisfactorily? Describe the agency's experience previous audit results and financial management staffing.
6. Cultural Competency:
   a. How does the agency recruit and retain staff members who are culturally diverse and reflective of the agency's target population?
   b. How does the agency involve diverse individuals in the planning, design, and implementation of HIV care services?
   c. How does the agency address the needs of individuals with special needs including non-English speaking clients, those with developmental disabilities, and/or people who are visually/hearing impaired?
7. Collaboration: Briefly describe formal and informal relationships the agency has with other organizations, especially HIV prevention providers, local health departments, medical clinics, and/or community-based organizations, as applicable. How does the agency coordinate care with other organizations to ensure PLWH are retained in HIV medical care?
8. Affordable Care Act:
   a. What processes does the agency have in place to ensure that uninsured or underinsured clients have access to the ACA insurances, the Healthy Michigan plan, and AIDS Drug Assistance Program funding for premium assistance?
   b. What steps does the agency take to vigorously pursue benefits counseling and enrollment to ACA for clients who are uninsured or underinsured?

Statement of Need

1. Describe the needs/gaps in services for your target population(s). Provide support for identified HIV care needs, preferably through the use of local or agency data. Although the agency may refer to information from the statewide Epidemiological Profile, statewide Needs Assessment, or statewide HIV care Comprehensive Plan, it is not necessary to restate this information in detail.
2. Describe specific barriers to providing services within the counties served by the agency.
3. What role will the agency play in the changing environment of ACA? How will the services provided by the agency fill the gaps left by ACA for PLWH?

Eligibility and Recertification Procedures

1. Describe the process the agency has (or will have) in place to ensure clients are initially eligible for Ryan White services and recertified in accordance with MDHHS/HCS guidance.

Quality Assurance and Quality Management

1. Explain how the agency ensures that client-level data is entered properly into CAREWare (or similar data system/spreadsheet). Discuss who enters the data, how often the data is entered, who reviews the data to make sure it is accurate, the frequency with which data is reviewed, and what is done when encountering errors. Detail how the applicant agency will ensure that CAREWare data will be entered by the 10th of the following month.
2. Describe a quality assurance process used at the agency (e.g., chart checklists, peer/supervisor review, etc.,). Discuss who conducts the quality assurance checks, how often, and how the findings are used.
3. Provide an example of how you have applied program data to improve services. What data did you use? What did you discover about your program? What changes did you make?

Ryan White Service Categories

This section addresses detailed information about the proposed service delivery model as well as core medical and support service categories.

For each core medical service category for which the agency is applying, answer each of the questions under the "Core Services Model" section for all proposed core services. Then, for each core service category, answer the questions under that heading as well as that under Health Outcomes. For example, Agency X is proposing funding for MCM and Emergency Financial Assistance (EFA); Agency X would answer Core Services Model describing their service delivery model for MCM and EFA, then answer each of the MCM and EFA service category questions, including the question about Health Outcomes. For more information, please refer to the HRSA/HAB *Ryan White National Monitoring Standards for Part B – Program* and review the corresponding section.

General (these questions must be answered)

1. Describe the service delivery model you propose to fund with this RFP. List the service categories for which you are requesting funds and how they fit in with the continuum of care services offered at the agency.
2. For all new programs or changes in service delivery models, describe your three-month start-up process. Specify steps that will be taken to implement the program and identify timeframes for each step.
3. Describe how program income (from fees for service or third party reimbursement) will be reinvested into your program, if applicable. Detail how the agency vigorously pursues insurance for clients who are uninsured or underinsured. Also, detail how the agency ensures Ryan White is the payer of last resort.
4. Describe how the proposed services will lead to improved health outcomes for PLWH.

Medical Case Management

1. Provide an overview of the medical case management services that will be supported by Ryan White Part B funds. Specify where the services will be provided (e.g., clinic-based, community-based), type of services provided, and how services will be delivered.
2. If your agency intends to incorporate non-medical case management into service delivery, how will non-medical case management and medical case management services work together to serve eligible clients?
3. Describe how medical case management services will engage new clients into services, especially those who have been lost to HIV medical care. Include how the agency will conduct outreach/engagement to recruit new clients.
4. Describe how the medical case management assessment and client acuity will be used to better understand client needs and to deliver services.
5. Describe how the medical case management services will ensure that clients are retained in HIV medical care. How will these efforts help client achieve viral suppression?
6. Describe how medical case managers will conduct treatment adherence counseling, including assessing readiness for and adherence to complex HIV treatments. Include a description of the evidence-based or best practice model used and why it is effective with the target population.
7. Discuss how medical case managers are supervised to ensure compliance with established standards, provision of quality services, and maintenance of ethical practices. Be specific as to who conducts supervision, how often, and trainings provided.
8. How does the agency determine a client has successfully completed medical case management services?

Outpatient/Ambulatory Medical Care

1. Provide an overview of what allowable and non-billable services will be provided using Ryan White funding. Be specific as to the type of services, location of services (e.g., hospital, federally qualified health center, free-standing clinic, etc.), and how services will be delivered. For more information, please refer to the HRSA/HAB Ryan White National Monitoring Standards for Part B – Program and review the corresponding section.
2. Describe how the agency will engage the previously identified target population in service delivery.
3. Describe how the outpatient/ambulatory medical care services will ensure that clients served are retained in HIV medical care. How will these efforts help clients achieve viral suppression?
4. Describe how the agency will conduct treatment adherence counseling, including assessing readiness for and adherence to complex HIV treatments. Include who will provide this service and a description of the evidence-based or best practice model used and why it is effective with the target population.
5. Describe the agency's approach to reengage clients who have been lost to HIV medical care.

6. Describe how the agency will coordinate other services for the client, including medical case management, behavioral health, and/or support services.

Health Insurance Premium and Cost-Sharing Assistance

1. Provide an overview of the cost-sharing assistance that will be supported by Ryan White Part B funds. Specify criteria for eligibility (anything that exceeds Ryan White eligibility and recertification), type of assistance provided, how often services will be provided, limitations on the services, and how services will be delivered.
2. Describe how the provision of services will contribute to the client being engaged and retained in HIV medical care.

Early Intervention Services

1. Provide an overview of the early intervention services that will be supported by Ryan White Part B funds. Specify where the services will be provided, type of services provided, and how the services will be delivered.
2. Describe agency's approach to engage clients who are newly diagnosed with HIV and/or those who have been lost to medical care. Identify specific points of entry with which you will establish relationships and the reasons why these referral sources will yield a high volume of out of care clients with HIV.
3. Describe how the agency will collaborate with medical case management services in order to serve PLWH.
4. Describe how early intervention services will ensure that clients served are linked to HIV medical care. Specify relationships that the agency already has with infectious disease providers in your target geographic area and process by which linkage is achieved.
5. Describe how early intervention services staff will conduct health education/risk reduction with clients. Include a brief description of topics covered.
6. Discuss how early intervention services staff are supervised to ensure compliance with established standards, provision of quality services, and maintenance of ethical practices. Be specific as to who conducts supervision, how often, and trainings provided.
7. How does the agency determine a client has successfully completed early intervention services?

Mental Health

1. Provide an overview of what allowable and non-billable services will be provided using Ryan White funding. Be specific as to the type of services, location of services, and how services will be delivered. For more information, please refer to the HRSA/HAB Ryan White National Monitoring Standards for Part B – Program and review the corresponding section.
2. Describe how the agency will engage the target population in service delivery.
3. Describe the process by which the agency will monitor that clients are achieving treatment goals.

4. Describe how the agency will coordinate other services for the client, including medical case management, medical care, and/or support services.
5. Discuss how therapists are supervised to ensure compliance with established standards, provision of quality services, and maintenance of ethical practices. Be specific as to who conducts supervision, how often, and trainings provided.

Medical Nutrition Therapy

1. Provide an overview of what allowable and non-billable services will be provided using Ryan White funding. Specify the type of services, location of services, and how services will be delivered. For more information, please refer to the HRSA/HAB Ryan White National Monitoring Standards for Part B – Program and review the corresponding section.
2. Describe how the agency will engage the target population in service delivery.
3. Describe the process by which the agency will monitor that clients are achieving treatment goals.
4. Describe how the agency will coordinate other services for the client, including medical case management, medical care, and/or support services.

Substance Abuse-Outpatient

1. Provide an overview of what allowable and non-billable services will be provided using Ryan White funding. Be specific as to the type of services, location of services, and how services will be delivered. For more information, please refer to the HRSA/HAB Ryan White National Monitoring Standards for Part B – Program and review the corresponding section.
2. Describe how the agency will engage the target population in service delivery.
3. Describe the process by which the agency will monitor that clients are achieving treatment goals.
4. Describe how the agency will coordinate other services for the client, including medical case management, medical care, and/or support services.
5. Discuss how therapists are supervised to ensure compliance with established standards, provision of quality services, and maintenance of ethical practices. Be specific as to who conducts supervision, how often, and trainings provided.

Home Health Care

1. Provide an overview of what allowable and non-billable services will be provided using Ryan White funding. Specify the type of services, location of services, and how services will be delivered. For more information, please refer to the HRSA/HAB Ryan White National Monitoring Standards for Part B – Program and review the corresponding section.
2. Describe how the agency will engage the target population in service delivery.
3. Describe the process by which the agency will monitor that clients are achieving treatment goals.
4. Describe how the agency will coordinate other services for the client, including medical case management, medical care, and/or support services.

Home and Community-Based Health Services

1. Provide an overview of what allowable and non-billable services will be provided using Ryan White funding. Specify the type of services, location of services, and how services will be delivered. For more information, please refer to the HRSA/HAB Ryan White National Monitoring Standards for Part B – Program and review the corresponding section.
2. Describe how the agency will engage the target population in service delivery.
3. Describe the process by which the agency will monitor that clients are achieving treatment goals.
4. Describe how the agency will coordinate other services for the client, including medical case management, medical care, and/or support services.

Hospice Services

1. Provide an overview of what allowable and non-billable services will be provided using Ryan White funding. Specify the type of services, location of services, and how services will be delivered. For more information, please refer to the HRSA/HAB Ryan White National Monitoring Standards for Part B – Program and review the corresponding section.
2. Describe how the agency will engage the target population in service delivery.
3. Describe the process by which the agency will monitor that clients are achieving treatment goals.
4. Describe how the agency will coordinate other services for the client, including medical case management, medical care, and/or support services.

Support Services

The questions below apply to the following allowable support services: non-medical case management, child care services, emergency financial assistance, food bank/home-delivered meals, health education/risk reduction, housing services, legal services, linguistic services, medical transportation services, psychosocial support, rehabilitation services, substance abuse services (residential), and treatment adherence counseling.

For each support service category for which the agency is applying, answer the following questions. For example, an agency applying to three support services would answer the three questions below for EACH service, for a total of six answers. For more information, please refer to the HRSA/HAB *Ryan White National Monitoring Standards for Part B – Program* and review the corresponding section.

1. Provide an overview of the services that will be supported by Ryan White Part B funds. Specify criteria for eligibility (anything that exceeds Ryan White eligibility and recertification), where the services will be provided, type of services provided, how often services will be provided, limitations on the services, and how services will be delivered.
2. Describe how the provision of services will contribute to the client being engaged and retained in HIV medical care.

3. Describe how the support service will lead to improved health outcomes for PLWH.

Minority AIDS Initiative/MDOC Outreach

1. What is the agency's history and experience providing services to people who have been incarcerated?
2. Briefly describe existing or planned collaborations the agency has/will have with MDOC as well as community resources that serve the re-entry population. How will the agency coordinate with these organizations to reach PLWH released from MDOC and link them to Ryan White resources?
3. Describe the agency's approach to engage clients at or before the point of release from MDOC.
4. Provide an overview of the services that will be supported by the Minority AIDS Initiative funds. Specify criteria for eligibility, where the services will be provided, type of services provided, how often services will be provided, limitations on the services, and how services will be delivered.
5. Describe how the provision of services will include benefits counseling and enrollment services to eligible insurances and ADAP. How will the agency ensure that clients have access to medications?
6. Describe how the provision of services will contribute to the client being engaged and retained in HIV medical care.
7. Describe how the agency will link clients being released from MDOC with medical case management services.

Budget Summary, Detail, and Narrative, by Service (not included in page limit)

The budget narrative should be prepared for a one year period. For each category below, provide a detailed description of the purpose of the expenditure and the methodology used to determine the specific cost. The description should clearly indicate the allocation between the service/program costs and the administrative costs (including overhead and indirect expenses).

Note that administrative costs in this budget must reflect the recent changes in the treatment of costs under the administrative cap for the Ryan White HIV/AIDS Program related to Part B. These changes provided by Policy Change Notification (PCN) 15-01 should provide greater flexibility in managing the 10% administrative cost cap on federal funds. MDHHS will continue to provide a mix of federal and rebate funding that allows sub-recipients to budget for a reasonable level. The Budget Template and Instructions (Appendix IV) will provide additional assistance in understanding and operationalizing the changes provided by PCN 15-01 as well as other HRSA and MDHHS requirements.

Salaries and Wages

For each staff position to be funded by Ryan White Part B and/or MAI funds, state the title, annual salary or wage, percent of a full time equivalent (FTE) dedicated to the program, and amount charged to the program. If partial funding is requested for a position, indicate the other sources of funds for this position. Provide a brief description of position responsibilities. For positions with both program and administrative responsibilities, indicate the allocation between the two categories.

Fringe Benefits
Indicate, by percentage of total salary or actual cost, fringe benefits associated with above salaries. Indicate items included in the amount and allocate between program and administrative based on salary allocation.

Travel
All travel must directly benefit the work supported by Ryan White Part B and/or MAI funding and includes staff travel costs incurred for client services and attendance at trainings and conferences. Foreign travel is not allowed with these funds. List all travel anticipated for the one year period. Be specific about who will travel, where, when and why it is necessary. Include reimbursement rates for mileage, lodging and meals. Indicate how many miles, overnights, etc., are to be supported annually. Do not include costs of travel provided to clients in this category, these costs should be included in "other expenses." Indicate the allocation between program and administrative if applicable.

Equipment
An article of nonexpendable, tangible property having a useful life of more than one year and an acquisition cost of $5,000. Proposed expenditures for purchase of equipment must be essential to the delivery of services and proportionate to the proposed programming.

Supplies and Materials
Describe the types of supplies and materials needed to support client services and general office supplies for staff associated with the program. Supplies should be reasonable, appropriate to the services supported under this RFP and be proportionate to the program. Computer software should be included in this category. Articles under $5,000 per unit should be included in this category. Indicate the allocation between program and administrative costs if applicable.

Contractual
Describe the services that will be provided by another organization through a subcontract, how payments are made to the subcontractor, for example an hourly rate and the number of hours/visits, and the total dollar amount of the subcontract. This category should include any subcontractors identified in the narrative and tables of the application. Contracts for a single service or project e.g. payroll, accounting, and mental health services are considered vendors, and should be budgeted under "other."

Other Expenses
This category includes all other costs associated with services funded by Ryan White Part B and/or MAI including, but not limited to, direct payments to providers of services made on behalf of clients, client travel, space costs, communication, lease payments for equipment, mailing costs, equipment maintenance costs, printing costs, accounting and auditing costs, general agency insurance, depreciation and consultants. Be specific in describing each item in terms of what it is, why it is necessary, and how it relates to the proposed program. Some specific requirements for the budget narrative include:

- Payments made to providers on behalf of clients should be itemized by service category and be proportionate to the service levels proposed in the narrative and Tables of the application.

- Description of space costs should describe the method of allocation to Ryan White Part B/MAI such as square footage occupied by staff, and costs to which the allocation is applied.
- Description of communications should detail method of determining costs allocated to Ryan White Part B/MAI and number of phone lines/internet connections required by staff.
- Description of equipment lease payments or maintenance should indicate the nature of the equipment and the purpose as it relates to Ryan White Part B/MAI funding.
- Description of printing and mailing costs should describe the nature of the items such as client mailings, client brochures, client service forms etc.
- Description of travel provided to clients should be specific about who will travel, where, when and why it is necessary. Include reimbursement rates for mileage; how many miles, etc., are to be supported annually.

Consultants are those persons or agencies that are utilized for a limited project that is not a direct client service such as accounting and audit fees. The nature and purpose of any services to be provided by consultants should be detailed.
Direct administrative costs examples include accounting and auditing costs, general agency insurance, and depreciation, and allocated costs of space, communication, etc. that do not support program staff.

Indirect costs are always administrative and when combined with other administrative costs, must fall under the 10% cap. This cost category can only be used if an agency has received an indirect rate approval from the State of Michigan or another Federal funding source. Nonprofits and State Universities must submit documentation of the indirect rate approval with their Ryan White Part B/MHI budgets.

Required Attachments (not included in page limit):

- 501(c)(3) certification (if applicable)
- Evidence of Medicaid-certification, if available
- Board of Directors (names, position on Board, professional affiliations, expertise represented, race/ethnicity, and gender)
- Organizational chart which clearly identifies position in the organization and reporting relationships relevant to this proposal.
- Most recent independent financial audit or financial statements if audit is unavailable.
- A brief 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.
- Memoranda of Agreement, Memoranda of Understanding, Letters of Agreement or Contracts
- Ryan White Service Category Table (for each service category for which you are applying)

Proposal Format Requirements

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

- Sequentially number all pages, including attachments and appendices.
- Include a table of contents and a list of attachments for the entire package submitted.
- Use Arial 12 point font, only. Budgets, figures, charts, tables, figure legends, and footnotes may be smaller in size, but must be readily legible.
- Use 1" margins (top and bottom, left and right)
- The entire proposal narrative section (excluding agency profile, budget, and required attachments) should not exceed 30 pages.
- Page limits specified in this RFP refer to single-spaced pages. Pages in excess of the maximum will not be read.

Proposal Submission

Proposals must be submitted via email as a PDF attachment to Hope McElhone at mcelhoneh@michigan.gov. Confirmatory receipts will be sent to submitting contact person.

Proposals are due no later than 3:00 pm EST on June 1, 2015.

Review Process

All proposals submitted by the deadline will undergo a preliminary evaluation for completeness by the Grants and Contracts Technician, then, reviewed by a panel of staff from the Michigan Department of Community of Health. Applicants who fail to include all required elements of the proposal package as described in the proposal narrative outline will be disqualified from the RFP process.

In preparing proposals, organizations should consider the aim of the MDHHS/HCS program to improve health outcomes and to achieve viral load suppression by:

- Identifying people who were previously unaware of their HIV status and linking them to medical care
- Reengaging PLWH who are lost to medical care
- Supporting PLWH in maintaining ongoing HIV medical care and treatment
- Providing resources to address social determinants and reducing HIV-related health disparities
- Supporting people with HIV at each stage of the treatment cascade from diagnosis to viral load suppression

MDHHS/HCS will make awards to sub-recipients possessing the ability to perform successfully under the terms and conditions of this RFP. As part of this review process, consideration will be given to such matters as agency integrity, compliance with public policy, record of past performance, financial and technical resources, the level of service needed in the proposed area, funding availability, collaborative agreements and

partnerships, organizational capacity, program efficiency, cost effectiveness and the ability to provide quality services.

Procedures for assessing the technical merit of applications have been developed for an objective review of applications and are included to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting relevant information related to that. These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review. Review Criteria are used to review and rank applications and are as follows:

Criterion 1: Organizational Capacity (20 points)

Corresponds to the Agency Capacity Section

- The organization's mission.
- The history and experience relevant to the provision of proposed services.
- The geographical service areas (e.g., counties) served by the organization and rationale for why these areas were chosen.
- The target population and the organization's history and experience serving the target population.
- The organization's experience in effectively administering programs, grants, or contracts.
- The organization's efforts to recruit and retain staff members who are culturally diverse and reflective of the organization's target population and are included in the planning, design, and implementation of HIV care services.
- The organization's efforts to address the needs of individuals with special needs including non-English speaking clients, those with developmental disabilities and/or people who are visually/hearing impaired.
- The organization's formal and informal relationships with other organizations.
- The processes the organization has in place to ensure that uninsured or underinsured clients have access to the ACA insurances.
- The steps the organization takes to vigorously pursue benefits enrollment for uninsured or underinsured clients.

Criterion 2: Need (25 points)

Corresponds to the Statement of Need Section

- The extent to which the organization describes the needs/gaps in services for the target population(s).
- Outlines specific barriers to providing services within the counties served by the organization.
- The extent of the organization's role in the changing environment of ACA and how services will be provided by the organization to fill the gaps left by ACA for PLWH.
- The strength of the epidemiologic and demographic data provided that demonstrates an ongoing and/or increasing burden of HIV infection.

- The extent to which the data provided in the application and the description of the local health care delivery system clearly demonstrate a need.

Criterion 3: Proposed Services Section (30 points)

Corresponds to the Eligibility and Recertification Procedures and Ryan White Service Categories

- The process the agency has (or will have) in place to ensure clients are initially eligible for Ryan White services and recertified in accordance with MDHHS/HCS guidance.
- The service categories funds requested will support and how they fit in with the continuum of care services offered at the agency.
- For new programs or changes in service delivery models, describe the three-month start-up process and the steps that will be taken to implement the program.
- An overview of the medical case management services that will be supported by Ryan White Part B funds.
- If non-medical case management will be incorporated into service delivery, the extent of how non-medical case management and medical case management services will work together to serve eligible clients.
- The strength of the medical case management services to engage new clients into services, especially those who have been lost to HIV medical care.
- The extent of how medical case management assessment and client acuity will be used to better understand client needs and to deliver services.
- The strength of the proposed services which will ensure that clients served are retained in HIV medical care.
- The efforts of medical case managers who will conduct treatment adherence counseling, including assessing readiness for and adherence to complex HIV treatments.
- The extent to which the organization's staff are supervised to ensure compliance with established standards, provision of quality services, and maintenance of ethical practices.
- Clearly outlines how the organization determines a client has successfully services and/or program.
- The extent of what allowable and non-billable services will be provided using Ryan White funding. Specifies as to the type of services, location of services, and how services will be delivered.
- The organization's efforts to engage the previously identified target population in service delivery.
- The organization's efforts to coordinate other services for the client.
- The extent of the cost-sharing assistance supported by Ryan White Part B funds the organization will provide.
- The extent of the early intervention services that will be supported by Ryan White Part B funds the organization will provide.
- The extent of how the agency will collaborate with medical case management services in order to serve PLWH.

- The extent of how early intervention services staff will conduct health education/risk reduction with clients.
- The processes by which the agency will monitor clients that are achieving treatment goals.

Criterion 4: Evaluative Measures (15 points)

Corresponds to the Quality Assurance and Quality Management Section

- The organization's ability to manage and monitor sub-recipient performance and compliance with RWHAP Part B requirements.
- The organization's ability to ensure that client-level data is entered properly into CAREWare (or similar data system/spreadsheet).
- The capabilities of the organization and the qualifications and/or experience of the personnel to fulfill the needs and requirements of the proposed project.
- The appropriateness of the staffing plan and the qualifications and/or experience of the personnel to provide HIV services.
- The strength of the evidence of the organization's ability to implement and support the proposed project.
- The organization's quality assurance process (e.g., chart checklists, peer/supervisor review, etc.).
- The extent to which the organization has applied program data to improve services.

Criterion 5: Budget (10 points)

Corresponds to the Budget Section

- Costs, as outlined in the budget section, are reasonable given the scope of work.
- The appropriateness of the requested funding level for each year of the proposed project period in comparison to the level of effort, performance, and the number of HIV-positive clients to be served.
- The budget and budget justification narrative are clearly linked to proposed services/activities as identified in the Need section.
- The administrative costs in this budget reflect the recent changes in the treatment of costs under the administrative cap for RWHAP Part B provided by Policy Change Notification 15-01. Administrative activities, including all indirect costs, are at a reasonable level (20%-22% of direct costs).

Criterion 6: MAI (100 points, scored separately)

Corresponds to the Minority AIDS Initiative/MDOC Outreach

- The organization's history and experience providing services to people who have been incarcerated.
- The extent of existing or planned collaborations the agency has/will have with MDOC as well as community resources that serve the re-entry population.
- The organization's approach to engage clients who are newly released from MDOC.
- The extent of the services that will be supported by the Minority AIDS Initiative funds.

- The organization's efforts to ensure that the clients have access to medications.
- The organization's efforts to link clients being released from MDOC with medical case management services.

Appendix I: Letter of Intent Form

Ryan White Part B RFP

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.)**

Must be sent to mcelhoneh@michigan.gov by 5 PM EST on Monday, May 11, 2015

Appendix II: 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	FY15/16			
		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 III: Application Checklist

- ☐ Letter of Intent (Due May 11, 2015)

- ☐ Proposal
  - o Agency Profile (Appendix II) (not included in page limit)
  - o Proposal Narrative (maximum 30 pages)
    - ▪ Agency Capacity
    - ▪ Statement of Need
    - ▪ Eligibility and Recertification Procedures
    - ▪ Quality Assurance and Quality Management
    - ▪ Ryan White Service Categories
    - ▪ Minority AIDS Initiative/MDOC Outreach (if applying)
  - o Budget Summary, Detail, and Narrative, by Service (not included in page limit)
- ☐ Required Attachments (not included in page limit):
  - o 501(c)(3) certification (if applicable)
  - o Evidence of Medicaid-certification, if available
  - o Board of Directors (names, position on Board, professional affiliations, expertise represented, race/ethnicity, and gender)
  - o Organizational chart which clearly identifies position in the organization and reporting relationships relevant to this proposal.
  - o Most recent independent financial audit or financial statements if audit is unavailable.
  - o A brief 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.
  - o Memoranda of Agreement, Memoranda of Understanding, Letters of Agreement or Contracts
  - o Ryan White Service Category Table (for each service category for which you are applying)
- ☐ Proposal Format Requirements
  - o Pages sequentially numbered, including attachments and appendices.
  - o Table of contents included with list of attachments
  - o Arial 12 point font, only. Budgets, figures, charts, tables, figure legends, and footnotes may be smaller in size, but must be readily legible.
  - o 1" margins (top and bottom, left and right)
  - o Proposal narrative does not exceed 30 pages.
  - o Page limits specified in this RFP refer to single-spaced pages.

Appendix IV: Sub-Recipient Budget Instructions for Ryan White Part B/Minority AIDS Initiative (MAI) RFP

A. Introduction to Budget Package

B. Guidelines for Determining Types of Costs

1. Direct Services
2. Planning and Evaluation
3. Quality Management
4. Administrative

C. Principles for the Proper Allocation of Administrative VS. Program Costs; and Unallowable Costs

D. Description of Budget Forms

1. Form 1: Funding-Year 1
2. Form 2: Staffing Plan
3. Form 3: Budget Justification
4. Form 4: Service Description Form
5. Form 5: Three Year Funding Summary

E. Budget Form Instructions

1. Form 1: Funding-Year 1
2. Form 2: Staffing Plan
3. Form 3: Budget Justification
4. Form 4: Service Description Form
5. Form 5: Three Year Funding Summary

F. Budget Checklist

Introduction to Budget Package

This budget package is to be used for all awards issued and administered by the Michigan Department of Health and Human Services (MDHHS) Division of Health, Wellness, and Disease Control, 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.

The administrative costs in this budget must reflect the recent changes in the treatment of costs under the administrative cap for RWHAP Part B. These changes provided by Policy Change Notification (PCN) 15-01 should provide greater ease in managing the administrative cap. However, MDHHS will continue to provide a mix of funding that allows our sub-recipients to budget for a reasonable level of administrative costs. This document will also assist you in understanding and operationalizing the changes provided by PCN 15-01.

Guidelines for Determining Types of Costs

There are four types of costs: Direct Services, Planning and Evaluation, Quality Management, and Administrative.

1. Direct Services 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 Direct Services 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; including a clinic receptionist's time providing direct RWHAP patient services (scheduling appointments and other intake activities)
   - Consultants who provide direct services to clients, develop program materials, or perform other program functions
   - Third party billing (Medicare, Medicaid, insurance, etc.) costs related to RWHAP
   - Facilities expenses such as rent, maintenance, utilities, etc. related to core medical or support services provided to RWHAP clients
   - The portion of malpractice insurance related to RWHAP clinical care
   - 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, including the portion of fees and services for electronic medical records maintenance, licensure, and annual updates; and staff time for data entry related to RWHAP clinical care and support services.

- Biannual RWHAP client re-certification
- The portion of medical waste removal and linen services related to the provision of RWHAP services
- ACA Outreach and Enrollment for RWHAP clients
- Supervisor time devoted to providing professional oversight and direction regarding RWHAP-funded core medical or support service activities

2. Planning and Evaluation costs are defined as the costs incurred for agency-wide evaluation and program specific evaluation.

   Examples of Planning and Evaluation costs are:
   - Staff salaries and fringe whose duties relate to agency wide evaluation activities, as well as program-specific evaluation
   - Program evaluation, customer satisfaction, needs assessment, and related activities
   - Travel related to evaluation activities, including client travel specifically for the participation in a focus group or other evaluation activity
   - Expenditures specifically for focus groups for program evaluation or needs assessment purposes (e.g., meeting room, client incentives)

3. Quality Management costs are defined as the costs incurred for Quality Management, Quality Assurance, Quality Control, and related activities.

   Examples of Quality Management costs are:
   - Staff whose duties relate to quality management (e.g., developing agency quality assurance protocols, reviewing a sample of charts to determine the quality of services agency-wide, or participating on an agency's/facility's quality committee).
   - Survey-related responsibilities
   - Work on a Quality Management Plan

     NOTE: This does not include supervisor quality assurance (e.g., reviewing charts with direct service staff to determine the appropriateness and comprehensiveness of services delivered to the staff person's clients). These costs can be included in administrative costs instead of quality management costs.

4. 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.

   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 and provide routine grant administration and monitoring activities

- Consultants and staff 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, and compliance activities
- Usual and recognized overhead activities, including established indirect rates for agencies

Principles for the Proper Allocation of Administrative vs. Program Costs, and Unallowable Costs

For costs to be allowable, they must be authorized by statute and must meet the federal criteria of being necessary, reasonable, allocable, and awarded consistent treatment.

For an inclusive list of all unallowable costs please refer to 45 CFR 75 Uniform Guidance-Subpart E-Cost Principles.

When allocating costs, please refer to the definitions of Direct Costs, Indirect Costs, and Indirect Cost Rates. To charge to items like rent or utilities to the Direct Services category, you must have a methodology in place to show how the cost is allocated appropriately.

- Direct Cost: A cost that can be accurately traced to a program/service activity with little effort
- Indirect (F & A Cost): Cost that is not directly traceable to a program service/activity
- Indirect Cost Rate: Device/methodology for determining fairly and conveniently how much of the common (hard to trace) cost each program should bear

When allocating between administrative and direct services costs, recipients must have a system of internal controls over the records that:

- Justify the costs
- Is reasonable over the long term
- Are entered into the record in a timely manner
- Are consistent
- Are auditable
  - For allocations to be valid, there should be written methodology that can be replicated
- Permits expenses to be appropriately charged to cost centers, object classes, funding sources, and multiple sites
- Common methodologies include:
  - Payroll: Direct or Time and Effort
  - Facility: Direct or Square Footage
  - Occupancy: Direct or Program/Cost Center

- Administration: Direct or Total Dollar Amount
- Communication: Program/Cost Center

NOTE: Per 45 CFR 75.414(f), any non-federal entity that has never received a Federal negotiated indirect cost rate may charge a *de minimis* rate of 10% of modified total direct costs. Governmental departments or agency units receiving more than $35M in federal funds MUST have a negotiated rate and may NOT charge the flat 10%.

NOTE: As described in §75.403, costs must be consistently charged as either indirect or direct costs, but may NOT be double-charged or inconsistently charged as both. If chosen, this methodology, once elected, must be used consistently for ALL federal awards until such time as a non-federal entity chooses to negotiate for a rate, which the non-federal entity may do at any time.

NOTE: Please see Policy Clarification Notice 15-01 for more information on administrative and direct cost allocation changes.

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 linked to 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 MDHHS 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 MDHHS 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 MDHHS.

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 for the period of October 1, 2015-September 30, 2016. Requested budget information for Year 2 and Year 3 are for the two subsequent years (Year 2: October 1, 2016-September 30, 2017; Year 3: October 1, 2017-September 30, 2018.)

NOTE: A separate budget tool must be completed and submitted if your agency is applying for both Ryan White Part B funds and Minority AIDS Initiative (MAI) funds. Each separate budget form must detail proposed costs specifically for Ryan White Part B, or specifically for MAI. If your agency is only applying for Ryan White Part B, or only MAI, only one budget form needs to be submitted.

Form 1, FUNDING-YEAR 1:

- Enter the agency name, total amount requested, and RFP number. Click the Program field drop-down and select the funding source for which you are applying, Ryan White Part B or Minority AIDS Initiative (MAI). This information is cell referenced to all forms. The Funding-Year 1 form will show a categorical line item budget in the "Direct Services", "Planning and Evaluation", "Quality Management", and "Administrative" columns that are cell referenced from other tabs in the workbook.
- Enter the amount of Indirect Charges in Cell H:25 after input of all the budget data for direct costs is in the "Budget Justification" is completed. Indirect costs are charges that are not directly traceable to a program/service activity. As described in §75.403, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both.
- In the Source of Funds-Year 1 table, input the projected dollar amounts for each funding category. This information is filled in after the budget is completed. "Total Source of Funds" must equal the total for all of the budget costs.

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

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 Direct Services (DIRECT SVS), Planning and Evaluation (P & E), Quality Management (QM), and Administrative (ADMIN).
- 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.

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.

- 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.

NOTE: The Budget Justification form should include all costs covered by ALL Sources of Funds used to support the program, including program income (fees and collections).

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 Direct Services (DIRECT SVS), Planning and Evaluation (P & E), Quality Management (QM), or Administrative (ADMIN). 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.

Travel

All travel must directly benefit the work supported by Ryan White Part B and/or MAI funding and includes staff travel costs incurred for client services and attendance at trainings and conferences. Foreign travel is not allowed with these funds. List all travel anticipated for the one year period. Be specific about who will travel, where, when and why it is necessary. Include reimbursement rates for mileage, lodging, and meals. Indicate how many miles, overnights, etc., are to be supported annually. Do not include costs of travel provided to clients in this category, these costs should be included in “other expenses.” Indicate the allocation between program and administrative if applicable.

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 an article of nonexpendable, tangible property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. Proposed expenditures for purchase of equipment must be essential to the delivery of services and proportionate to the proposed programming. 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 supplies to provide service and program support. Describe in detail the type, cost, and purpose of purchases and the allocation methodology. The narrative must justify why these costs are required to carry out your program. Articles under $5,000 per unit should be included in this category. Indicate the allocation between program and administrative costs if applicable.

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.

Other

The other category can include items such as 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 (State Agreement amount ONLY) at the top of the Service Category Funding-Year 1 form, which in addition should reflect indirect costs, if applicable.

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 Service Description 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 number of clients with unmet need proposed to be served during the award period.
- Column 5: **You do not need to enter data in this column**. The form calculates the proposed cost per client by dividing Column 3 by Column 4.
- Column 6: Indicate whether the services in Column 1 are provided by a contractor by selecting “Yes” or “No"

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 MDHHS 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 MDHHS.

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

BUDGET CHECKLIST

Applicant agencies should complete the following budget forms return to MDHHS with the entire proposal.

- ❑ 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 V: RFP Resources

MDHHS Policy Guidance

MDHHS Ryan White Program Guidance #14-01 - Eligibility and Recertification

PURPOSE
This guidance sets forth requirements related to eligibility and recertification for clients served by Michigan Department of Community Health (MDHHS)-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. MDHHS must assure that sub-grantees make reasonable efforts to secure non-Ryan White funds whenever possible for services to individual clients. MDHHS 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 MDHHS-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

   Proof of eligibility criteria include:

Eligibility Criteria	Accepted Proof/Documentation
HIV Status	• Eligible laboratory documentation confirming HIV diagnosis test results include: o 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: o As allowed under Michigan law verifying that the individual is HIV positive. • Other documentation: o 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

2. MDHHS-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 Insurance Status	Collect and document acceptable proof in individual's health record	Talk to the individual about eligibility status 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	Collect and update acceptable proof in individual's health record (same information collected at initial eligibility)

MDHHS Ryan White Program Guidance #14-02 - Administration Expense Cap

PURPOSE

This guidance sets forth requirements related to Ryan White legislation regarding the cap on sub-recipient administration costs.

BACKGROUND

The legislative intent for Ryan White funds is to fund services and keep administrative costs to a minimum. Sub-recipients must keep administrative costs to 10% of the total Ryan White budget unless MDHHS provides the sub-recipient a written exception. There are also caps on evaluation costs (5%) and quality management (5%). The cumulative total of administrative, evaluation and quality management cannot exceed 15%.

IMPLEMENTATION

Administrative Costs

The following items are considered administrative expenses and should be identified in the budget narrative as such when creating your budget.

A. Salaries
   1. Management and oversight: This includes staff that has agency management responsibility but no direct involvement in the program or the provision of services.

   2. Quality management, quality assurance, quality control and related activities: This includes staff whose duties relate to agency-wide quality assurance (e.g., developing agency quality assurance protocols, reviewing a sample of charts to determine the quality of services agency-wide, or participating on an agency's/facility's quality committee). This does not include supervisor quality assurance (e.g., reviewing charts with direct service staff to determine the appropriateness and comprehensiveness of services delivered to the staff person's clients). **These costs can be included in quality management costs instead of administrative costs.**

   3. Finance and Contract administration: This includes proposal, work plan and budget development, receipt and disbursal of contract funds, and preparation of programmatic and financial reports as required by the grant. A position or percentage of a position may be considered administrative. Examples of titles that are 100% administrative: Controller, Accounting Manager, Director of Operations, Bookkeeper, Accountant, Payroll Specialist, Finance Coordinator, Maintenance Worker, or Security Officer. Examples of titles that may in part involve administrative duties: Deputy Executive Director; Program Manager, Program Coordinator, or Clinic Manager.

   4. Planning and Evaluation: This includes evaluation and needs assessment activities. This can include everything from designing an evaluation process

to implementing the evaluation and analyzing the results to serving on a Needs Assessment Committee, assisting with drafting the assessment, facilitating focus groups to gather information about consumer needs, or writing the report. **These costs can be included in planning and evaluation costs instead of administrative costs.**

B. Fringe
The fringe rate should be applied to the amount of staff salaries devoted to administration in order to calculate the amount of administrative fringe benefits.

C. Supplies
All funds budgeted for office supplies are considered administrative. Supplies such as educational or clinical materials would be considered programmatic.

D. Travel
Travel pertaining to the financial operations or overall management of the organization is considered administrative. Client travel or travel of program staff to training would be considered programmatic. For employees who work a portion of their time in different categories of expense (administrative, quality management, planning and evaluation, and/or program), travel should align with employee time sheet activity reporting.

E. Equipment
Equipment purchased for administrative staff or for the financial operations or overall management of the organization is considered administrative. Equipment purchased for program staff or to support or enhance service delivery would be considered programmatic.

F. Miscellaneous
Includes 100% of rent, utilities, computers (desktop and laptop), telecommunications (except for those that relate to a unique number or service purchased specifically for this program), audit expenses, general liability and board insurance. In addition, the percentage of staff time devoted to administration (as calculated on the salary page) should be applied to items of expense shared by program and administrative staff (such as photocopiers, printers, and maintenance agreements).

G. Subcontracts/Consultant
Includes contractors who perform non-service delivery functions, e.g. bookkeepers, payroll services, accountants, security, maintenance, etc.

H. Indirect
100% of funds budgeted in the indirect line are administrative. Only sub-recipients with a federally approved indirect cost rate agreement may request indirect costs (capped at 10%). This rate must be 10% or less for Ryan White contractors. We recognize that some administrative resources are needed by contractors to support direct service programs; however, it is important to note

that Ryan White funds are meant to support direct services rather than administration. Upon review of the budget, MDHHS staff will work with you, if necessary, to reduce administrative costs.

Evaluation Costs

The following items are considered evaluation expenses and should be identified in the budget narrative as such when creating your budget.

A. Salaries
   Program evaluation, customer satisfaction, needs assessment and related activities: This includes staff whose duties relate to agency-wide evaluation activities as well as program specific evaluation. **These costs can be included in administrative costs instead of evaluation costs.**

B. Fringe
   The fringe rate should be applied to the amount of staff salaries devoted to evaluation in order to calculate the amount of evaluation fringe benefits.

C. Travel
   Travel pertaining to evaluation activities can be considered an evaluation cost. Client travel specifically for the purpose of participation in a focus group or other evaluation activity can included in evaluation costs.

D. Equipment
   Equipment purchased for evaluation staff exclusively for evaluation activities can be considered an evaluation cost.

E. Miscellaneous
   Expenditures specifically for focus groups for program evaluation or needs assessment purposes (e.g., meeting room, client incentives) can be considered an evaluation cost.

F. Subcontracts/Consultant
   Includes contractors who perform evaluation activities.

Quality Management Costs

The following items are considered quality management expenses and should be identified in the budget narrative as such when creating your budget.

A. Salaries
   Quality management, quality assurance, quality control and related activities: This includes staff whose duties relate to agency-wide quality assurance (e.g., developing agency quality assurance protocols, reviewing a sample of charts to determine the quality of services agency-wide, or participating on an agency's/facility's quality committee). This does not include supervisor quality assurance (e.g., reviewing charts with direct service staff to determine the

appropriateness and comprehensiveness of services delivered to the staff person's clients). **These costs can be included in administrative costs instead of quality management costs.**

B. Fringe
The fringe rate should be applied to the amount of staff salaries devoted to quality management in order to calculate the amount of quality management fringe benefits.

C. Travel
Travel pertaining to the quality management activities of the organization can be considered a quality management cost.

D. Equipment
Equipment purchased for quality management staff exclusively for quality management activities can be considered a quality management costs.

E. Subcontracts/Consultant
Includes contractors who perform quality management activities.

MDHHS Ryan White Program Guidance #14-03 - Incentives

PURPOSE

This guidance sets forth requirements related to accounting for gift cards used as incentives for client participation.

BACKGROUND

Ryan White funds allow grantees and sub-recipients to use gift cards for client incentives, with some conditions:

- Gift cards may not be redeemed for cash; VISA and MasterCard pre-paid cards are not allowed.
- Gift cards may not be used for unallowable items, including but not limited to, purchase of alcohol, tobacco, illegal drugs or other substance, or firearms. They also may not be used to purchase tickets to entertainment, recreational or sports events, or clothing. For further explanation see HRSA Policy Notice 10-02.

INSTRUCTIONS

1. Sub-recipients must have a written policy for providing incentives to project participants. At a minimum the policy must address:
   - Potential IRS tax implications
   - Cost basis used to determine that the amount is consistent with the impact participation poses on the daily life of the project participant.
   - Annual dollar limit to any one individual.

2. Sub-recipients must have written procedures for implementing policy on incentives to project participants. At a minimum the procedures must address:
   - Provision that individual recipients of gift card incentives must sign a statement acknowledging and agreeing to the purposes of and restrictions (e.g., unallowable costs) of the incentive.

3. Sub-recipient must maintain appropriate documentation for each participant gift card. At a minimum this includes:
   - List of each gift card by number with name of participant who received the card with that number, the value of the card, the date the card was provided to the participant, and the purpose for which the participant received the incentive.
   - Copy of the participants signed acknowledgement/agreement.
   - Record of the number of incentives and cumulative total amount received by each participant during each contract year.

4. The purchase of incentives must be explicitly identified in the budget submitted for the annual contract and all amendments. The budget narrative should describe the purpose of the incentives, the individual value and total cost, and a description of the type of incentive (e.g., gas card). Sub-recipients will be monitored for policy and procedure at the annual site visit, and review of records related to incentives may be reviewed at any time.