MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HIV AND STI PROGRAMS

TECHNICAL ASSISTANCE (TA) REQUEST FORM

HIV Care, Prevention, Surveillance & STI staff will contact you within three business days of receiving this form.

Agency Name:	**Date of Request:**
Contact Person:	**Phone:**
Email Address:	

Please Identify Funding Sources (select all that apply)

Prevention: ☐ PS 18-1802 ☐PS 20-2010

Ryan White: ☐ Part A ☐ Part B ☐Part C ☐ Part D ☐ Minority AIDS Initiative (MAI)

Non-Federal: ☐ Care Coordination ☐Medical Care ☐ Data 2 Care ☐ HIV Housing Assistance ☐ Dementia Care ☐ HIV Consultation Program ☐ Aids Research Education ☐ PrEP Clinic

Surveillance: ☐National HIV Behavioral Surveillance ☐ Medical Monitoring Project

STI: ☐PS 19-1901

Other:

Seeking TA for (select all that apply)

Prevention: ☐ CTR ☐ Partner Svcs ☐ Evaluation ☐ PrEP ☐ nPEP ☐ SSP ☐ Evidence Based Interventions

Ryan White: ☐ Part B ☐ Part D ☐ MAI ☐ MIDAP ☐ QM ☐ CAREWare

Non-Federal: ☐ Care Coordination ☐Medical Care ☐ Data 2 Care ☐ HIV Housing Assistance ☐ Dementia Care ☐ HIV Consult Program ☐ Aids Research Education ☐ PrEP Clinic

STI: ☐ Local HD ☐ Specialty Services ☐ Outreach Education ☐ Screening & Referral

Administrative: ☐Training ☐Communications ☐ Budget/Fiscal ☐ Grants/Contracts

Other:

Description of TA Needs:	**TA Format Requested (select all that may apply):** ☐ Virtual Call ☐ In-Person ☐ Tools/Resource Materials ☐ Webinar ☐ Other
Description of Expected Outcome after TA:	

Please click Submit **once complete**

FOR MDHHS USE ONLY

Date Request Received:	**Date G&C Sent Receipt Confirmation:**	
TA Disposition: ☐ Accepted ☐ Denied	**If Denied, provide reason:**	
Name of TA Lead(s):		
Priority Rating: ☐ High ☐ Moderate ☐ Low	**Estimated Date for Completion:**	
TA Follow-up Date:	**TA Format:**	**Actual Date for Completion:**
TA Action Plan:		
TA Outcome:		