New York State
Department of Health
Division of HIV/STD/HCV Prevention
Office of Population Health and Prevention Programs

Request for Applications
Grants Gateway #s: DOH01-PSCOCA-2024, DOH01-PSCOCB-2024, DOH01-PSCOCC-2024, DOH01-PSCOCD-2024, DOH01-PSCOCE-2024; DOH01-PSCOCF-2024

RFA Number: #**20407/Internal Program #23-0004**

High Impact Prevention and Services that Address Social Determinants of Health and Reduce Health Disparities within Communities of Color

In order to apply for this RFA, eligible applicants must be prequalified in the New York State Grants Gateway, unless exempt, and must submit an application via the New York State Grants Gateway.

Applicants may only submit one application per component and no more than two (2) applications in total in response to the RFA.

This is a procurement which encompasses six (6) components.

Component A: Prevention and Essential Support Services for Men within Communities of Color (DOH01-PSCOCA-2024)
Component B: Prevention and Essential Support Services for Transgender and Gender Non-Conforming (TGNC) Individuals, particularly in Communities of Color (DOH01-PSCOCB-2024)
Component C: Prevention and Essential Support Services for Women and Young Women within Communities of Color (DOH01-PSCOCC-2024)
Component D: New York State (NYS) HIV/STI/Hepatitis C Hotline and Social-Media Based Outreach for English and Spanish Speakers (DOH01-PSCOCD-2024)
Component E: Training and Technical Assistance on HIV-Related Violence Targeting Lesbian Gay Bisexual Transgender and Queer (LGBTQ) Individuals (DOH01-PSCOCE-2024)
Component F: Capacity Building for High Impact Prevention for Hispanic/Latino Gay/Men who have Sex with Men (MSM) (DOH01-PSCOCF-2024)

KEY DATES

Release Date:	**October 19, 2023**
Applicant Conference:	**October 31, 2023 at 11:00 AM ET**
Applicant Conference Registration:	**https://aidsinstituteny-org.zoom.us/webinar/register/WN_krJRGF9uTuepjqEpLpxtNw**
Questions Due:	**November 2, 2023, by 4:00 PM ET**
Questions, Answers and Updates Posted: (on or about)	**November 16, 2023**
Applications Due:	**December 7, 2023, by 4:00 PM ET**

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I. INTRODUCTION

The New York State Department of Health AIDS Institute (NYSDOH AI), Division of HIV/STD/HCV[1] Prevention, Office of Population Health and Prevention Programs, announces the availability of **$7,294,000** annually in New York State (NYS) funds to address social determinants of health (SDOH) and health disparities by funding programs that promote HIV/STI/Hepatitis C (HCV) prevention and sexual health and wellness services for communities of color through the implementation of sexual health, health equity, and SDOH frameworks.

The purpose of this funding is to identify community-based agencies to implement innovative, data driven, culturally affirming, strength-based, sex-positive approaches to support and increase access to HIV/STI/HCV prevention interventions, sexual and behavioral health services for communities of color (Black, Latino/Latinx, Indigenous people and Asian populations). It also supports structural interventions including the state-wide HIV/STI/HCV hotline and social media-based outreach, training, and technical assistance on HIV-Related Violence Targeting Lesbian Gay Bisexual Transgender and Queer (LGBTQ) Individuals (particularly LGBTQ persons of color), and capacity building activities for the delivery of High Impact Prevention for Latino Men who Have Sex with Men (MSM).

This solicitation promotes NYS's Ending the Epidemic (ETE) goals and AIDS Institute priorities and call to action letters[2] and emphasizes activities that seek to address SDOH and health disparities which can result in barriers to positive health outcomes and the overall wellbeing for the priority population(s). Funded applicants will provide interventions that support a status neutral approach and help to improve quality of care experiences and health outcomes through the elimination of barriers such as institutional racism, unconscious and implicit bias, and structural stigma utilizing sexual health, health equity, stigma-free and SDOH frameworks. This approach meets people where they are, offering a "whole person" approach to prevention and support, and putting the needs of the person ahead of their HIV status.

It is important to note the diversity of the priority populations in this RFA including, but not limited to sexual identity, sexual expression, gender identity, gender expression, social networks, age, race/ethnicity, language, culture, religion, education, socioeconomic status, as well as knowledge of and use of technology. In addition, the populations to be reached by this solicitation historically confront health disparities. It is likely that successful efforts to engage these populations will be those that acknowledge this diversity and the overlapping risks and challenges these populations face and will attempt to take a holistic approach that addresses SDOH in order to improve their health status and general well-being.

The primary goals of this RFA are to**:**

- Address health disparities and inequities by identifying barriers to positive health outcomes and provide relevant prevention, navigation, and essential support services to priority populations with a focus on communities of color;
- Reduce new HIV infections and improve the health outcomes of persons with diagnosed HIV;
- Facilitate the prompt access to quality, non-discriminatory, stigma-free, culturally competent medical care and essential support services for persons living with HIV and/or diagnosed with an STI or HCV;
- Offer tools and support to strengthen self-management skills and encourage persons living with HIV and those who will benefit from prevention services to identify and apply personal strengths and self-advocacy skills to achieve positive health outcomes;
- Increase awareness about treatment as prevention and biomedical interventions for those who are HIV negative including Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP);
- Enhance sexual health education efforts while also assisting with linkage to HIV testing, STI, and HCV screening and treatment;
- Integrate trauma-informed approaches and design interventions and services from a stigma-free and SDOH frameworks;

[1] HIV-Human Immunodeficiency Virus, STD-Sexually Transmitted Diseases, HCV- hepatitis C
[2] https://www.health.ny.gov/diseases/aids/ending_the_epidemic/

- Offer HIV/STI/HCV health promotion, referrals, and support; and
- Enhance provider capacity via the provision of training/technical assistance to promote the health and wellness of the priority population(s).

This RFA contains six (6) components:

Component A: Prevention and Essential Support Services for Men within Communities of Color

Component B: Prevention and Essential Support Services for Transgender and Gender Non-Conforming (TGNC) Individuals, particularly in Communities of Color

Component C: Prevention and Essential Support Services for Women and Young Women within Communities of Color

Component D: NYS HIV/STI/Hepatitis C Hotline and Social-Media Based Outreach for English and Spanish Speakers

Component E: Training and Technical Assistance on HIV-Related Violence Targeting Lesbian Gay Bisexual Transgender and Queer (LGBTQ) Individuals

Component F: Capacity Building for High Impact Prevention for Hispanic/Latino Gay/Men who have Sex with Men (MSM)

A. Background/Intent

To effectively address HIV/STI/HCV transmission and sustained engagement in medical care and achieve NYS's Ending the Epidemic (ETE) goals, the NYSDOH AI recognizes the importance of a holistic (biological, psychological, and social) approach which extends beyond an individual's risk behaviors, particularly for disproportionately affected communities.

Although this funding prioritizes communities of color, it is important to highlight the disproportionate impact of HIV amongst Black people. Black people have shouldered the heaviest burdens of HIV. In 2018, Black people, who make up 13% of the US population, represented 42% of all new HIV diagnoses. Only 51% of Black people living with HIV (PLWH) in the US were virally suppressed compared with 56% of PLWH overall.

In NYS, the rate of new HIV diagnoses among Black individuals in 2020 was 8.1 times higher than the rate for non-Hispanic White individuals. Also, in 2020, Black people constituted 14.4% of the population of New York State, but 45.1% of PLWH. Promising reductions in HIV diagnoses were made from 2014 to 2018 among Black people overall, but HIV diagnoses increased 7% for Black people 25 to 34 years of age. The data highlights the importance of supporting interventions and services that center around this population.

On June 2014, NYS announced a three-point plan to move us closer to the end the AIDS epidemic in NYS.[3] The goal is to achieve the first ever decrease in HIV prevalence in New York State by the end of 2020. The three-point plan:

1) Identify persons with HIV who remain undiagnosed and get them linked to care;

2) Link and retain persons diagnosed with HIV in health care to maximize viral suppression; and

3) Increase access to Pre-Exposure Prophylaxis (PrEP) for persons who are HIV negative.

[3] https://www.health.ny.gov/diseases/aids/ending_the_epidemic/index.htm

NYS has been laying the groundwork for ending the AIDS epidemic since the disease emerged in the early 1980s. NYS's response to the HIV/AIDS epidemic has involved the development of comprehensive service delivery systems that evolved over time in sync with the evolution of AIDS from a terminal illness to a manageable chronic disease. This strategy enabled the state to implement new technologies as they were introduced, including new treatments, new diagnostic tests and, more recently, PrEP (pre-exposure prophylaxis). Due to the historic and robust State response over the last 36 years, NYS has bent the curve on the HIV epidemic, reversing the decades-long increase in the number of people in NYS that are diagnosed with HIV.

NYS was on track to end the epidemic by the end of 2020, with outcomes measuring Ending the Epidemic (ETE) progress available by December 2021. However, the State and providers on the frontline have spent the majority of 2020 and early 2021 responding to an unprecedented pandemic. Providers adapted to the new landscape and found innovative ways to deliver services and support clients. Still, the public health emergency has delayed the achievement of ETE goals. Since the start of the COVID-19 pandemic, there have been increases in HIV cases in certain parts of the state, significant reductions in HIV testing and reporting of diagnoses, and decreases in the number of persons accessing PrEP. Persistent challenges remain and are often rooted in unequal access to care, social determinants of health, and stigma. Hispanic and non-Hispanic Black populations account for 34 percent of the state population, yet 74 percent of new HIV diagnoses, while non-Hispanic White individuals make up 55 percent of the state population and 20 percent of new diagnoses. Racial disparities have accounted for over 50,000 new HIV diagnoses in New York State. As a result, NYS is revising the ETE timeline and pledges to reach ETE goals and end the epidemic by the end of 2024, with outcomes measuring ETE progress available by December 2025. Health equity, social determinants of health, and addressing racial disparities will be the center of focus as we move forward.

The RFA specifically addresses these ETE Blueprint (BP) recommendations:

BP2: Expand targeted testing;
BP4: Improve referral and engagement;
BP5: Continuously act to monitor and improve rates of viral suppression;
BP8: Enhance and streamline services to support the non-medical needs of all persons living with HIV;
BP11: Undertake a statewide education campaign on PrEP and Post-Exposure Prophylaxis (PEP);
BP22: Access to care for residents of rural, suburban and other areas of the state;
BP23: Promote comprehensive sexual health education;
BP25: Treatment as prevention information and anti-stigma media campaign; and
BP29: Expand and enhance the use of data to track and report progress.

The ETE BP continues to guide all ETE efforts. The ETE Addendum Report is a written report that provides an overview of the past five years of New York State's ETE initiatives, as well as a summary of the community feedback sessions that were conducted in 2020 to assist in identifying areas of focus for ETE beyond 2020.

2018 HCV Elimination Strategy in NYS

In November 2021, NYS released its plan to eliminate HCV as a public health problem in NYS by 2030[4]. To achieve the goal of HCV elimination, concerted efforts are needed to ensure access to timely diagnosis, care, and treatment for all people with the HCV. NYS plans to eliminate HCV by:

- Enhancing HCV prevention, testing and linkage to care services for people who inject drugs, people who are incarcerated, men who have sex with men, and other populations disproportionately impacted by HCV infection;
- Expanding HCV screening and testing to identify people living with HCV who are unaware of their status and link them to care;

4 Hepatitis C (ny.gov)

- Providing access to clinically appropriate medical care and affordable HCV treatment without restrictions and ensure the availability of necessary supportive services for all New Yorkers living with HCV;
- Enhancing NYS HCV surveillance, set and track HCV elimination targets, and make this information available to the public; and
- Addressing SDOH.

Other relevant resources are the National HIV/AIDS Strategy (NHAS), the Sexually Transmitted Infections National Strategic Plan and the NYS Prevention Agenda. The NHAS is a five-year plan that details principles, priorities, and actions to guide our collective national response to the HIV epidemic.[5] The NYS Prevention Agenda is the blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability and low socioeconomic groups, as well as other populations who experience them. [6]

Demonstration of a Commitment to Health Equity

Health Equity (HE) is the fair and just opportunity for everyone to achieve optimal holistic health and well-being regardless of social position or other social or structural determinants of health. This requires addressing avoidable inequalities (e.g., access to affordable and high-quality food, housing, education, health care/services, and safe environments), historical and contemporary injustices (e.g., economic injustice/poverty, racism, classism, ableism, sexism, homophobia, transphobia, xenophobia, and other forms of oppression, discrimination, and/or stigma), and valuing health differences equally. We also acknowledge the historical and structural underpinnings of race, racism, and genocide in the United States that perpetuate many of the racial inequities we see manifested today. Because health equity can never truly be achieved without racial equity, we work toward achieving both.

The NYSDOH AI works closely with its community partners to identify and respond to current needs. The needs are wide and varied, but they center on addressing SDOH e.g., socioeconomic status, education, housing, transportation, employment, cultural competence, access to healthcare services, and discrimination.

The NYSDOH AI is committed to ensuring our funded programs and partners are equipped with the knowledge, skills, and expertise to adequately address health and social inequities. We are all accountable to pay attention to the intersections of race and health equity. We are committed to the implementation of new and tailored approaches to address the challenges faced by our Black/Brown, Indigenous, and People of Color (BIPOC) communities. In our mission to ensure that everyone has a fair chance to experience optimal health, we are employing the following health equity principles:

- Be Explicit.
- Identify and Effectively Address Racism and Racial Implicit Biases.
- Adopt a “Health in all Policies” Approach.
- Create an Internal Organization-Wide Culture of Equity.
- Respect and Involve Communities in Health Equity Initiatives.
- Measure and Evaluate Progress in Reducing Health Disparities.

In addition, the NYSDOH AI is committed to achieving health equity by promoting the implementation of interventions and services that focus not only on HIV prevention and care efforts, but also on how programs, practices, and policies affect communities of color and other populations that experience health disparities.

[5] National HIV/AIDS Strategy for the United States 2022–2025
[6] Prevention Agenda 2019-2024: New York State's Health Improvement Plan (ny.gov)

Status Neutral Approach
The priority populations should be engaged utilizing a status neutral approach to HIV-related service delivery. This aims to deliver high-quality, culturally affirming health care and services at every engagement, supporting optimal health for people with and without HIV.
https://www.cdc.gov/hiv/pdf/policies/issue-brief/Issue-Brief-Status-Neutral-HIV-Care.pdf

B. Available Funding

Component A:

A total of **$3,200,000** annually for five years in State funding is available for this component. Awards will support the provision of HIV testing with Linkage to Care, interventions that address SDOH, and Health Promotion and Prevention Support Services for men living with HIV and men who would benefit from Prevention Services within Communities of Color.

Funding for Component A will be allocated as stated in the chart below. **Annual awards will not exceed $200,000.**

NYSDOH Region	Annual Award Amount	Number of Awards
Long Island (Nassau and Suffolk counties)	$200,000	1-2
New York City – Manhattan	$200,000	1-2
New York City – Brooklyn	$200,000	1-2
New York City – Bronx	$200,000	1-2
New York City – Queens	$200,000	1-2
New York City - Staten Island	$200,000	0-1
Hudson Valley (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties)	$200,000	1-2
Northeastern New York (Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties)	$200,000	1-2
Central New York (Onondaga, Madison, Cayuga, Oswego, Oneida, Herkimer, Lewis, Jefferson, and St. Lawrence counties)	$200,000	1-2
Southern Tier (Otsego, Delaware, Cortland, Chenango, Tompkins, Chemung, Tioga, and Broome counties)	$200,000	1-2
Finger Lakes (Monroe, Wayne, Ontario, Livingston, Steuben, Yates, Schuyler, and Seneca counties)	$200,000	1-2
Western New York (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming counties)	$200,000	1-2

Component B:

A total of **$1,150,000** annually for five years in State funding is available for this component. Awards will support interventions that address SDOH and Health Promotion and Prevention Support Services for Transgender and Gender Non-Conforming (TGNC) individuals with a focus on Communities of Color.

Funding for Component B will be allocated as stated in the chart below.
Annual awards will not exceed $200,000.

NYSDOH Region	Annual Award Amount	Number of Awards
Long Island (Nassau and Suffolk counties)	$200,000	0-1
New York City – Multi-borough	$200,000	2-3
Hudson Valley (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties)	$150,000	1-2
Northeastern New York (Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties)	$150,000	1-2
Central New York (Onondaga, Madison, Cayuga, Oswego, Oneida, Herkimer, Lewis, Jefferson, and St. Lawrence counties)	$150,000	1-2
Southern Tier (Otsego, Delaware, Cortland, Chenango, Tompkins, Chemung, Tioga, and Broome counties)	$150,000	0-1
Finger Lakes (Monroe, Wayne, Ontario, Livingston, Steuben, Yates, Schuyler, and Seneca counties)	$150,000	1-2
Western New York (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming counties)	$150,000	1-2

Component C:

A total of **$2,275,000** annually for five years in State funding is available for this component. Awards will support HIV Testing with Linkage to Care, interventions that address SDOH, and Health Promotion and Prevention Support Services for women and young women within Communities of Color.

Funding for Component C will be allocated as stated in the chart below.
Annual awards will not exceed $200,000.

NYSDOH Region	Annual Award Amount	Number of Awards
Long Island (Nassau and Suffolk counties)	$200,000	1-2
New York City – Manhattan	$200,000	1-2
New York City – Brooklyn	$200,000	1-2
New York City – Bronx	$200,000	1-2
New York City – Queens	$200,000	1-2
New York City - Staten Island	$200,000	0-1
Hudson Valley (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties)	$175,000	1-2
Northeastern New York (Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties)	$175,000	1-2
Central New York (Onondaga, Madison, Cayuga, Oswego, Oneida, Herkimer, Lewis, Jefferson, and St. Lawrence counties)	$175,000	1-2
Southern Tier (Otsego, Delaware, Cortland, Chenango, Tompkins, Chemung, Tioga, and Broome counties)	$175,000	1-2
Finger Lakes (Monroe, Wayne, Ontario, Livingston, Steuben, Yates, Schuyler, and Seneca counties)	$175,000	1-2
Western New York (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming counties)	$175,000	1-2

Component D:

A total of **$269,000** annually for five years in State funding is available for this component. The award will support a statewide HIV/STI/Hepatitis C Hotline and Social Media-Based Outreach for English and Spanish speakers who reside in NYS.

Funding for Component D will be allocated as stated in the chart below.
The annual award will not exceed $269,000.

Region	Annual Award Amount	Number of Awards
Statewide	$269,000	1

Component E:

A total of **$175,000** annually for five years in State funding is available for this component. The award will support the provision of training and technical assistance on HIV-related violence for LGBTQ individuals. Activities funded under this component will support the provision of services that address the intersection of HIV/AIDS and HIV-related violence impacting the lives of infected and affected LGBTQ individuals, particularly LGBTQ individuals of color.

Funding for Component E will be allocated as stated in the chart below.
The annual award will not exceed $175,000.

Region	Annual Award Amount	Number of Awards
New York City	$175,000	1

Component F:

A total of **$225,000** annually for five years in State funding is available for this component. The award will support the provision of capacity building and technical assistance to increase awareness and promote the health and wellness of Hispanic/Latino Gay/Men who have Sex with Men (MSM).

Funding for Component F will be allocated as stated in the chart below.
The annual award will not exceed $225,000.

Region	Annual Award Amount	Number of Awards
Statewide	$225,000	1

The following information applies to <u>all</u> Components of the RFA:

Applicants are requested to select their primary region of service for each Component specific application submitted. The primary region of service for the application should be based on the location where the largest number of clients is served. This does not preclude an applicant from proposing to serve one or more counties outside a defined service region.

Applicants may apply for multiple components; however, applicants may <u>only submit one application per component</u> and <u>no more than two (2) applications in total in response to the RFA</u>. If more than one application is submitted for a component, the first application received will be reviewed. If more than two (2) applications are submitted in response to this RFA, the first two (2) applications that are received will be reviewed and considered for funding. All other applications will be rejected.

For each Component:

- Awards will be made to the highest scoring applicants in each region, up to the minimum number of awards indicated for that region. Remaining funding will be awarded to the next highest acceptable scoring applicant(s) from any region until the remaining funding is exhausted or awards have been made to all acceptable scoring applicants.

- If there is an insufficient number of acceptable applications (scoring 70 or above) received from any region, NYSDOH AI reserves the right to:
  - Fund an application scoring in the range of (60-69) from a region; and/or
  - Apply unawarded funding to the next highest scoring applicant(s) in other region(s) until the maximum number of awards per region is met.

- If there is an insufficient number of fundable applications in a region, the maximum number of awards may not be met for that region. NYSDOH AI reserves the right to re-solicit any region where there are an insufficient number of fundable applications.

- If funding remains available after the maximum number of acceptable scoring applications is awarded to each region, NYSDOH AI reserves the right to exceed the maximum number of awards.

- NYSDOH AI reserves the right to revise the award amounts as necessary due to changes in availability of funding.

- NYSDOH AI reserves the right to shift funding from one Component of the RFA to another Component should there be an insufficient number of fundable applications received in any Component.

Should additional funding become available, the NYSDOH may select an organization from the pool of applicants deemed not funded, due to limited resources. If it is determined that the needed expertise/services are not available among these organizations, the NYSDOH AI reserves the right to establish additional competitive solicitations.

Current Contractors: If you choose to not apply for funding, the NYSDOH AI highly recommends notifying your community partners of your intent. This will ensure community members and providers are aware of the discontinuation of the program and services.

II. WHO MAY APPLY

A. Minimum Eligibility Requirements

All applicants must meet the following minimum eligibility requirements:

Components A, B, C and E:

- Applicant must be prequalified in the New York State Grants Gateway, if not exempt, on the date applications are due;
- Applicant must be a not-for-profit organization that is tax-exempt under Section 501(c)(3) of the Internal Revenue Code, a government entity, or a tribal organization;
- Applicant must address ***ALL*** elements of the chosen Program Model;
- Applicant must be located in and provide services within the region for which they are applying; and
- Applicant must upload **Attachment 1: Statement of Assurances** signed by the Chief Executive Officer (CEO) or Designee to certify the organization meets all criteria list on **Attachment 1.** This form, once signed, must be submitted via the Grants Gateway in the Pre-Submission Uploads section of the online application.

Components D and F:

- Applicant must be prequalified in the New York State Grants Gateway, if not exempt, on the date the applications are due;
- Applicant must be a not-for-profit organization that is tax-exempt under Section 501 (c) (3) of the Internal Revenue Code, a government entity, or a tribal organization;
- Applicant must address ***ALL*** elements of the chosen Program Model; and
- Applicant must submit the **Attachment 1: Statement of Assurances** signed by the Chief Executive Officer (CEO) or Designee to certify the organization meets all criteria listed on **Attachment 1**. This form, once signed, must be submitted via the Grants Gateway in the Pre-Submission Uploads section of the online application.

III. PROJECT NARRATIVE/WORK PLAN OUTCOMES

Component A

Component A: Prevention and Essential Support Services for Men within Communities of Color

The purpose of this funding is to support a high impact approach to prevention and essential support services to achieve ETE and Beyond initiative goals and reduce/eliminate disparities and inequities in HIV incidence in men of color, (e.g., Black, Hispanic/Latinx, Indigenous people, and Asian/Pacific Islander populations). Funding supports programs that provide HIV/STI/HCV prevention interventions and essential support services for men of color and seek to address SDOH and promote health equity.

Priority Population:
The priority population of this component are men who are living with HIV and men who could benefit from prevention services, with a focus on communities of color.

The overall goals are to:

- Prevent new HIV/STI/HCV infections by increasing access to comprehensive sexual health information, behavioral, and biomedical interventions such as PrEP/PEP, and essential support services; and
- Identify individuals who are living with HIV/STI/HCV and unaware of their status and ensure access to early, high quality medical care and prevention services.

The initiative aims to impact the NYSDOH AI efforts to:

- Reduce disease incidence;
- Decrease risk of sexual and drug using behaviors among persons living with HIV and persons who engage in behaviors that put them at risk of HIV/STI/HCV infection;
- Increase the number of persons living with HIV/STI/HCV who are aware of their status; and;
- Increase the number of persons living with HIV/STI/HCV who are linked to prevention, partner services, and treatment/medical care.

Grantees are expected to:

- Conduct client recruitment and engagement in a manner that is culturally and linguistically sensitive and appropriate;
- Offer direct provision of HIV testing, including access to HIV self-tests;
- Integrate linkages to STI and HCV screening and treatment;
- Establish and/or maintain collaboration agreements (e.g., memoranda of understanding (MOU), memoranda of agreement, service agreements) with other community-based organizations and medical providers to ensure delivery of comprehensive services across the care continuum, with an emphasis on partnerships with organizations that address social determinants such as housing, nutrition, employment, transportation, etc. **Refer to Attachment 2: NYSDOH AI's Cross Sector Collaborations Requirements);**
- Facilitate access to PrEP and PEP;
- Screen for and address SDOH as well as the underlying causes of risk behaviors to remove barriers to health care and prevention services for the priority population and move closer to health equity;
- Use strengths-based approaches to identify needs and promote access and use of sexual and other health services by the priority population;
- Support persons living with HIV in maintaining their treatment regimen in order to improve their overall health outcomes and prevent transmission of HIV to their sexual and needle sharing partners; and
- Incorporate condom promotion, education, and distribution into all funded program activities.

Component A, B, and C Program Models

Applicants for Components A, B, or C are required to select one of the Program Models described

below. The program model will serve as the foundation for the delivery of services. Applicants should select the program model that best addresses the unmet needs of the priority population, and which will most effectively be integrated into the applicant's continuum of services.

This RFA recognizes the community's expertise in reaching the priority population. Therefore, applicants may propose the interventions and support that they understand will best engage the priority population and reach the intended goals and outcomes of this RFA.

Program Model Descriptions:

Program Model 1

Required Interventions/ Services

1. **HIV Testing:** Direct provision of HIV testing with linkage to prevention and HIV medical care; including access to HIV self-tests; HIV testing must include referrals and linkage to STI/HCV screening for those presenting with risk factors as part of the HIV testing service.
2. **Implement at least one (1) SDOH Interventions:** Identify and address at least one SDOH that is informed by an assessment of the populations' priority needs. Intervention(s) must aim to increase client stability and reduce barriers to accessing HIV prevention and care services and other essential support services. Examples include but are not limited to:
    - **Employment:** interventions that increase access to opportunities for employment, including related education and employment/workforce/vocational services; job readiness services and employment workshops;
    - **Education:** interventions that increase access to respectful, safer, and affirming educational opportunities;
    - **Healthcare:** interventions that increase access to physical, sexual, mental, and behavioral healthcare that is regionally accessible, affordable, and delivered by staff that are both skilled in providing care to and provide services in an affirming manner;
    - **Housing Navigation:** interventions that increase access to safe, quality, affordable, and gender-affirming housing, and the supports necessary to maintain that housing;
    - **Counseling Services:** psychosocial counseling provided by a licensed mental health professional;
    - **Legal Services:** legal workshops/clinics; and
    - Other innovative interventions that support initiative and program objectives.
3. **Implement at least one (1) Health Promotion Activity/Prevention Support Service:** Health Promotion including community events and media campaigns that address, but are not limited to: healthcare access, testing, or the elimination of stigma, racism, homophobia, and/or transphobia. Health Promotion/Prevention Support Service activities should aim to reach priority populations, providers, frontline staff, and/or the community/general population at large. Activities may also include Peer Services/Peer Training Programs; a high impact prevention public health strategy (i.e., ARTAS, Social Network Strategy for HIV Testing, Testing Together); HIV Navigation Services as defined by the CDC; an EBI specific to the priority population proposed to be served; formalized PrEP and PEP support program; and/or locally developed interventions that support access to HIV testing, STI and HCV screening, and linkage and navigation services with an emphasis on access to PrEP/PEP and PrEP support services; or increased social support, reduced social isolation, and increasing self-esteem for the priority population proposed to be served.

Program Model 2

Required Interventions/ Services

1. **Referral to HIV Testing:** Provided via documented MOU with linkage to prevention and HIV medical care; including access to HIV self-tests.

2. **Implement at least two (2) SDOH Interventions**: Identify and address at least two (2) SDOHs that are informed by an assessment of the populations' priority needs. Interventions must aim to increase client stability and reduce barriers to accessing HIV prevention and care services and other essential support services. Examples include but are not limited to:
    - Employment: interventions that increase access to opportunities for employment, including related education and employment/workforce/vocational services; job readiness services and employment workshops;
    - Education: interventions that increase access to respectful, safer, and affirming educational opportunities;
    - Healthcare: interventions that increase access to physical, sexual, mental, and behavioral healthcare that is regionally accessible, affordable, and delivered by staff that are both skilled in providing care, and provide services in an affirming manner;
    - Housing Navigation: interventions that increase access to safe, quality, affordable and gender-affirming housing, and the supports necessary to maintain that housing;
    - Counseling Services: psychosocial counseling provided by a licensed mental health professional;
    - Legal Services: legal workshops/clinics; and
    - Other innovative interventions that support initiative and program objectives.

3. **Implement at least one (1) Health Promotion Activity/Prevention Support Service:** Health Promotion including community events and media campaigns that address, but are not limited to: healthcare access, testing, or the elimination of stigma, racism, homophobia, and/or transphobia. Health Promotion/Prevention Support Service activities should aim to reach priority populations, providers, frontline staff, and/or the community/general population at large. Activities may also include Peer Services/Peer Training Programs; a high impact prevention public health strategy (i.e., ARTAS, Social Network Strategy for HIV Testing, Testing Together); HIV Navigation Services as defined by the CDC; an EBI specific to the priority population proposed to be served; formalized PrEP and PEP support program; and/or locally developed interventions that support access to HIV testing, STI and HCV screening, and linkage and navigation services with an emphasis on access to PrEP/PEP and PrEP support services; or increased social support, reduced social isolation, and increasing self-esteem for the priority population proposed to be served.

Note: All Program Model 2 applicants are required to conduct STI and/or HCV testing either directly or via referral in conjunction with referrals to HIV testing.

Failure to address ALL elements of the chosen Program Model will result in the application being deemed ineligible.

Component A: Annual Program Service Targets

The priority population for this component is men of color within communities of color (Black, Hispanic/Latinx, Indigenous people, and Asian/Pacific Islander populations).

Note: The annual program service targets in the table below are specific to men of color. Proposed interventions and essential support services to individuals outside of the priority population (men of color) will not count towards minimum program service targets.

Component A: Annual Program Service Targets - Program Model 1 Interventions

Applicants should serve a minimum of **250** unduplicated clients annually through all funded program services.

Program Model 1 Interventions	Annual Program Service Targets	Expected Outcomes
HIV Testing and Linkage to Care	200 unduplicated clients	Increase the number of individuals who are aware of their HIV status **NYC:** Three (3) newly diagnosed individuals. **Rest of State:** Two (2) newly diagnosed individuals Increase integrated screenings for STI and HCV
SDOH Intervention	A minimum of 75 unduplicated clients annually	A minimum of 25% of clients served through these services should be linked to HIV testing and/or STI/HCV screening.
Health Promotion Activity/Prevention Support Service	A minimum of 75 unduplicated clients annually	A minimum of 25% of clients served through these services should be linked to HIV testing and/or STI/HCV screening.
Note: Clients served are required to be unduplicated within interventions but not between interventions. For example, the same client can participate in multiple activities (e.g., the same 150 clients could receive HIV testing and an SDOH intervention).		

Component A: <u>Annual Service Targets</u> - Program Model 2 Interventions

Applicants should serve a minimum of **250** unduplicated clients annually through all funded program services.

Program Model 2 Interventions	Annual Program Service Targets	Expected Outcomes
Referral to HIV Testing	200 unduplicated clients	Increase the number of individuals who are aware of their HIV status **NYC:** Three (3) newly diagnosed individuals. **Rest of State:** Two (2) newly diagnosed individuals Increase integrated screenings for STI and HCV
SDOH Intervention	A minimum of 150 unduplicated clients annually	
Health Promotion Activity/Prevention Support Service	A minimum of 75 unduplicated clients annually	

All proposed interventions will support and demonstrate connection to HIV testing, STI and HCV screening, and linkage and navigation services, and access to PrEP/PEP.

Component B

Component B: Prevention and Essential Support Services for Transgender and Gender Non-Conforming (TGNC) Individuals, particularly in Communities of Color

The purpose of this funding is to support a high impact approach to prevention and essential support services to achieve ETE and Beyond initiative goals and reduce/eliminate disparities and inequities in HIV incidence in transgender and gender non-confirming individuals, particularly in communities of color (e.g., Black, Hispanic/Latinx, Indigenous people, and Asian/Pacific Islander populations). Funding supports programs that provide HIV/STI/HCV prevention interventions and essential support services for transgender and gender non-confirming individuals, particularly in communities of color that and seek to address SDOH and promote health equity.

Priority Population:

The priority population for this component include transgender and gender non-conforming persons who are living with HIV and transgender and gender non-conforming persons who could benefit from prevention services particularly in communities of color:

The overall goals are to:

- Prevent new HIV/STI/HCV infections;
- Increase HIV/STI/HCV testing and screening services; and
- Facilitate access to prevention, medical, and essential supportive services.

Grantees are expected to:

- Conduct client recruitment and community engagement activities;
- Integrate direct provision of or documented referrals to HIV, STI, and HCV screening, including expanding access to HIV self-tests;
- Establish and/or maintain collaboration agreements (e.g., memoranda of understanding (MOU), memoranda of agreement, service agreements) with other community-based organizations and medical providers to ensure delivery of comprehensive services across the care continuum, with an emphasis on partnerships with organizations that address social determinants such as housing, nutrition, employment, transportation, etc. **Refer to Attachment 2: NYSDOH AI's Cross Sector Collaborations Requirements);**
- Provide appropriate access to PrEP and PEP;
- Support persons living with HIV in maintaining their treatment regimen in order to improve their overall health outcomes and prevent transmission of HIV to their sexual and needle sharing partners; and
- Incorporate condom promotion, education, and distribution into all funded program activities.

Component B: Annual Program Service Targets

Note: Service targets are specific to transgender and gender non-confirming individuals, particularly in communities of color. Serving individuals outside of this population will not count towards minimum program service targets.

Component B: Annual Service Targets - Program Model 1 Interventions

Funded applicants should serve a minimum of **200** unduplicated clients annually through all funded program services.

Program Model 1 Interventions	Annual Program Service Targets	Expected Outcomes
Direct HIV Testing	100 unduplicated clients	Increase the number of individuals who are aware of their HIV status

		NYC: Three (3) newly diagnosed individuals. **Rest of State:** Two (2) newly diagnosed individuals Increase integrated screenings for STI and HCV
SDOH Intervention	A minimum of 75 unduplicated clients annually	
Health Promotion Activity/Prevention Support Service	A minimum of 75 unduplicated clients annually	

Component B: <u>Annual Service Targets</u> - Program Model 2 Interventions

Funded applicants must serve a minimum of **200** unduplicated clients annually through all funded program services.

Program Model 2 Interventions	Annual Program Service Targets	Expected Outcomes
Referral to HIV Testing	100 unduplicated clients	Increase the number of individuals who are aware of their HIV status **NYC:** Three (3) newly diagnosed individuals. **Rest of State:** Two (2) newly diagnosed individuals Increase integrated screenings for STI and HCV
SDOH Intervention	A minimum of 100 unduplicated clients annually	
Health Promotion Activity/Prevention Support Service	A minimum of 75 unduplicated clients annually	

Component C

Component C: Prevention and Essential Support Services for Women and Young Women within Communities of Color

The purpose of this funding is to support a high impact approach to prevention and essential support services to achieve ETE and Beyond initiative goals and reduce/eliminate disparities and inequities in HIV incidence in women and young women of color (e.g., Black, Hispanic/Latinx, Indigenous people, and Asian/Pacific Islander populations). Funding supports programs that provide HIV/STI/HCV prevention interventions and essential support services for women and young women of color that seek to address SDOH and promote health equity.

<u>Priority Population:</u>

The priority population of this component are women and young women who are living with HIV and women and young women who can benefit from prevention services with a focus on communities of color.

The overall goals are to:

- Prevent new HIV/STI/HCV infections by increasing access to comprehensive sexual health information, behavioral, and biomedical interventions such as PrEP/PEP, and essential supportive services; and
- Identify individuals who are living with HIV/STI/HCV and unaware of their status and ensure access to early, high quality medical care and prevention services.

The initiative aims to impact the NYSDOH AI efforts to:

- Reduce disease incidence;
- Decrease risk of sexual and drug using behaviors among persons living with HIV and persons who engage in behaviors that put them at risk of HIV/STI/HCV infection;
- Increase the number of persons living with HIV/STI/HCV who are aware of their status; and
- Increase the number of persons living with HIV/STI/HCV who are linked to prevention, partner services, and treatment/medical care.

Grantees are expected to:

- Conduct client recruitment and engagement in a manner that is culturally and linguistically sensitive and appropriate;
- Integrate direct provision of HIV testing, including access to HIV self-tests;
- Integrate direct provision of or documented referrals to STI and HCV screening;
- Establish and/or maintain collaboration agreements (e.g., memoranda of understanding (MOU), memoranda of agreement, service agreements) with other community-based organizations and medical providers to ensure delivery of comprehensive services across the care continuum, with an emphasis on partnerships with organizations that address social determinants such as housing, nutrition, employment, transportation etc**. Refer to Attachment 2: NYSDOH AI's Cross Sector Collaborations Requirements);**
- Provide appropriate access to PrEP and PEP;
- Screen for and address SDOH that impact the priority populations with the goal of reducing health inequities/disparities identified within communities of color;
- Support persons living with HIV in maintaining their treatment regimen in order to improve their overall health outcomes and prevent transmission of HIV to their sexual and needle sharing partners; and
- Incorporate condom promotion, education, and distribution into all funded program activities.

Component C: Annual Program Service Targets

The priority population for this component is women and young women of color within communities of color (Black, Latino/Latinx, Indigenous people, and Asian/Pacific Islander).

Component C: Annual Service Targets - Program Model 1 Interventions

Funded applicants must serve a minimum of **250** unduplicated clients annually through all funded program services.

Note: Service targets are specific to women and young women of color. Serving individuals outside of this population will not count towards minimum program service targets.

Program Model Interventions	Annual Program Service Targets	Expected Outcomes
Direct HIV Testing	200 unduplicated clients	Increase the number of individuals who are aware of their HIV status **NYC:** Three (3) newly diagnosed individuals. **Rest of State:** Two (2) newly diagnosed individuals

		Increase integrated screenings for STI and HCV
SDOH Intervention	A minimum of 75 unduplicated clients annually	
Health Promotion Activity	A minimum of 75 unduplicated clients annually	
Note: Clients served are required to be unduplicated within interventions but not between interventions. For example, the same client can participate in multiple activities (e.g., the same 150 clients could receive HIV testing and receive screening for STIs) and may also participate in a prevention/supportive intervention, high impact public health strategy, EBI, or locally developed intervention.		

Component C: <u>Annual Service Targets</u> - Program Model 2 Interventions

Funded applicants must serve a minimum of **250** unduplicated clients annually through all funded program services.

Program Model 2 Intervention	Annual Program Service Targets	Expected Outcomes
Referral to HIV Testing	200 unduplicated clients	Increase the number of individuals who are aware of their HIV status **NYC:** Three (3) newly diagnosed individuals. **Rest of State:** Two (2) newly diagnosed individuals Increase integrated screenings for STI and HCV
SDOH Intervention	A minimum of 150 unduplicated clients annually	
Health Promotion Activity	A minimum of 75 unduplicated clients annually	

All proposed interventions will support and demonstrate connection to HIV testing, STI and HCV screening, and linkage and navigation services, and access to PrEP/PEP.

<u>Scope of Services Components A, B, and C</u>

<u>Direct Provision of HIV Testing and Linkage to Care</u>

Targeted HIV testing should occur in a variety of settings most effective in identifying members of the priority population with undiagnosed HIV infection (e.g., onsite testing within the organization; venue-based testing; provision, of HIV self-test kits; and/or mobile testing/field testing). Applicants are strongly encouraged to include HIV self-testing as a component of their HIV testing services when in- person testing is not practical or preferable to the client. HIV self-testing is an effective way to reach persons who are uncomfortable or unable to access HIV testing at an office or mobile site. HIV testing services must include linkage to prevention, medical, and social services available in the region to address individualized prevention needs, improve health, and enhance quality of life.

Applicants funded for direct provision of HIV testing or referral for HIV testing are expected to provide referrals and linkage to STI and/or HCV screening (if not providing direct STI/HCV screening) as part of the HIV testing process.

This RFA does NOT support the direct provision of routine HIV testing in healthcare settings. Routine HIV testing in healthcare settings has been supported by NYS Public Health Law since 2010. Licensed Medical Providers are required to offer HIV testing as part of routine primary care for all persons aged 13 and older.

The NYSDOH AI recommends using an HIV AG/AB rapid test for initial HIV screening. Other FDA-approved rapid HIV tests using capillary whole blood specimens are allowable as directed by the authorizing medical provider and/or limited-service laboratory director. The RFA supports oral fluid use for the FDA-approved OraQuick® in home HIV test only.

All funded applicants will be required to adhere to **Attachment 3: NYSDOH AI's Targeted HIV Testing Requirements** for in-person testing encounters. All funded applicants implementing HIV home/self-test programs will be required to follow **Attachment 4: NYSDOH AI Division of HIV/STD/HCV Prevention's HIV Home/Self-Test Program Guidance.**

STI and HCV Screening

STI screening services should include linkage to prevention, medical, and social services available in the region to address individualized prevention needs, improve health, and enhance quality of life. STI screening should occur in a variety of settings most effective in identifying members of the priority population (e.g., onsite testing within the organization; venue-based testing; provision, mobile testing/field testing). Three site testing (vaginal/cervical or urethral, rectal, and pharyngeal) should be conducted as appropriate on clients seeking testing services.

Hepatitis screening, education regarding hepatitis transmission and prevention, HCV risk reduction strategies, healthy liver messages, and information about hepatitis A and B vaccination should also be addressed.

All grantees directly providing STI and HCV screening will be required to adhere to **Attachment 5: NYSDOH AI's STI/HCV Screening Requirements.**

Health Promotion Activities

Health Promotion Activities include raising the priority population's health awareness through educational activities, media campaigns, community activities (when appropriate and practical), etc. Activities must utilize culturally affirming, strengths-based, sex-positive approaches to support and increase access to sexual and behavioral health high impact prevention information and services. Interventions and activities may address and promote access to health, wellness, and human services; and provide education and training in areas such as: stigma, racism, homophobia, and/or transphobia; the promotion of timely health care and treatment; lack of health insurance; information regarding health risks such as HIV, sexually transmitted infections, viral hepatitis and other infectious and chronic diseases; sexual and reproductive health; and PrEP and PEP. Health promotion activities should aim to reach priority populations, providers, frontline staff, and/or the community/general population at large.

SDOH Interventions

A variety of factors may influence high-risk behaviors as well as the ability for members of the priority population to be retained in care. Interventions must address SDOH that adversely affect HIV and sexual health related outcomes in efforts to promote and achieve health equity among the priority population. Interventions should aim to address barriers to HIV/STI/HCV prevention that increase vulnerability to HIV/STI/HCV and impede individuals from accessing needed services. Key SDOH such as economic stability, education, social and community factors, health care etc. should be considered when developing interventions that address the HIV related needs of the priority population. Applicants can propose innovative strategies, interventions, and activities that are designed to provide support to the priority population and that prevent new HIV/STI/HCV transmissions, link clients to HIV prevention and care services, and provide essential support services that aid in reducing HIV-related disparities and health inequities.

Funding may support the cost related to the implementation of SDOH interventions including but not limited to:

- Clothing (for employment services);
- Financial Assistance - housing related expenses; rental support;
- Food Vouchers/Gift Cards for purchasing food items (Food Security);
- Child Care Assistance (can also be provided via Visa Gift Cards);
- Visa/Master Card Gift Cards to support basic and essential needs of daily living; and
- Transportation support.

Prevention Support Services

Proposed Prevention Support Services should employ a health equity lens by integrating multiple approaches to reach the priority population and address SDOH and factors that influence high risk behaviors, participation and retention in program services, and healthcare access. Interventions will include the implementation of evidence-based practices and interventions that address SDOH and the underlying causes of risk behaviors such as social isolation, substance use, trauma, childhood sexual abuse and sexual/physical violence, intimate partner violence, lack of housing, employment, and transportation needs amongst other issues. Interventions may be provided on the group and individual level (in person and/or virtually). Includes: PEP and PrEP Support Program; Prevention/Supportive Interventions; Peer Services/Peer Training Programs; High Impact Prevention Public Health Strategy; Evidence Based Behavioral Interventions including Locally Developed Interventions, HIV Navigation Services, or increased social support, reduced social isolation, and increasing self-esteem for the priority population being proposed to be served.
Applicants may subcontract components of the scope of work. For those applicants that propose subcontracting, it is preferable to identify subcontracting agencies during the application process.

Applicants that plan to subcontract are expected to state in the application the specific components of the scope of work to be performed through subcontracts. Applicants should note that the lead organization (contractor) will have overall responsibility for all contract activities, including those performed by subcontractors, and will be the primary contact for the NYSDOH AI. All subcontractors must be approved by the NYSDOH AI during contract negotiations.

Component D:

NYS HIV/STI/HCV Hotline Services and Social Media-Based Outreach for English and Spanish Speakers

This component supports a statewide hotline for English and Spanish speakers. It funds the operation of a **toll-free** telephone hotline and social media-based outreach to provide information, referrals, and resources to residents of NYS. Applicants are expected to develop a mechanism to respond to telephone and social media inquiries and provide HIV/STI/HCV information and tackle misconceptions about transmission, prevention and treatment, LGBTQ health and wellness, and drug user health information. Messaging must be clear, specific, consistent, and culturally and linguistically appropriate and must reflect today's scientific knowledge of HIV/STI/HCV disease progression, its impact on community and individual health, and the importance of early detection and treatment. The hotline will also offer referrals to prevention, support, and care services throughout NYS.

Funded applicants must ensure hotline services and social media-based outreach activities are:

- Available in English and Spanish; and
- Accessible at a minimum of 40 hours per week.

The overall goals are to:

- Provide clear, accurate and science-based information;
- Promote Drug User Health Services and provide referrals to Opioid Overdose Prevention Programs, Syringe Exchange, and Expanded Syringe Access Programs (ESAP);
- Promote LGBTQ Health and Wellness;
- Facilitate access to early, medical care/treatment and essential support services; and

- Facilitate access to behavioral and biomedical prevention services including HIV testing, STI and HCV screening, effective behavioral interventions, PEP, PrEP, and Treatment as Prevention (TasP), referred to as Undetectable=Untransmittable, or U=U.

Funding allows for the provision of a toll-free statewide hotline and social media-based outreach for English and Spanish speakers and supports the following:

- Mechanisms to receive and respond to telephone and social media inquiries in English and Spanish;
- Culturally and linguistically appropriate and accurate /up to date information on HIV/STI/HCV and related topics;
- Referrals for HIV/STI/HCV prevention, support, and care/treatment related services throughout NYS;
- Program staff who provide information and referral services and have knowledge of Ending the Epidemic Initiative goals, harm reduction strategies, PrEP and PEP interventions, understand the ethnic/cultural norms that influence HIV risk and the importance of advancing health equity within the organization;
- Collaboration with State and local health departments, community-based organizations, and medical providers to facilitate delivery of effective Hotline Services and Social Media Based Outreach; and
- Collaboration with State and local health departments to respond to emerging health related issues.

Component D Program Model

Scope of Services Component D

Required Services:

1. Hotline Services and Social Media Outreach Promotion: promote Hotline Services and implement social media outreach activities.

Hotline program promotion/marketing and caller engagement social media approaches supported with this funding include:

- Conducting community and provider engagement events to promote the hotline number and social media presence;
- Establishing and/or maintaining collaborative relationships with State and local health departments, community-based organizations, and medical providers to facilitate hotline promotion and social media activities. **Refer to Attachment 2: NYSDOH AI's Cross Sector Collaborations Requirements);**
- Distributing hotline marketing materials, promoting NYSDOH AIDS Institute HIV/STI/HCV prevention, treatment and care, LGBTQ health and wellness, and drug user health-related educational campaigns and providing educational materials; and
- Using social media sites (e.g., Twitter, Facebook, Instagram, Snapchat) to expand audience reach and advertise the hotline number and services as well as promoting community-based activities led by partner agencies (e.g., posting information about a health fair at a partner agency, etc.).

2. Health Promotion, Education, and Referrals: health promotion and education activities that address lack of essential information about HIV/STI/HCV and tackle misconceptions about transmission, prevention, and treatment. Messaging must be clear, specific, consistent, culturally and linguistically appropriate and must reflect today's scientific knowledge of HIV/STI/HCV disease progression, its impact on community and individual health, and the importance of early detection and treatment.

Health promotion and education activities can also cover other health conditions that are impacted by SDOH (e.g., mental illness, chronic diseases, tobacco/drug use, etc.).

Funded activities include:

- Responding to telephone and social media inquiries;
- Providing individuals with accurate, culturally and linguistically appropriate answers as well as consistent information in an affirming, non-threatening, non-judgmental manner;

- Dedicating time to dialogue and increase the individual's knowledge, build health protective skills, promote prevention behaviors, and provide support as appropriate;
- Providing referrals for all needed services and offer free printed materials to individuals on HIV/STI/HCV and other health related topics;
- Expanding audience reach via the use of social media sites (e.g., Twitter, Facebook, Instagram) to address misinformation, and provide credible, science-based health information regarding HIV/STI/HCV and other health related topics;
- Educating and providing facts via the use of use of social media sites to increase knowledge of HIV related topics such as HIV testing, PEP and PrEP access, TasP, U=U, syphilis and other STIs, LGBTQ health and wellness and drug user health; and
- Educating and raising public awareness via the use of use of social media sites to promote HIV/STI/HCV public health messaging and annual observances such as PrEP Awareness Week, Pride Month, STI Awareness Month, National HIV Testing Day, World AIDS Day, and other emerging health issues as needed.

3. Condom Promotion, Education, and Distribution: upon request, condoms and other safer sex supplies should be made available to the caller(s) at no cost. The Hotline Program will also use social media sites (e.g., Twitter, Facebook, Instagram, Snapchat) to promote condom access and education.

Other Requirements include:

- Operate during hours and days that optimize opportunities for callers to receive clear, accurate/science-based education and appropriate referrals that meet the needs of callers or social media users as appropriate;
- Develop mechanisms to provide information to individuals who speak a language other than English or Spanish or are deaf and/or hearing impaired;
- Maintain / update informational and referral resource materials for use by hotline operators; and
- Provide training and on-going staff development for program staff.

Component E:

Training and Technical Assistance on HIV-Related Violence Targeting LGBTQ Individuals
This component supports the provision of services that address the intersection of HIV/AIDS and HIV-related violence impacting the lives of infected and affected LGBTQ individuals, particularly LGBTQ individuals of color.

The overall goals are to:

- Increase access to services for LGBTQ individuals who are victims of violence, victimization, hate, assault, and/or sexual intimate partner violence;
- Raise awareness of HIV-related violence;
- Increase provider skills and knowledge to provide culturally responsive/sensitive services to LGBTQ populations; and
- Increase provider skills and knowledge to provide competent post-victimization services for LGBTQ individuals who have experienced violence.

Funded applicants are expected to:

- Conduct client recruitment and engagement;
- Integrate direct provision or linkages to HIV, STI and HCV screening;
- Establish and/or maintain collaboration agreements (e.g., memoranda of understanding (MOU), memoranda of agreement, service agreements) with other community-based organizations and medical providers to ensure delivery of comprehensive services across the care continuum, with an emphasis on partnerships with organizations that provide services to LGBTQ individuals with a focus on communities of color. **Refer to Attachment 2: NYSDOH AI's Cross Sector Collaborations Requirements);**
- Provide appropriate access to PrEP and PEP; and

- Incorporate condom promotion, education and distribution into all funded program activities.

Funding will support recruitment and engagement of LGBTQ individuals into violence and post-victimization related services/interventions; provision of community education to raise awareness around the various forms of violence experienced by LGBTQ victims of hate, assault and sexual intimate partner violence; linkage and navigation services; provider education and training on the provision of culturally /sensitive services to LGBTQ populations; and provider education and training on the provision of competent post-victimization services for LGBTQ individuals who have experienced violence.

Component E Scope of Services

- Recruitment and engagement of LGBTQ individuals into violence and post-victimization related services/interventions;
- Provision of community education to raise awareness around the various forms of violence experienced by LGBTQ individuals;
- Navigation to crisis intervention and support services for LGBTQ victims of hate, assault and sexual intimate partner violence;
- Linkage and navigation services to HIV/STI/HCV testing, medical care, prevention/supportive services, PrEP and PEP and other needed services;
- Provider education and training on the provision of culturally responsive services to LGBTQ populations; and
- Provider education and training on the provision of competent post-victimization services for LGBTQ individuals who have experienced violence.

1. Client Recruitment/Engagement

Applicants are expected to propose innovative strategies to engage LGBTQ individuals in violence and post-victimization interventions and services. Applicants should describe client recruitment/engagement strategies that demonstrate access to the priority population and the ability to engage them in the proposed services. Applicants should describe how the selected strategies will engage the priority population, how immediate needs will be addressed and the messages and methods to be used to ensure a connection is made to funded services.

2. Anti-Violence Education and Training Interventions

At a minimum, funded applicant activities should include:

- Provider education and training on the provision of culturally responsive services to LGBTQ populations, particularly within communities of color on issues specific to LGBT communities, e.g., creating safe environment for LGBTQ clients, offering effective referrals in the face of limited options, and working with clients who have strong feelings of internalized hatred and low self-esteem which hinder engagement in services;
- Provider education and training on the provision of competent post-victimization services for LGBTQ individuals who have experienced violence; and
- Provision of community education to raise awareness around the various forms of violence experienced by LGBTQ individuals. Activities should include a mechanism where people can share their own experiences on such issues as being the target of violence, experiencing intimate partner violence and/or being sexually assaulted.

3. Linkage and Navigation Services

This service involves facilitating navigation to crisis intervention and support services for LGBTQ victims of hate, assault and sexual intimate partner violence and the provision of linkage and navigation services to HIV/STI/HCV testing, medical care, prevention/supportive services, PrEP and PEP and other needed services.

4. Pre-Exposure Prophylaxis (PrEP)

PrEP is an HIV prevention intervention in which HIV negative individuals take antiretroviral medication to lower their chances of acquiring HIV. Providing PrEP has been identified as one of the core strategies in the Governor's three-point plan to reduce the number of persons living with HIV in NYS to sub-epidemic levels by

the end of 2020. PrEP is recommended for individuals who do not regularly use condoms while having sex with partners who have unknown HIV status, are current or former injection drug users, and/or have partners who may be bisexual or engage in sex with other men. PrEP is also recommended for serodiscordant couples. In addition, PrEP is one of several options to protect an uninfected woman who has a partner who is living with HIV/AIDS during conception and pregnancy. A complete list of persons who may benefit from PrEP is included in the NYSDOH PrEP Guidance Document..

Funded applicants are required to raise awareness about this biomedical HIV prevention tool, educate their clients about PrEP, screen and assess the priority population for PrEP, and link appropriate clients to medical providers for PrEP assessment and possible PrEP initiation. Programming to educate LGBT individuals about PrEP should be integrated into the interventions and activities being proposed. Referrals should be provided to the NYS PrEP Assistance Program as appropriate:

5. Post-Exposure Prophylaxis (PEP)

Post-exposure Prophylaxis (PEP) is used for anyone who may have been exposed to HIV during a single event. It is not the right choice for people who may be exposed to HIV frequently. Applicants should detail the process for assuring that individuals who have been exposed to HIV are referred for PEP services. In addition, clients should be made aware that they can seek out PEP within 36 hours of unprotected sex. Decisions regarding initiation of PEP beyond 36 hours post exposure should be made by the clinician in conjunction with the patient.

Component F:

Capacity Building for High Impact Prevention for Hispanic/Latino Gay/Men who have Sex with Men (MSM)

This component supports the implementation of training and technical assistance activities through the coordination of capacity building meeting/events and the provision of individualized agency specific technical assistance.

Component F Program Model

The funded applicant will develop and coordinate at least two (2) Training/Technical Assistance meetings to promote learning, foster cross sector collaboration and strengthen provider capacity to effectively serve Hispanic/Latino gay men/MSM and agency specific technical assistance and support.

Meetings will offer an opportunity for participants to foster awareness about the priority health issues and concerns affecting Hispanic/Latino gay men/MSM. Meeting topics may include understanding how disparities/SDOH can result in barriers to prevention/health care access, the role of social justice in ending the HIV and HCV epidemics, the importance of cultural communication, policy updates, the need for workforce development, and innovative approaches to HIV programming (e.g., PEP and PrEP resources and access, the value of early diagnosis (HIV/STI and HCV) and treatment, the benefits of navigation services, the need for accurate data collection and reporting, and program sustainability).

The provider will also engage in individualized/agency specific technical assistance and capacity building for providers on an as needed basis with AIDS Institute approval. The capacity building/technical assistance may cover the following areas: organizational development and sustainability, fiscal management, board development, staff recruitment, program development, and data management/evaluation.

In developing, coordinating, and implementing activities, the funded applicant is required to:

- Work with existing coordinating and community planning bodies such as ETE regional committees, NY Links and New York Knows to plan, promote, and implement events, as well as leverage resources;
- Establish relationships with other organizations (e.g., academic, faith, health centers/hospitals, prevention and support services, immigration, substance use, behavioral health, housing, employment,

etc.) and local health departments to address various domains of wellness for Hispanic/Latino gay men/MSM and help identify innovative strategies to achieve collective impact;
- Use community assets and strengths-based approaches to identify needs and promote access and use of sexual and other health services by Hispanic/Latino gay men/MSM;
- Include Hispanic/Latino gay men /MSM in the planning and evaluation process to gain a better understanding of barriers, effective strategies, and available resources;
- Foster a spirit of community partnership among members of the priority population (both people living with HIV and those who could benefit from prevention) and the community-based organizations who serve them to achieve positive health outcomes and move closer to health equity;
- Enhance provider capacity to effectively serve Hispanic/Latino gay men/MSM and address cultural competency deficiencies that may prevent this community from accessing prevention and treatment;
- Offer HIV testing, linkage to care, PEP and PrEP services, Partner Services, and sexual health information and tools (e.g., condoms) during meetings as appropriate. Interventions offered should be meet the needs of the participants and must be anti-stigma, non-discriminatory, culturally affirming, trauma-informed approaches to service delivery; and
- Use technology and social media platforms (e.g., Facebook, Twitter, YouTube, Grindr) to support event promotion, increase general awareness, provide accurate and science-based education and address misinformation. The applicant should consider existing social media efforts to enhance awareness/education. Applicants can develop their own campaign materials but are strongly encouraged to use existing campaign resources (with permission, as appropriate) such as those available from CDC, NYSDOH and NYC Department of Health and Mental Hygiene and tailor them to meet the needs of the priority population and geographic area.

A. Requirements for the Program – All Components

All applicants selected for funding will be required to:

1. Adhere to Health Literacy Universal Precautions (https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html);
2. Adhere to all objectives, tasks and performance measures as listed in **Work Plan** for the component you are applying for;
3. Serve a cross-section of clients who are representative of the overall priority population the Applicant is proposing to serve;
4. Participate in a collaborative process with the NYSDOH AI to assess program outcomes and provide monthly narrative reports describing the progress of the program with respect to:
    - implementation,
    - success in meeting Work Plan performance measures and significant accomplishments achieved,
    - barriers encountered, and
    - plans to address noted problems.
5. Inform program efforts by using the most current evidence and data available about needs and concerns of the priority population (s) (e.g. community needs assessments, surveillance data, special reports, etc.). All interventions and essential support services must incorporate and promote health equity.
6. Submit educational materials to NYSDOH AI Contract Manager for approvals by the NYSDOH AI Materials Review Board prior to use; and submit statistical reports on clients served, and other data using the AIDS Institute Reporting System (AIRS). Successful applicants must demonstrate the capacity to collect and report all required data, both personnel and hardware-related using AIRS. AIRS is a data reporting system that is required by the NYSDOH AI to report client demographic information as well as program activities. NYSDOH AI requires maintenance and reporting of unduplicated client level data, including demographics and service histories, in accordance with applicable federal and/or state reporting requirements. NYSDOH AI provides and supports the AIRS software to enable providers to meet data submission requirements. Details on this software product may be obtained by accessing the following Internet address, www.airsny.org; and

7. Address and assess the specific social and/or structural determinants of health. The unequal distribution of social and/or determinants can lead to disparities and ultimately inequities in health and health outcomes. Strategies should prioritize those populations that are most impacted, negatively, by social and structural determinants of health.

   Please see **Attachment 6** for **Health Equity Definitions and Examples** of social and structural determinants of health.

IV. ADMINISTRATIVE REQUIREMENTS

A. Issuing Agency

This RFA is issued by the New York State Department of Health AIDS Institute (hereinafter referred to as NYSDOH AI, or the Department), (Division of HIV/STD/HCV Prevention Office of Population Health and Prevention Programs. The Department is responsible for the requirements specified herein and for the evaluation of all Applications. *See,* Section V.C. (Review and Award Process).

B. Question and Answer Phase

All substantive questions by Applicants with respect to any aspect of the RFA must be submitted in writing to Nkechi Oguagha, NYSDOH AI, *Office of Population Health and Prevention Programs,* at the following email address: cocrfa@health.ny.gov. This includes Minority and Women Owned Business Enterprise (M/WBE) questions and questions pertaining to the M/WBE forms. *See,* Section IV.I. (Minority & Women-Owned Business Enterprise (M/WBE) Requirements). Questions of a technical nature related to formatting or other minor details related to preparation of an Application may also be addressed in writing to the email address noted above. Questions are of a technical nature if they are limited to how to prepare your Application (e.g., formatting) rather than relating to the substance of the Application.

To the degree possible, each question submitted by a potential Applicant pursuant to the terms of this RFA should cite the RFA section and paragraph to which it refers. Written questions will be accepted until the date posted on the Cover Page of this RFA.

Some helpful links for questions of a technical nature are below. Questions regarding specific opportunities or applications should be directed to the NYSDOH contact listed on the cover of this RFA.

- https://grantsmanagement.ny.gov/resources-grant-applicants

- Grants Gateway Videos: https://grantsmanagement.ny.gov/videos-grant-applicants

- Grants Gateway Team Email: grantsgateway@its.ny.gov
  Phone: 518-474-5595
  Hours: Monday thru Friday 8am to 4pm
  (Application Completion, Policy, Prequalification and Registration questions)

- Agate Technical Support Help Desk
  Phone: 1-800-820-1890
  Hours: Monday thru Friday 8am to 8pm
  Email: helpdesk@agatesoftware.com
  (After hours support w/user names and lockouts)

Prospective Applicants should note that all responses to questions submitted with respect to this RFA which result in clarifications of or exceptions to the terms, conditions, and provisions of this RFA, including those relating to the terms and conditions of the Master Contract for Grants that will be required to be entered into by each successful Applicant, are to be raised prior to the submission of an Application and will be published by the Department to ensure equal access and knowledge by all prospective Applicants at

https://grantsgateway.ny.gov/IntelliGrants_NYSGG/module/nysgg/goportal.aspx by the date specified on the Cover Page of this RFA.

This RFA has been posted on the NYS Grants Gateway website at: https://grantsgateway.ny.gov/IntelliGrants_NYSGG/module/nysgg/goportal.aspx and a link provided on the Department's public website at: https://www.health.ny.gov/funding/.

All Questions must be received by the date and time specified on the Cover Page of this RFA, under "Key Dates", opposite the heading "Questions Due".

All questions submitted by email should state the RFA Title and Number set forth on the Cover Page (*RFA#20407, High Impact Prevention and Services That Address Social Determinants of Health and Reduce Health Disparities within Communities of Color***) in the subject line of the email.**

C. Letter of Interest

Letters of Interest are not a requirement of this RFA.

D. Applicant Conference

An Applicant Conference WILL be held for this project. This conference will be held at on the date and time posted on the Cover Page of this RFA. The Department requests that potential Applicants register for this conference by using the following link to ensure that adequate accommodations be made for the number of prospective attendees:
https://aidsinstituteny-org.zoom.us/webinar/register/WN_krJRGF9uTuepjqEpLpxtNw

The failure of any potential Applicant to attend the Applicant Conference will not preclude the submission of an Application by that Applicant.

E. How to File an Application

Applications must be submitted online via the Grants Gateway by the date and time posted on the Cover Page of this RFA under the heading "Key Dates".

Reference materials and videos are available for Grantees applying to funding opportunities on the NYS Grants Gateway. Please visit the Grants Management website at the following web address: https://grantsmanagement.ny.gov/ and select the "Apply for a Grant" from the Apply & Manage menu. There is also a more detailed "Grants Gateway: Vendor User Guide" available in the documents section under Training & Guidance; For Grant Applicants on this page as well. Training webinars are also provided by the Grants Gateway Team. Dates and times for webinar instruction can be located at the following web address: https://grantsmanagement.ny.gov/live-webinars.

To apply for this opportunity (that is, to submit an Application):

1. Log into the Grants Gateway as either a "Grantee" or "Grantee Contract Signatory".
2. On the Grants Gateway home page, click the "View Opportunities" button".
   Use the search fields to locate an opportunity; search by State agency (NYSDOH) or enter the Grant Opportunity name: *High Impact Prevention and Services That Address Social Determinants of Health and Reduce Health Disparities within Communities of Color*.
3. Click on "Search" button to initiate the search.
4. Click on the name of the Grant Opportunity from the search results grid and then select the "APPLY FOR GRANT OPPORTUNITY" button located bottom left of the Main page of the Grant Opportunity.

Once the Application is complete, a prospective Applicant is **strongly encouraged** to submit their Application at least **48 hours prior to the** Application's due date and time specified on the Cover Page of this RFA. This

will allow sufficient opportunity for the Applicant to obtain assistance and take corrective action should there be a technical issue with the submission process. **Failure to leave adequate time to address issues identified during this process may jeopardize an Applicant's ability to submit their Application.** Both NYSDOH and Grants Gateway staff are available to answer Applicant's technical questions and provide technical assistance prior to the application due date and time. Contact information for the Grants Gateway Team is available under Section IV. B. (Question and Answer Phase) of this RFA.

PLEASE NOTE: Although NYSDOH and the Grants Gateway staff will do their best to address concerns that are identified less than 48 hours prior to the due date and time for the submission of an Application, there is no guarantee that they will be resolved in time for the Application to be submitted on time and, therefore, considered for funding.

The Grants Gateway will always notify an Applicant of successful submission of the Applicant's Application. If a prospective Applicant does not get a successful submission message assigning their Application a unique ID number, it has **NOT** successfully submitted an Application. During the application process, please pay particular attention to the following:

- Not-for-profit Applicants must be prequalified, if not exempt, on the date and time Applications in response to this Requestion for Applications (RFA) are due as specified in the "Key Dates" set forth on the Cover Page of this RFA. Be sure to maintain prequalification status between funding opportunities. **NOTE:** Three of a not-for-profit's essential financial documents - the IRS990, its Financial Statement, and its Charities Bureau filing - expire on an annual basis. If these documents are allowed to expire, the not-for-profit's prequalification status expires as well, and it will not be eligible for State grant funding until its documentation is updated and approved, and prequalified status is reinstated.
- Only individuals with the roles "Grantee Contract Signatory" or "Grantee System Administrator" can submit an Application on behalf of an Applicant.
- Prior to submission, the Grants Gateway will automatically initiate a global error checking process to protect against an incomplete Application. An Applicant may need to attend to certain parts of the Application prior to being able to submit the Application successfully. An Applicant must be sure to allow time after pressing the submit button to clean up any global errors that may arise. An Applicant can also run the global error check at any time in the application process. (see p.68 of the Grants Gateway: Vendor User Guide).
- Applicants should use numbers, letters, and underscores when naming their uploaded files. There cannot be any special characters in the uploaded file name. Also, be aware of the restriction on file size (10 MB) when uploading documents. Applicants should ensure that any attachments uploaded with their application are **not** "protected" or "pass-worded" documents.

The following table will provide a snapshot of which roles are allowed to Initiate, Complete, and Submit the Grant Application(s) in the Grants Gateway.

Role	Create and Maintain User Roles	Initiate Application	Complete Application	Submit Application	Only View the Application
Delegated Admin	X				
Grantee		X	X		
Grantee Contract Signatory		X	X	X	
Grantee Payment Signatory		X	X		
Grantee System Administrator		X	X	X	
Grantee View Only					X

PLEASE NOTE: Waiting until the last several days to complete your Application online can be dangerous, as you may have technical questions. Beginning the process of applying as soon as possible will produce the best results.

Applications will not be accepted via fax, e-mail, paper copy or hand delivery.
LATE APPLICATIONS WILL NOT BE ACCEPTED.

F. Department of Health's Reserved Rights

The Department of Health reserves the right to:

1. Reject any or all applications received in response to this RFA.
2. Withdraw the RFA at any time, at the Department's sole discretion.
3. Make an award under the RFA in whole or in part.
4. Disqualify any Applicant whose conduct and/or proposal fails to conform to the requirements of the RFA.
5. Seek clarifications and revisions of applications, in the Department's sole discretion.
6. Use Application information obtained through site visits, management interviews, and the state's investigation of an Applicant's qualifications, experience, ability, or financial standing, and any material or information submitted by the Applicant in response to the Department's request for clarifying information in the course of evaluation and/or selection under the RFA.
7. Prior to Application opening, amend the RFA specifications to correct errors or oversights, or to supply additional information, as it becomes available.
8. Prior to Application opening, direct Applicants to submit proposal modifications addressing subsequent RFA amendments.
9. Change any of the scheduled dates.
10. Waive any requirements that are not material.
11. Award more than one contract resulting from this RFA.
12. Negotiate with successful Applicants within the scope of the RFA in the best interests of the State.
13. Conduct contract negotiations with the next responsible Applicant, should the Department be unsuccessful in negotiating with the selected Applicant.
14. Utilize any and all ideas submitted with the Applications received, at the Department's sole discretion.
15. Unless otherwise specified in the RFA, every offer in an Applicant's Application is firm and not revocable for a period of 60 days from the Application opening.
16. Waive or modify minor irregularities in Applications received after prior notification to the Applicant.
17. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an Applicant's Application and/or to determine an Applicant's compliance with the requirements of the RFA.
18. Eliminate any term of this RFA that cannot be complied with by any of the Applicants.
19. Award grants based on geographic or regional considerations to serve the best interests of the State.

G. Term of Contract

Any Contract resulting from this RFA will be effective only upon approval by the New York State Office of the Comptroller.

It is expected that contracts resulting from this RFA will have the following multi-year time period: (May 1, 2024 – April 30, 2029)

Continued funding throughout this period is contingent upon availability of funding and state budget appropriations and the Grantee's continued satisfactory performance of its obligations under the Contract. NYSDOH also reserves the right to revise the award amount as necessary due to changes in the availability of funding.

A sample New York State Master Contract for Grants can be found in the Forms Menu once an application to this funding opportunity is started.

H. Payment & Reporting Requirements of Grant Awardees

1. The Department may, at its discretion, make an advance payment to a successful not-for-profit grant Applicant under this RFA (a “Grantee”) in an amount not to exceed 25% percent of the annual grant provided for under the Grantee’s Contract.

2. The Grantee will be required to submit invoices and required reports of expenditures based upon the terms for payment set forth in Attachment A-1 to its Grant Contract to the State's designated payment office (below) or, if requested by the Department, through the Grants Gateway:

AIDS Institute
New York State Department of Health
Empire State Plaza
Albany, NY 12237
Reports - fmubudgets@health.ny.gov
Vouchers - fmuvouchers@health.ny.gov

A Grantee must provide complete and accurate billing invoices in order to receive payment of the grant funding provided for under the terms of its Grant Contract. Invoices submitted to the Department must contain all information and supporting documentation required by the Contract, the Department, and the Office of the State Comptroller (OSC). Payment for invoices submitted by the Grantee shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner of Health, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with OSC’s procedures and practices to authorize electronic payments. Authorization forms are available at OSC’s website at: http://www.osc.state.ny.us/epay/index.htm, by email at: epayments@osc.state.ny.us or by telephone at 855-233-8363. Each Grantee acknowledges that it will not receive payment on any claims for reimbursement submitted under its Grant Contract if it does not comply with OSC’s electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

Payment of claims for reimbursement by the State (Department) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be: Contractor will be reimbursed for actual expenses incurred as allowed in the Contract Budget and Work Plan.

2. The Grantee will be required to submit the following reports to the Department of Health at the address above or, if requested by the Department, through the Grants Gateway:
   - A monthly narrative addressing program implementation, barriers and accomplishments.
   - Monthly client service and outcome data through the AIDS Institute Reporting System (AIRS). http://www.airsny.org/

   All payment and reporting requirements will be detailed in Attachment D of the final NYS Master Grant Contract.

I. Minority & Woman-Owned Business Enterprise Requirements

Pursuant to New York State Executive Law Article 15-A, the Department recognizes its obligation to promote opportunities for maximum feasible participation of New York State-certified minority- and women-owned business enterprises (M/WBEs) and the employment of minority group members and women in the performance of NYSDOH contracts.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises: Evidence from New York" (“Disparity Study”). The report found evidence of statistically significant

disparities between the level of participation of minority- and women-owned business enterprises in state procurement contracting versus the number of minority- and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority- and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that NYSDOH establish goals for maximum feasible participation of New York State Certified minority- and women-owned business enterprises ("MWBE") and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for M/WBEs

For purposes of this solicitation, the Department of Health hereby establishes a goal of **30%** as follows:

1) For Not-for-Profit Applicants: Eligible Expenditures include any subcontracted labor or services, equipment, materials, or any combined purchase of the foregoing under a contract awarded from this solicitation.
2) For-Profit and Municipality Applicants: Eligible Expenditures include the value of the total amount of the Budget provided for the Work Plan in the Grant Contract entered into pursuant to this RFA.

The goal on the Eligible Expenditures portion of a Grant Contract awarded pursuant to this RFA will be 15% for Minority-Owned Business Enterprises ("MBE") participation and 15% for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs and outreach efforts to certified M/WBE firms). A Grantee awarded a Grant Contract pursuant to this RFA must document good faith efforts to provide meaningful participation by M/WBEs as subcontractors or suppliers in the performance of the Grant Contract and Grantee will agree under the terms of its Grant Contract that NYSDOH may withhold payment pending receipt of the required M/WBE documentation required by the Department or the OSC. For guidance on how NYSDOH will determine "good faith efforts," refer to 5 NYCRR §142.8.

The directory of New York State Certified M/WBEs can be viewed at: https://ny.newnycontracts.com. The directory is found on this page under "NYS Directory of Certified Firms" and accessed by clicking on the link entitled "Search the Directory". Engaging with firms found in the directory with like product(s) and/or service(s) is strongly encouraged and all communication efforts and responses should be well documented by a Grantee to evidence its good faith efforts to encourage M/WBE participation in the performance of its obligations under its Grant Contract.

By submitting an Application, each Applicant and potential Grantee agrees to complete an **M/WBE Utilization plan** as directed in **Attachment 7** of this RFA. NYSDOH will review the M/WBE Utilization Plan submitted be each Grantee. If a Grantee's M/WBE Utilization Plan is not accepted, NYSDOH may issue a Notice of Deficiency. If a Notice of Deficiency is issued, Grantee agrees that it shall respond to the Notice of Deficiency within seven (7) business days of receipt. NYSDOH may disqualify a Grantee as being **non-responsive** under the following circumstances:

a) If a Grantee fails to submit a M/WBE Utilization Plan;
b) If a Grantee fails to submit a written remedy to a Notice of Deficiency;
c) If a Grantee fails to submit a request for waiver (if applicable); or
d) If NYSDOH determines that the Grantee has failed to document good-faith efforts to meet the established NYSDOH M/WBE participation goals for the procurement.

In addition, Grantees will be required to certify they have an acceptable Equal Employment Opportunity policy statement.

J. Vendor Identification Number

Effective January 1, 2012, in order to do business with New York State, you must have a vendor identification number. As part of the Statewide Financial System (SFS), the Office of the State Comptroller's Bureau of State

Expenditures has created a centralized vendor repository called the New York State Vendor File. In the event of an award of a grant to a successful Applicant pursuant to the terms of this RFA and in order to initiate a Grant Contract with the New York State Department of Health, a Grantee must be registered in the New York State Vendor File and have a valid New York State Vendor ID.

If already enrolled in the Vendor File, The Applicant should include the Vendor Identification number in your organization information. If not enrolled, to request assignment of a Vendor Identification number, an Applicant should please submit a New York State Office of the State Comptroller Substitute Form W-9, which can be found on-line at: https://www.osc.state.ny.us/files/vendors/2017-11/vendor-form-ac3237s-fe.pdf

Additional information concerning the New York State Vendor File can be obtained on-line at: http://www.osc.state.ny.us/vendor_management/index.htm, by contacting the SFS Help Desk at 855-233-8363 or by emailing at helpdesk@sfs.ny.gov.

K. Vendor Responsibility Questionnaire

The Department strongly encourages each Applicant to file the required Vendor Responsibility Questionnaire online via the New York State VendRep System. The Vendor Responsibility Questionnaire must be updated and certified every six (6) months. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at https://www.osc.state.ny.us/state-vendors/vendrep/file-your-vendor-responsibility-questionnaire or go directly to the VendRep system online at https://www.osc.state.ny.us/state-vendors/vendrep/vendrep-system.

An Applicant must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the Office of the State Comptroller's Help Desk at 866-370-4672 or 518-408-4672 or by email at itservicedesk@osc.ny.gov.

Applicants opting to complete online should complete and upload the **Vendor Responsibility Attestation** as **Attachment 8** of the RFA. The Attestation is located under Pre-Submission Uploads and once completed should be uploaded in the same section.

Applicants opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website, www.osc.state.ny.us/vendrep, and upload it with their Application in the Pre-Submission Uploads section in place of the Attestation.

L. Vendor Prequalification for Not-for-Profits

Each not-for-profit Applicant subject to prequalification is required to prequalify prior to submitting its Application in the Grants Gateway.

Pursuant to the New York State Division of Budget Bulletin H-1032, dated July 16, 2014, New York State has instituted key reform initiatives to the grant contract process which requires a not-for-profit Applicant to register in the Grants Gateway and complete the Vendor Prequalification process in order for any Application submitted by that Applicant to be evaluated. Information on these initiatives can be found on the Grants Management Website.

An Application received from a not-for-profit Applicant that (a) has not Registered in the Grants Gateway or (b) has not Prequalified in the Grants Gateway on the Application's due date specified on the Cover Page of this RFA cannot be evaluated. Such Applications will be disqualified from further consideration.

Below is a summary of the steps that must be completed to meet registration and prequalification requirements. The Vendor Prequalification Manual on the Grants Management Website details the requirements and an online tutorial are available to walk users through the process.

1) Register for the Grants Gateway

- On the Grants Management Website, download a copy of the Registration Form for Administrator. A signed, notarized original form must be sent to the NYS Grants Management office at the address provided in the submission instructions. You will be provided with a Username and Password allowing you to access the Grants Gateway.

If you have previously registered and do not know your Username, please email grantsgateway@its.ny.gov. If you do not know your Password, please click the Forgot Password link from the main log in page and follow the prompts.

2) Complete your Prequalification Application

- Log in to the Grants Gateway. **If this is your first time logging in,** you will be prompted to change your password at the bottom of your Profile page. Enter a new password and click SAVE.

- Click the *Organization(s)* link at the top of the page and complete the required fields including selecting the New York State agency from which you have received the most grants. This page should be completed in its entirety before you SAVE. A *Document Vault* link will become available near the top of the page. Click this link to access the main Document Vault page.

- Answer the questions in the *Required Forms* and upload *Required Documents*. This constitutes your Prequalification Application. Optional Documents are not required unless specified in this Request for Application.

- Specific questions about the prequalification process should be referred to your primary New York State agency representative or to the Grants Gateway Team at grantsgateway@its.ny.gov.

3) Submit Your Prequalification Application

- After completing your Prequalification Application, click the ***Submit Document Vault*** Link located below the Required Documents section to submit your Prequalification Application for State agency review. Once submitted the status of the Document Vault will change to *In Review*.

- If your Prequalification reviewer has questions or requests changes you will receive email notification from the Gateway system.

- Once your Prequalification Application has been approved, you will receive a Gateway notification that you are now prequalified to do business with New York State.

All potential Applicants are strongly encouraged to begin Grants Gateway Registration and Prequalification process as soon as possible in order to participate in this opportunity.

M. General Specifications

1. By submitting the "Application Form" each Applicant attests to its express authority to sign on behalf of the Applicant.

2. Grantees will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of any Contract awarded pursuant to this RFA will possess the qualifications, training, licenses, and permits as may be required within such jurisdiction.

3. Submission of an Application indicates the Applicant's acceptance of all conditions and terms contained in this RFA, including the terms and conditions of the Master Contract for Grants. Any exceptions allowed by the Department during the Question and Answer Phase of this RFA (*See,* Section IV.B.) must be clearly noted in a cover letter included with the Application submitted by an Applicant wishing to incorporate any of such exceptions in its Applicants and in the Grant Contract awarded pursuant to this RFA if it is a successful (funded) Applicant.

4. An Applicant may be disqualified from receiving an award if such Applicant or any subsidiary, affiliate, partner, officer, agent, or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts, in the State of New York or otherwise.

5. Provisions Upon Default

a. If an Applicant is awarded a grant pursuant to this RFA, the services to be performed by the successful Applicant pursuant to the terms of the Grant Contract entered into with the Department shall be at all times subject to the direction and control of the Department as to all matters arising in connection with or relating to the Contract resulting from this RFA.

b. In the event that the Grantee, through any cause, fails to perform any of the terms, covenants, or promises of any Contract resulting from this RFA, the Department acting for and on behalf of the State, shall thereupon have the right to terminate the Contract by giving notice in writing of the fact and date of such termination to the Grantee.

c. If, in the judgement of the Department, the Grantee acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate any Contract resulting from this RFA by giving notice in writing of the fact and date of such termination to the Grantee. In such case the Grantee shall receive equitable compensation for such services as shall, in the judgement of the State Comptroller, have been satisfactorily performed by the Grantee up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Grantee was engaged in at the time of such termination, subject to audit by the State Comptroller.

V. COMPLETING THE APPLICATION

A. Application Format/Content

Please refer to the Grants Gateway: Vendor User Guide for assistance in applying for this procurement through the NYS Grants Gateway. This guide is available on the Grants Management website at: https://grantsmanagement.ny.gov/vendor-user-manual. Additional information for applicants is available at: https://grantsmanagement.ny.gov/resources-grant-applicants.

The Grants Gateway works well in most cases with all browsers, including Microsoft Edge, Google Chrome, Safari, and Firefox. However, you will need to use Internet Explorer Compatibility Mode in Microsoft Edge if you need to save 250-character limit fields in the Work Plan. You can access Internet Explorer mode by right-clicking on a tab in Edge and selecting the option "Reload Tab in Internet Explorer Mode".

Please respond to each of the sections described below when completing the Grants Gateway online Application. Your responses comprise your Application. Please respond to all items within each section. When responding to the statements and questions, be mindful that Application reviewers may not be familiar with your agency and its services. Your answers should be specific, succinct, and responsive to the statements and questions as outlined. Please be aware that the value assigned to each section described below indicated the relative weight that will be given to each section of your Application when scoring your Application.

It is each Applicant's responsibility to ensure that all materials included in its Application have been properly

prepared and submitted. Applications must be submitted via the Grants Gateway by the Application deadline date and time specified on the Cover Page of this RFA.

1. Pre-Submission Uploads

As a reminder, the following attachments need to be uploaded under the Pre-Submission Uploads section of the Grants Gateway in order to submit an application in the system. (Reminder: Applicants should ensure that any attachments uploaded with their application are **not** "protected" or "pass-worded" documents)

Attachment 1: Statement of Assurances*
Attachment 7: M/WBE Utilization Plan*
Attachment 8: Vendor Responsibility Attestation*
Attachment 9: Application Cover Page*
Attachment 10: Locally Developed Interventions* (If applicable)
Attachment 11: CLIA Permit* (If applicable)
Attachment 12: Service Linkages Chart*
Attachment 16: Agency Capacity and Staffing Information*
Attachment 17: Agency Organizational Chart*
Attachment 19: Statement of Activities for past three (3) years*
Attachment 20: Agency Time and Effort Policy*
Attachment 21: Funding History for HIV/STI/HCV Services*

All applicants are required to complete and upload **Attachment 9 - Application Cover Page. Attachment 9** should be submitted via the Grants Gateway in the Pre-Submission Uploads section of the online application.

APPLICANTS FOR COMPONENTS A, B, and C COMPLETE THE FOLLOWING QUESTIONS

Application Format

1.	Program Abstract		Not Scored
2.	Community and Agency Description	Maximum Score:	15 points
3.	Health Equity	Maximum Score:	15 points
4.	Program Design and Implementation	Maximum Score:	50 points
5.	Budget and Justification	Maximum Score:	20 points
			100 points

1. Program Abstract **Not Scored**

Applicants should provide a program abstract with the following information:

1a) Describe the proposed program. Include what will be completed and how.

1b) What are the Project goals and objectives?

1c) What is the geographic region to be served?

1d) Describe the priority population. Indicate the total number of unduplicated clients to be served.

1e) What types of outcomes does your organization expect to achieve? How will success be measured?

2. Community and Agency Description **Total 15 Points**

2a) Describe your organization's existing sexual health and HIV/STI/HCV prevention related activities/services, highlighting those serving the priority population. Include the length of time each service has been provided and an estimate of the number of individuals from the priority population

that your organization has served through program services over the past two (2) years.

2b) Describe the gaps and strengths in services for the priority population in the region and how these gaps will be addressed with this funding. Include how community/population strengths and assets will be leveraged to benefit the program.

2c) Describe how the agency has created an affirming environment for communities of color. Include evidence/information to support that your agency has a history providing ethnically, linguistically, and culturally affirming/responsive services to communities of color. Responses should address the following areas: staff recruitment, staff training, client services, development of agency, and program policies and procedures.

2d) Describe any prior grants your organization has received from the NYSDOH AI that are relevant to this proposal. Include the results of the program and successes of those grants. OR if your organization has not received funding from the NYSDOH AI, describe any similar types of programs that your organization has undertaken in the past, including the identified results of the program and the successes in achieving those results.

3. **Health Equity** **Total 15 Points**

3a) Which SDOH barriers will you address with the priority population served by this funding?

3b) Please provide the most current data that you have used to identify the SDOH barriers affecting the population served by this funding.

3c) Describe how will you monitor and evaluate the immediate impact of your efforts to address the SDOH. (i.e., if you have offered nutrition or housing services, for example, to a client and they have responded, has it improved their adherence with treatment?)

3d) What is your organization's policy around addressing SDOH? What is the agency's capacity (staff knowledge, staff training, support for collaboration and evaluation) at addressing this?

3e) How does the organization's leadership reflect the population served?

4. Program Design and Implementation **Total 50 Points**

4a) Briefly describe your proposed program model. Please address the following items in your response:
1. Describe the community or communities you will serve through this funding. Include a description of the priority population(s); geographic area to be served; service location(s) within the proposed service area; and site accessibility for the priority population.

2. Describe your overall program design. Include specific strategies for implementing the program services, any innovative strategies you will utilize to implement the program model, the rationale for the selection of the strategy or strategies and why your program is well positioned to implement the proposed program model. Strategies should align with the prescribed program model.

3. Indicate previous outcomes and any changes that were made to the model being proposed to improve it. If this is a new service, include a rationale for why your organization expects this model will work. Include any evidence of pilot programs to demonstrate potential success.

4b) Explain how members of the priority population were involved in the development of the program design (e.g., community needs assessment and other planning/assessment activities) and how their input will continue to be incorporated in the program design and implementation of the proposed program services.

4c) Describe the activities that your program will provide to promote and meet the program objectives outlined in the RFA and workplan. Include the specific public health strategy, EBI and/or locally developed intervention, Prevention/Support Services, and/or Health Promotion activities that will be provided and describe how the proposed strategy/intervention(s) is/are designed to support connection to HIV testing, STI and HCV screening, PrEP/PEP, and/or linkage and navigation services. Explain how the proposed services will meet the needs of the priority population(s) and the total number of individuals projected to be served in a 12-month period.
Applicants proposing a locally developed intervention and/or Peer Services/Peer Training Program should complete **Attachment 10: NYSDOH AI's Locally Developed Interventions**. **Attachment 10** can be found in and uploaded to the Pre-Submission Uploads section of the Grants Gateway online application.

4d) Describe the specific interventions that will be provided to address SDOH impacting the priority population. Include how the proposed intervention(s) was/were selected and include data to support the need for the intervention. Explain how the proposed services will meet the needs of the priority population(s) and how the intervention will provide connection to HIV testing, STI and HCV screening, PrEP/PEP, and/or linkage and navigation services. Indicate the total number of individuals projected to be served in a 12-month period.

4e) Describe the targeted client recruitment and engagement strategies that will be used to engage individuals in the proposed services/interventions. Applicants should demonstrate access to the priority population and the ability to bring them in for each proposed service. If social media has been chosen for client recruitment/engagement activities, indicate the social media tools that will be used and how they will be utilized in the proposed program.

Complete questions 4f - 4g if applying for Program Model 1- Direct Provision of HIV Testing

4f) Describe how, by whom, and where targeted HIV testing will be provided. Include which rapid HIV test technology(ies) will be used. Indicate whether the program will offer HIV self-test and how it will be implemented within the program. A copy of the agency's valid **CLIA Permit** should be uploaded as **Attachment 11** in the pre-submission section of the Grants Gateway online application.

4g) Explain the process for how confirmatory HIV testing will be conducted including how you will ensure the timely provision of test results and how you will follow up with and locate individuals who test positive for HIV and do not return for a test result appointment. For newly diagnosed clients, please describe how your program will ensure timely reporting of the diagnosis to NYSDOH, as well as linkage to HIV medical care with HIV-related lab work within 30 days of diagnosis, Partner Services, and prevention services.

Complete question 4h if applying for Program Model 2- Documented Referral to HIV Testing

4h. Describe the process used to refer clients to HIV testing services and include the process that will be used to document and confirm that services were received.

Applicants are required to answer questions for the method by which STI and HCV screening will be provided (i.e., direct, paid subcontract or via linkage).

Direct STI and HCV Screening – Program Model 1
If directly providing STI and HCV Screening, please complete questions "4.i.- 4.l." below.

4i) Indicate which STI screening methods (e.g., syphilis serology, NAAT) will be used. Include the name of the lab to be used for processing specimens and whether they have current CLEP approval to conduct the necessary laboratory tests on the specimen types. A copy of the agency's valid **CLIA Permit**

should be uploaded as **Attachment 11** in the pre-submission section of the Grants Gateway online application.

4j) Indicate which anatomic sites (e.g., vaginal/cervical or urethral, rectal, pharyngeal) will be tested for STIs. Include a description of the procedures that are currently in place for three site testing.

4k) Explain how your program will ensure linkage to STI treatment and medical care within 72 hours of diagnosis including scheduling the medical appointment and follow up to confirm client has accessed treatment/care. For clients with HCV reactive results, include how your program will ensure linkage to HCV diagnostic testing and/or medical care including scheduling the medical appointment and follow up to confirm client has accessed treatment/care.

4l) Explain how you will ensure support and linkages to Partner Services and prevention services for STI positive individuals and include how you will fulfill your reporting obligations under NYS Sanitary Code for HCV and/or STIs and/or applicable public health law.

Documented referral to STI and HCV Screening – Program Model 2
If providing STI and HCV screening via documented referral, please complete question "4m" below.

4m) Describe the process used to refer clients to STI and HCV screening services and include the process that will be used to document and confirm that services were received.

All applicants must complete questions 4n-4r.

4n) Describe your process for delivering linkage and navigation services from client readiness to case closure. Include how you will track linkages to ensure services were received and the outcomes of the linkages.

4o) Complete **Attachment 12: Service Linkages Chart** to indicate the services clients will be linked to for medical, prevention and supportive services providers. **Attachment 12** can be found in the Pre-Submission Uploads section of the Grants Gateway online application and once completed should be uploaded in the same section.

4p) What are your program's indicators for success? How will you use them to drive program improvement? Be specific. Indicate how you will monitor progress in meeting program objectives, completing tasks/activities, and achieving key performance indicators as indicated in the **Work Plan** (**Attachment 13 for Component A, Attachment 14 for Component B and Attachment 15 for Component C**). Include information on how your results will inform future program changes.

4q) Indicate how the proposed program will be staffed. Identify the titles, roles, and responsibilities of each position needed to operate and manage the proposed program, including peers (as appropriate) and AIRS data collection and entry. Indicate whether each position is to be hired (TBH) or existing staff. Describe the plan for initial and ongoing staff training and support. Applicants are required to complete **Attachment 16 – Agency Capacity and Staffing Information**. Applicants are instructed to upload their **Agency Capacity and Staffing Information** as **Attachment 16** and their **Agency Organizational Char**t as **Attachment 17** in the Pre-Submission Uploads section of the Grants Gateway online application. Organizational charts should be submitted as a .PDF document.

4r) Have you addressed all required elements and answered all questions for the selected Program Model?

5. Budgets and Justifications **Total 20 Points**

Complete and submit a budget following these instructions:

5a) Applicants are instructed to prepare an annual budget based on the maximum award as listed for the region in which they are applying. The budget for year one (**5/1/2024 – 4/30/2025**) must be entered into the Grants Gateway. Refer to **Grants Gateway Expenditure Budget Instructions - Attachment 18**. All budget lines should be calculated as whole dollar amounts. All costs should be related to the proposed activities, as described in the application narrative and work plan, and should be justified in detail. All costs should be reasonable and cost-effective. Contracts established resulting from the RFA will be cost reimbursable.

5b) For staff listed in the Personal services (Salary and Fringe) section of the budget, include a breakdown of the total salary needs for staff. Indicate how the positions relate to program implementation. Applicants are instructed to include a justification for each of the requested FTE's and for the fringe benefits requested.

5c) For each item listed under Non-Personal services, describe how it is necessary for program implementation. Non-Personal services include: Contractual, Travel, Equipment, Space/Property & Utilities, Operating Expenses and Other costs.

5d) Indicate the percentage of the budget and the budget categories directly allocated to the support and implementation of SDOH interventions i.e. childcare, nutrition, employment, housing support, reproductive healthcare etc.

5e) For the last three (3) years, does your organizations' Statement of Activities from your yearly audit show that revenues exceeded expenses or expenses exceeded revenue? If the expenses exceeded revenues, please describe both the cost reduction plan and the deficit reduction plan that will correct this. Please attach the Statement of Activities from your yearly audit for the last three (3) years. The Statement of Activities must show total support and revenue and total expenditures. The **Statement of Activities** should be uploaded to the Grants Gateway as **Attachment 19**. If uploaded as a .PDF document, Attachment 19 cannot be Secure or Password Protected.

5f) Applicants are required to upload a copy of their **Agency Time and Effort Policy** as **Attachment 20** in the Pre-Submission uploads section of the Grants Gateway online application.

5g) Describe the specific internal controls your agency uses to comply with the Federal Uniform Guidance (2 CFR 200).

5h) Applicants are required to complete **Funding History for HIV/STI/HCV Services - Attachment 21**. The completed **Attachment 21** should be uploaded to the Pre-Submission uploads section of the Grants Gateway online application.

5i) Funding requests must adhere to the following guidelines:

- An indirect cost rate of up to 10% of modified total direct costs can be requested. If your organization has a federally approved rate, an indirect cost rate of up to 20% of modified total direct costs can be requested. If your agency has a federally approved rate of less than 20%, the maximum indirect rate that can be requested is the federally approved rate.
- Funding may only be used to expand existing activities and create new activities pursuant to this RFA. Funds may **not** be used to supplant funds for currently existing staff and activities. Agencies currently funded by the NYSDOH AI to provide program services in accordance with the requirements of this RFA must apply for continuation of funding. Agencies currently funded by the NYSDOH AI to provide program services in accordance with the requirements of this RFA must apply for continuation of funding *(for currently funded RFAs)*.
- Ineligible budget items will be removed from the budget prior to contracting. Ineligible items are those items determined by NYSDOH to be inadequately justified in relation to the proposed Work Plan or not

fundable under existing federal guidance (Uniform Guidance). The budget amount requested will be reduced to reflect the removal of the ineligible items.

6. Work Plan

For the Grants Gateway **Work Plan Project Summary**, applicants are instructed to insert the Project Summary as it is listed in Work Pla**n for Component A (Attachment 13); Component B (Attachment 14); and Component C (Attachment 15).** In the Grants Gateway **Work Plan Organizational Capacity** section, applicants are instructed to list this as "not applicable." Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Work Pla**n for Component A (Attachment 13); Component B (Attachment 14); and Component C (Attachment 15).** Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.

It is the applicant's responsibility to ensure that all materials to be included in the application have been properly prepared and submitted. Applications must be submitted via the Grants Gateway by the date and time posted on the cover of this RFA. The value assigned to each section is an indication of the relative weight that will be given when scoring your application.

APPLICANTS FOR COMPONENT D COMPLETE THE FOLLOWING QUESTIONS

Application Format

1.	Program Abstract		Not Scored
2.	Community and Agency Description	Maximum Score:	15 points
3.	Health Equity	Maximum Score:	15 points
4.	Program Design and Implementation	Maximum Score:	50 points
5.	Budgets and Justifications	Maximum Score:	20 points
			100 points

1. Program Abstract **Not Scored**

Applicants should provide a program abstract with the following information:

1a) Summarize the proposed program. Briefly describe the program design, proposed services, and activities.

1b) What are the project goals and objectives?

1c) What types of outcomes does your organization expect to achieve? How will success be measured?

2. Community and Agency Description **Total 15 Points**

2a) Describe why your agency is qualified to implement the proposed program. Describe your agency's existing HIV/STI/HCV prevention services including the length of time services have been provided and locations where services are delivered. Indicate the total number of individuals served in the past calendar year and what interventions and services were provided.

2b) Describe your experience establishing collaborations with state and local health departments, community-based organizations and medical providers to promote services and facilitate community access to information and referrals across the care continuum.

2c) Describe your agency's experience providing culturally competent and linguistically appropriate services and include one example of this experience.

2d) Please describe any prior grants your organization has received from the AIDS Institute that are relevant to this proposal. Include the results of the program and successes of those grants. OR, if your organization has not received funding from the AIDS Institute, describe any similar types of programs that your organization has undertaken in the past, including the identified results of the program and the successes in achieving those results.

3. Health Equity **Total 15 Points**

3a) Please provide the most current data that you have used to identify the greatest SDOH barriers affecting the priority populations that access the statewide hotline.

3b) Describe the hotline's process for assisting callers with linkages to prevention, care, and treatment services and how potential barriers and disparities that may prevent a caller from accessing interventions and services (i.e., information and linkages to a transportation resource when lack of transportation is cited as a barrier) will be addressed.

3c) Describe how you will monitor and evaluate the hotline staff's efforts to address caller's SDOH needs and/or barriers (i.e., information and linkages to a transportation resource when lack of transportation is cited as a barrier).

3d) What is your organization's policy around addressing SDOH? What is the agency's capacity (staff knowledge, staff training, support for collaboration and evaluation) at addressing this?

3e) How does the organization's leadership reflect the population served?

4. **Program Design and Implementation** **Total 50 Points**

4a) Describe the overall program design. Include specific strategies on how funded services will be implemented in compliance with the program model including: hotline program promotion/marketing and caller engagement social media approaches; provision of information, education, and referral services, and condom promotion, education, and distribution.

4b) Explain how your agency will receive and respond to telephone and social media inquiries in English and Spanish. Indicate the mechanism for addressing individuals who speak a language other than English or Spanish or are deaf or hearing impaired.

4c) Describe how you will engage other programs and agencies in NYS that are relevant to your proposed program model and how you will leverage these programs to maximize benefit to program participants.

4d) Describe how your organization will collaborate with these agencies to ensure adequate coverage of HIV/STI/HCV prevention and care services.

4e) Describe how the proposed program and messaging will be informed by contextual factors such as culture, language, health literacy levels, norms, stigma, discrimination, and health care disparities.

4f) Describe how the proposed program will be staffed. Identify the titles, roles, and responsibilities of each position needed to operate and manage the proposed program, including peers (as appropriate) and AIRS data collection and entry. Indicate whether each position is to be hired (TBH) or existing staff. Describe the plan for initial and ongoing staff training and support. The **Agency Organizational Chart** should be uploaded as **Attachment 17** in the Pre-Submission Uploads section of the online application. Organizational charts should be submitted as a .PDF document.

4g) Indicate the type of program evaluation activities that you will conduct to track your progress in meeting key performance measures. Explain how information will be used to change or improve the program.

4h) Have you addressed all required elements and answered all questions for the selected Program Model?

5. Budgets and Justifications **Total: 20 Points**

Complete and submit a budget following these instructions:

5a) Applicants are instructed to prepare an annual budget based on the maximum award as listed for the region in which they are applying. The budget for year one (**5/1/2024 – 4/30/2025**) must be entered into the Grants Gateway. Refer to **Grants Gateway Expenditure Budget Instructions - Attachment 18.** All budget lines should be calculated as whole dollar amounts. All costs should be related to the proposed activities, as described in the application narrative and work plan, and should be justified in detail. All costs should be reasonable and cost-effective. Contracts established resulting from the RFA will be cost reimbursable.

5b) For staff listed in the Personal services (Salary and Fringe) section of the budget, include a breakdown of the total salary needs for staff. Indicate how the positions relate to program implementation. Applicants are instructed to include a justification for each of the requested FTE's and for the fringe benefits requested.

5c) For each item listed under Non-Personal services, describe how it is necessary for program implementation. Non-Personal services include: Contractual, Travel, Equipment, Space/Property & Utilities, Operating Expenses and Other costs.

5d) For the last three (3) years, does your organizations' Statement of Activities from your yearly audit show that revenues exceeded expenses or expenses exceeded revenue? If the expenses exceeded revenues, please describe both the cost reduction plan and the deficit reduction plan that will correct this. Please attach the Statement of Activities from your yearly audit for the last three (3) years. The Statement of Activities must show total support and revenue and total expenditures. The **Statement of Activities** should be uploaded to the Grants Gateway as **Attachment 19**. If uploaded as a .PDF document, Attachment 19 cannot be Secure or Password Protected.

5e) Applicants are required to upload a copy of their **Agency Time and Effort Policy** as **Attachment 20** in the Pre-Submission uploads section of the Grants Gateway online application.

5f) Describe the specific internal controls your agency uses to comply with the Federal Uniform Guidance (2 CFR 200).

5g) Applicants are required to complete **Funding History for HIV/STI/HCV Services as Attachment 21. Attachment 21** should be uploaded to the Pre-Submission uploads section of the Grants Gateway online application.

5h) Funding requests must adhere to the following guidelines:

- An indirect cost rate of up to 10% of modified total direct costs can be requested. If your organization has a federally approved rate, an indirect cost rate of up to 20% of modified total direct costs can be requested. If your agency has a federally approved rate of less than 20%, the maximum indirect rate that can be requested is the federally approved rate.
- Funding may only be used to expand existing activities and create new activities pursuant to this RFA. Funds may **not** be used to supplant funds for currently existing staff and activities. Agencies currently

funded by the NYSDOH AI to provide program services in accordance with the requirements of this RFA must apply for continuation of funding. Agencies currently funded by the NYSDOH AI to provide program services in accordance with the requirements of this RFA must apply for continuation of funding *(for currently funded RFAs)*.

- Ineligible budget items will be removed from the budget prior to contracting. Ineligible items are those items determined by NYSDOH to be inadequately justified in relation to the proposed Work Plan or not fundable under existing federal guidance (Uniform Guidance). The budget amount requested will be reduced to reflect the removal of the ineligible items.

6. **Work Plan**

For the Grants Gateway **Work Plan Project Summary**, applicants are instructed to insert the Project Summary as it is listed in **Work Plan for Component D - Attachment 22.** In the Grants Gateway **Work Plan Organizational Capacity** section, applicants are instructed to list this as "not applicable." Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in the **Work Plan for Component D - Attachment 22**. Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.

It is the applicant's responsibility to ensure that all materials to be included in the application have been properly prepared and submitted. Applications must be submitted via the Grants Gateway by the date and time posted on the cover of this RFA. The value assigned to each section is an indication of the relative weight that will be given when scoring your application.

APPLICANTS FOR COMPONENT E COMPLETE THE FOLLOWING QUESTIONS

1.	Program Abstract		Not Scored
2.	Community and Agency Description	Maximum Score:	15 points
3.	Health Equity	Maximum Score:	15 points
4.	Program Design and Implementation	Maximum Score:	50 points
5.	Budgets and Justifications	Maximum Score:	20 points
			100 points

1. **Program Abstract** **Not Scored**

1a) Describe the proposed program. Include what will be completed and how. Indicate the program model selected and briefly describe the program design, proposed services, and interventions/activities.

1b) What are the project goals and objectives?

1c) What is the geographic region to be served?

1d) Describe the priority population. Indicate the total number of unduplicated clients to be served.

1e) What types of outcomes does your organization expect to achieve? How will success be measured?

2. **Community and Agency Description** **Total 15 Points**

2a) Describe why your agency is qualified to implement the proposed program. Describe your existing HIV/STI/HCV prevention related activities/services, highlighting those serving the priority population. State the length of time each service has been provided.

2b) Provide an estimate of the number of individuals your organization proposes to serve through the proposed program. Indicate the number of LGBTQ individuals that have received anti-violence and post-victimization services and technical assistance/training in the past two years by your organization.

2c) Describe how your agency has created an affirming environment for LGBTQ individuals, particularly LGBTQ persons of color. Provide evidence/information to support that your agency has a history providing ethnically/culturally competent and language appropriate affirming/responsive services. Responses should address the following areas: staff recruitment, staff training, client services, development of agency and program policies and procedures.

2d) Provide information to demonstrate the agency's understanding of the social and cultural norms of the priority population. Provide information to demonstrate that your agency/program and staff has the capacity to work with populations and cultures that fall outside that of the dominant agency culture. Provide evidence to demonstrate that the applicant has developed trust and credibility with the priority population.

2e) What are the other programs and agencies in the geographic area that are relevant to your proposed program design and describe how you will leverage these programs to maximize the benefit to LGBTQ individuals in your community without supplanting other resources?

2f) Please describe any prior grants your organization has received from the AIDS Institute that are relevant to this proposal. Include the results of the program and successes of those grants. OR, if your organization has not received funding from the AIDS Institute, describe any similar types of programs that your organization has undertaken in the past, including the identified results of the program and the successes in achieving those results.

2g) Describe how members of the community were involved in the planning and design of the proposed program and describe the method for maintaining their ongoing involvement in an advisory capacity.

3. **Health Equity** **Total 15 Points**

3a) Which SDOH barriers will you address with the priority population served by this funding?

3b) Please provide the most current data that you have used to identify the SDOH barriers affecting the population served by the funding.

3c) Describe how will you monitor and evaluate the immediate impact of your efforts to address the SDOH. (i.e., if you have offered nutrition or housing services, for example, to a client and they have responded, has it improved their adherence with treatment?)

3d) What is your organization's policy around addressing SDOH? What is the agency's capacity (staff knowledge, staff training, support for collaboration and evaluation) at addressing this?

3e) How does the organization's leadership reflect the population served?

4. **Program Design and Implementation** **Total 50 Points**

4a) Describe the community or communities you will serve through this funding. Include a description of the priority population; the geographic area to be served; the service location(s) within the proposed service area; and site accessibility for the priority population.

4b) Describe your overall program design. Include specific strategies for implementing the program services and any innovative strategies you will utilize to implement the program model. Explain the rationale for the selection of the strategy or strategies. Strategies should align with the prescribed

program model.

4c) Describe the specific Anti-Violence Education and Training Interventions that will be provided and the implementation plan for the intervention(s).

4d) Describe the assessment process used to determine the proposed interventions. Indicate the appropriateness for the priority population and how these services will meet the needs of the priority population. Indicate the total number of unduplicated individuals projected to be served in a 12-month period.

4e) Describe how your proposed program and messaging will be informed by contextual factors such as culture, language, health literacy levels, norms, stigma, discrimination, and health care disparities.

4f) Describe how the proposed program will be staffed. Identify the titles, roles, and responsibilities of each position needed to operate and manage the proposed program, including peers (as appropriate) and AIRS data collection and entry. Indicate whether each position is to be hired (TBH) or existing staff. Describe the plan for initial and ongoing staff training and support. The **Agency Organizational Chart** should be uploaded as **Attachment 17** in the Pre-Submission Uploads section of the online application. Organizational charts should be submitted as a .PDF document.

4g) Describe how your proposed program will be integrated with other programs within your organization serving the priority population.

4h) Indicate the type of program evaluation activities that you will conduct to track your progress in meeting key performance measures. Explain how information will be used to change or improve the program.

5. **Budgets and Justifications** **Total 20 Points**

Complete and submit a budget following these instructions:

5a) Applicants are instructed to prepare an annual budget based on the maximum award as listed for the region in which they are applying. The budget for year one (**5/1/2024 – 4/30/2025**) must be entered into the Grants Gateway. Refer to **Grants Gateway Expenditure Budget Instructions - Attachment 18**. All budget lines should be calculated as whole dollar amounts. All costs should be related to the proposed activities, as described in the application narrative and work plan, and should be justified in detail. All costs should be reasonable and cost-effective. Contracts established resulting from the RFA will be cost reimbursable.

5b) For staff listed in the Personal services (Salary and Fringe) section of the budget, include a breakdown of the total salary needs for staff. Indicate how the positions relate to program implementation. Applicants are instructed to include a justification for each of the requested FTE's and for the fringe benefits requested.

5c) For each item listed under Non-Personal services, describe how it is necessary for program implementation. Non-Personal services include: Contractual, Travel, Equipment, Space/Property & Utilities, Operating Expenses and Other costs.

5d) For the last three (3) years, does your organizations' Statement of Activities from your yearly audit show that revenues exceeded expenses or expenses exceeded revenue? If the expenses exceeded revenues, please describe both the cost reduction plan and the deficit reduction plan that will correct this. Please attach the Statement of Activities from your yearly audit for the last three (3) years. The Statement of Activities must show total support and revenue and total expenditures. The **Statement of Activities** should be uploaded to the Grants Gateway as **Attachment 19**. If uploaded as a .PDF document, Attachment 19 cannot be Secure or Password Protected.

5e) Applicants are required to upload a copy of their **Agency Time and Effort Policy** as **Attachment 20** in the Pre-Submission uploads section of the Grants Gateway online application.

5f) Describe the specific internal controls your agency uses to comply with the Federal Uniform Guidance (2 CFR 200).

5g) Applicants are required to complete **Funding History for HIV/STI/HCV Services** as **Attachment 21. Attachment 21** should be uploaded to the Pre-Submission uploads section of the Grants Gateway online application.

5h) Funding requests must adhere to the following guidelines:

- An indirect cost rate of up to 10% of modified total direct costs can be requested. If your organization has a federally approved rate, an indirect cost rate of up to 20% of modified total direct costs can be requested. If your agency has a federally approved rate of less than 20%, the maximum indirect rate that can be requested is the federally approved rate.
- Funding may only be used to expand existing activities and create new activities pursuant to this RFA. Funds may **not** be used to supplant funds for currently existing staff and activities. Agencies currently funded by the NYSDOH AI to provide program services in accordance with the requirements of this RFA must apply for continuation of funding. Agencies currently funded by the NYSDOH AI to provide program services in accordance with the requirements of this RFA must apply for continuation of funding *(for currently funded RFAs)*.
- Ineligible budget items will be removed from the budget prior to contracting. Ineligible items are those items determined by NYSDOH to be inadequately justified in relation to the proposed Work Plan or not fundable under existing federal guidance (Uniform Guidance). The budget amount requested will be reduced to reflect the removal of the ineligible items.

6. **Work Plan**

Applicants are not required to enter the performance measures for each work plan objective in the Grants Gateway Work Plan. Applicants should review the performance measures as they are listed in **Attachment 23 – Component E Work Plan**.

Funded applicants will be held to the performance measures as listed in the **Component E Work Plan** - **Attachment 23** and will be required to enter the performance measures into the Grants Gateway if funding is awarded.

For the Grants Gateway Work Plan Project Summary, applicants are instructed to insert the Project Summary as it is listed in the **Component E Work Plan - Attachment 23.** In the Grants Gateway Work Plan Organizational Capacity section, applicants are instructed to list this as “not applicable.” Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

APPLICANTS FOR COMPONENT F COMPLETE THE FOLLOWING QUESTIONS

1.	Program Abstract		Not Scored
2.	Community and Agency Description	Maximum Score:	15 points
3.	Health Equity	Maximum Score:	15 points
4.	Program Design and Implementation	Maximum Score:	50 points
5.	Budgets and Justifications	Maximum Score:	20 points
			100 points

1. Program Abstract **Not Scored**

1a) Summarize the proposed program. Indicate the program model selected and briefly describe the program design, proposed services, and activities.

1b) What are the project goals and objectives?

1c) Describe the priority population.

1d) What types of outcomes does your organization expect to achieve? How will success be measured?

2. Community and Agency Description **Total 15 Points**

2a) Indicate your agency staff experience with the provision of technical assistance and capacity building services in support of the priority population you propose to reach as per the proposed program model. Provide a specific example to demonstrate your agency's leadership role regarding strengthening capacity building in support of the priority population.

2b) Explain your agency's experience in bringing together individuals/entities who have different perspectives and vested interests to support a shared goal. Provide a brief example that demonstrates your agency's experience building cross-sector collaboration and leveraging shared resources.

2c) Describe your agency's experience working with a variety of existing communication platforms (e.g., social media, video, print).

2d) Please describe any prior grants your organization has received from the AIDS Institute that are relevant to this proposal. Include the results of the program and successes of those grants. If your organization has not received funding from the AIDS Institute, describe any similar types of programs that your organization has undertaken in the past, including the identified results of the program and the successes in achieving those results.

3. Health Equity **Total 15 Points**

3a) Which SDOH will you address through capacity building and training activities? Describe how the capacity building and training activities will increase providers' capacity to address SDOH with their priority population(s)/clients.

3b) Please provide the most current data that you have used to identify the SDOH barriers affecting Hispanic/Latino Gay Men/MSM in NYS.

3c) Describe how will you monitor and evaluate the immediate impact of your capacity building and training efforts to address the SDOH. (i.e., how providers address SDOH with Hispanic/Latino Gay Men/MSM within their program).

3d) What is your organization's policy around addressing SDOH? What is the agency's capacity (staff knowledge, staff training, support for collaboration and evaluation) at addressing this?

3e) How does your organization's leadership reflect the population served?

4. Program Design and Implementation **Total 50 Points**

4a) Describe your overall program design, include specific and/or innovative strategies for implementing the program services. Explain the rationale for the selection of the strategy or strategies.

4b) Describe how you will work with existing coordinating and community planning bodies to plan, promote

and implement events, share resources and encourage learning.

4c) Explain how you will involve members of the priority population in the planning process and how their input will be incorporated in the design of events and related activities.

4d) Indicate how existing and new relationships with other organizations will be established or re-established to accomplish program objectives of the program model selected (e.g., promote community wide collaboration/learning, address various domains of wellness, identify innovative strategies).

4e) Indicate how you will work with community partners to address knowledge, attitudes and beliefs that may prevent members of the priority community from accessing prevention, support and medical services.

4f) Indicate how you will work with community partners to strengthen capacity to understand the contextual factors such as culture, norms, stigma, discrimination, and health care disparities experienced by the priority population(s).

4g) Describe what communication platforms (e.g., print, video, social media) you will use to support event promotion, increase general awareness, provide accurate and science-based information and address misinformation.

4h) Indicate how community messaging will be informed by contextual factors such as culture, language, health literacy levels, norms, stigma, discrimination and health care disparities experienced by the priority population.

4i) Describe how the proposed program will be staffed. Identify the titles, roles, and responsibilities of each position needed to operate and manage the proposed program, including peers (as appropriate) and AIRS data collection and entry. Indicate whether each position is to be hired (TBH) or existing staff. Describe the plan for initial and ongoing staff training and support. The **Agency Organizational Chart** should be uploaded as **Attachment 17** in the Pre-Submission Uploads section of the online application. Organizational charts should be submitted as a .PDF document.

4j) Indicate the type of program evaluation activities that you will conduct to track your progress in meeting key performance measures. Indicate how your agency plans to share findings from program evaluation activities with community partners. Explain how information will be used to change or improve the program and inform future events.

5. Budgets and Justifications **Total 20 Points**

Complete and submit a budget following these instructions:

5a) Applicants are instructed to prepare an annual budget based on the maximum award as listed for the region in which they are applying. The budget for year one ((**5/1/2024 – 4/30/2025**) must be entered into the Grants Gateway. Refer to **Grants Gateway Expenditure Budget Instructions - Attachment 18**. All budget lines should be calculated as whole dollar amounts. All costs should be related to the proposed activities, as described in the application narrative and work plan, and should be justified in detail. All costs should be reasonable and cost-effective. Contracts established resulting from the RFA will be cost reimbursable.

5b) For staff listed in the Personal services (Salary and Fringe) section of the budget, include a breakdown of the total salary needs for staff. Indicate how the positions relate to program implementation. Applicants are instructed to include a justification for each of the requested FTE’s and for the fringe benefits requested.

5c) For each item listed under Non-Personal services, describe how it is necessary for program implementation. Non-Personal services include: Contractual, Travel, Equipment, Space/Property & Utilities, Operating Expenses and Other costs.

5d) For the last three (3) years, does your organizations' Statement of Activities from your yearly audit show that revenues exceeded expenses or expenses exceeded revenue? If the expenses exceeded revenues, please describe both the cost reduction plan and the deficit reduction plan that will correct this. Please attach the Statement of Activities from your yearly audit for the last three (3) years. The Statement of Activities must show total support and revenue and total expenditures. The **Statement of Activities** should be uploaded to the Grants Gateway as **Attachment 19.** If uploaded as a .PDF document, Attachment 19 cannot be Secure or Password Protected.

5e) Applicants are required to upload a copy of their **Agency Time and Effort Policy** as **Attachment 20** in the Pre-Submission uploads section of the Grants Gateway online application.

5f) Describe the specific internal controls your agency uses to comply with the Federal Uniform Guidance (2 CFR 200).

5g) Applicants are required to complete **Funding History for HIV/STI/HCV Services as Attachment 21. as Attachment 21. Attachment 21** should be uploaded to the Pre-Submission uploads section of the Grants Gateway online application.

5h) Funding requests must adhere to the following guidelines:

- An indirect cost rate of up to 10% of modified total direct costs can be requested. If your organization has a federally approved rate, an indirect cost rate of up to 20% of modified total direct costs can be requested. If your agency has a federally approved rate of less than 20%, the maximum indirect rate that can be requested is the federally approved rate.
- Funding may only be used to expand existing activities and create new activities pursuant to this RFA. Funds may **not** be used to supplant funds for currently existing staff and activities. Agencies currently funded by the NYSDOH AI to provide program services in accordance with the requirements of this RFA must apply for continuation of funding.
- Ineligible budget items will be removed from the budget prior to contracting. Ineligible items are those items determined by NYSDOH to be inadequately justified in relation to the proposed Work Plan or not fundable under existing federal guidance (Uniform Guidance). The budget amount requested will be reduced to reflect the removal of the ineligible items.
- **Agencies currently funded by the NYSDOH AI to provide program services in accordance with the requirements of this RFA must apply for continuation of funding *(for currently funded RFAs)*.**

6. Work Plan

Applicants are not required to enter the performance measures for each work plan objective in the Grants Gateway Work Plan. Applicants should review the performance measures as they are listed in **Attachment 24 – Component F Work Plan**.

Funded applicants will be held to the performance measures as listed in the **Component F Work Plan** - **Attachment 24** and will be required to enter the performance measures into the Grants Gateway if funding is awarded.

For the Grants Gateway Work Plan Project Summary, applicants are instructed to insert the Project Summary as it is listed in the **Component F Work Plan - Attachment 24.** In the Grants Gateway Work Plan Organizational Capacity section, applicants are instructed to list this as "not applicable." Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of

your application.

B. Freedom of Information Law

All Applications may be disclosed or used by NYSDOH to the extent permitted by law. NYSDOH may disclose an Application to any person for the purpose of assisting in evaluating the Application or for any other lawful purpose. All Applications will become State agency records, and will be available to the public in accordance with the New York State Freedom of Information Law (FOIL). **Any portion of an Application that an Applicant believes constitutes proprietary information entitled to confidential handling, as an exception to the general rule regarding the availability to the public of State agency records under the provisions of the Freedom of Information Law, must be clearly and specifically designated in the Application.** If NYSDOH agrees with the Applicant's claim regarding the proprietary nature of any portion of an Application, the designated portion of the Application will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

C. Review & Award Process

An Application which meets ALL of the guidelines set forth above will be reviewed and evaluated competitively by the NYSDOH AI. An Application that does not meet the minimum criteria (PASS/FAIL) will not be evaluated. An Application that does not provide all required information will be omitted from consideration.

In the event of a tie score, the applicant with the highest score for Section 3 – Health Equity – will receive the award. Should there still be a tie score, the applicant with the highest score in **Section 4. Program Design and Implementation** will receive the award.

Applications with minor issues (for example, an Application missing information that is not essential to timely review and would not impact review scores) MAY be processed and evaluated, at the discretion of the State, but any issues with an Application which are identified by the Department **must** be resolved prior to time of award. An Application with unresolved issues at the time award recommendations are made will be determined to be non-responsive and will be disqualified.

If changes in funding amounts are necessary for this initiative or if additional funding becomes available, funding will be modified and awarded in the same manner as outlined in the award process described above.

NYSDOH AI reserves the right to revise the award amounts as necessary due to changes in the availability of funding. If changes in funding amounts are necessary for this initiative, funding will be modified and awarded in the same manner as outlined in the award process described above. NYSDOH AI reserves the right to review and rescind all subcontracts.

Applicants will be deemed to fall into one of three categories: 1) not approved, 2) not funded due to limited resources, and 3) approved and funded. Not funded applications may be awarded should additional funds become available.

Once awards have been made pursuant to the terms of this RFA, an Applicant may request a debriefing of their own Application (whether their application was funded or not funded). The debriefing will be limited only to the strengths and weaknesses of the Application submitted by the Applicant requesting a debriefing and will not include any discussion of ANY OTHER Applications. Requests for a debriefing must be received by the Department no later than fifteen (15) Calendar days from date of the award or non-award announcement to the Applicant requesting a debriefing.

To request a debriefing, please send an email to cocrfa@health.ny.gov. In the subject line, please write: *Debriefing Request: High Impact Prevention and Services That Address Social Determinants of Health and Reduce Health Disparities within Communities of Color.*

Unsuccessful Applicants who wish to protest the award(s) resulting from this RFA on legal and/or factual grounds, should follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found on the OSC website at https://www.osc.state.ny.us/state-agencies/gfo/chapter-xi/xi17-protest-procedures (Section XI. 17.).

VI. ATTACHMENTS

Please note that certain Attachments to this RFA are accessed under the "Pre-Submission Uploads" section of the Grants Gateway online Application and are not included in the RFA document. In order to access the online Application and other required documents such as the Attachments, a prospective Applicant must be registered and logged into the NYS Grants Gateway in the user role of either a "Grantee" or a "Grantee Contract Signatory".

Attachment 1: Statement of Assurances*
Attachment 2: Cross Sector Collaboration Requirements**
Attachment 3: Targeted HIV Testing Requirements**
Attachment 4: HIV Home Self-Test Kit Guidance**
Attachment 5: STI and HCV Screening Requirements**
Attachment 6: Health Equity Definitions and Examples**
Attachment 7: M/WBE Utilization Plan*
Attachment 8: Vendor Responsibility Attestation*
Attachment 9: Application Cover Page*
Attachment 10: Locally Developed Interventions* (If applicable)
Attachment 11: CLIA Permit* (If applicable)
Attachment 12: Service Linkages Chart*
Attachment 13: Work Plan - Component A**
Attachment 14: Work Plan - Component B**
Attachment 15: Work Plan - Component C**
Attachment 16: Agency Capacity and Staffing Information*
Attachment 17: Agency Organizational Chart*
Attachment 18: Grants Gateway Expenditure Budget Instructions**
Attachment 19: Statement of Activities for past three (3) years*
Attachment 20: Agency Time and Effort Policy*
Attachment 21: Funding History for HIV/STI/HCV Services*
Attachment 22: Work Plan - Component D**
Attachment 23: Work Plan - Component E**
Attachment 24: Work Plan - Component F**

*These attachments are located / included in the Pre-Submission Upload section of the Grants Gateway online Application.

**These attachments are attached to the RFA and are for applicant information only. These attachments do not need to be completed.

Attachment 2
NYSDOH AIDS Institute's Cross Sector Collaborations Requirements

High Impact Prevention and Services that Address Social Determinants of Health and Reduce Health Disparities within Communities of Color

RFA #20407
Internal Program #23-0004

Funded applicants are required to establish collaboration agreements (e.g., memorandum of understanding [MOU], memorandum of agreement [MOA], service agreements) with a comprehensive network of medical providers, community-based organizations, and State and local health departments to ensure adequate coverage of HIV/STI/HCV prevention and care services for clients of the priority population(s). The goal of the network is to encourage collaboration, facilitate information exchange, reduce duplication of efforts, and to facilitate timely client-centered linkages. Signed Authorization for Release of Health Information and Confidential HIV-Related Information (DOH-2557) forms must be signed by clients to authorize the release of health information including HIV-related information between medical providers and community-based organizations. **NYSDOH AI encourages that releases be made valid for a period of two (2) years or based on the client's request for a shorter timeframe.**

When establishing collaboration agreements, consider the following:

1. Proximity and accessibility of the medical provider and/or community-based organization within your service area(s);
2. The medical provider's capacity and history as it relates to care and treatment of HIV positive persons, STI and HCV services, and the priority population; and
3. The community-based organization's capacity and history of providing supportive services to the priority population, HIV positive persons, and those of unknown HIV status (e.g., housing, substance abuse services, counseling, mental health services, treatment adherence, etc.).

Establish collaboration agreements that include, but are not limited to, the following:

1. Name and address of the provider(s);
2. Name, title, and contact information for the primary point of contact for the provider;
3. Description of the services provided at the agency and/or medical provider;
4. Description of reimbursement mechanisms;
5. Specific linkage procedures;
6. Description of the exchange of patient identifying health information;
7. Description of how agencies will obtain results regarding the outcome of the linkage;
8. Medical Care: Description of the agreed-upon processes that will be used to link newly diagnosed and out-of-care HIV positive individuals to **HIV medical care with CD4 or viral load tests performed within 30 days of date of diagnosis** and client's readiness to reengaging in HIV medical care; and
9. Essential Supportive Services: Description of the agreed-upon processes that will be used to deliver supporting services pending client's readiness to engage in services.

Attachment 3
NYSDOH AIDS Institute's Targeted HIV Testing Requirements

High Impact Prevention and Services that Address Social Determinants of Health and Reduce Health Disparities within Communities of Color
RFA #20407
Internal Program #23-0004

HIV testing is an essential part of a comprehensive high-impact HIV prevention program. Applicant organizations will be required to develop new or enhance existing *targeted* HIV testing programs aimed at reaching members of the priority population(s) at risk of acquiring HIV and not already confirmed to be HIV positive. Targeted HIV testing should occur in a variety of settings most effective in identifying members of the priority population(s) with undiagnosed HIV infection. Examples include but are not limited to onsite testing within the organization; venue-based testing; and/or mobile testing/field testing.

This RFA does not support direct provision of HIV testing in healthcare settings. Routine HIV testing in healthcare settings has been supported by NYS Public Health Law since 2010. Licensed Medical Providers are required to offer HIV testing as part of routine primary care for all persons aged 13 and older.

The New York State Department of Health AIDS Institute (NYSDOH AI) recommends using an HIV AG/AB rapid test for initial HIV screening. Other FDA-approved rapid HIV tests using capillary whole blood specimens are allowable as directed by the authorizing medical provider and/or limited service laboratory director. **The RFA supports oral fluid use for the FDA-approved OraQuick® in home HIV test only.** Agencies implementing HIV home/self-test programs must follow the **NYSDOH AI Division of HIV/STD/HCV Prevention HIV Home/Self-Test Program Guidance (Attachment 4).**

The NYSDOH regulates HIV testing. HIV testing must operate under the supervision of a medical provider (e.g., MD, NP, PA).

As a part of the HIV testing session, applicant organizations are expected to:

1. Complete a brief assessment to ascertain clients' risks (e.g., sexual risk behaviors, drug use behaviors);
2. Provide brief risk reduction education messaging when appropriate;
    - Brief risk reduction education messaging provides factual HIV education (e.g., transmission, window period, and risk reduction methods) associated with and appropriate for the HIV rapid test result.
3. Link clients to appropriate prevention strategies and activities following rapid and/or confirmatory testing;
    - Persons with a non-reactive HIV test result who are at high or substantial risk for HIV infection must receive: linkages to PrEP and PEP services; screening or referral for screening for STIs and HCV; and linkage to other prevention and essential support services.
    - For rapid reactive/newly identified HIV cases, contractors are required to:
        a) Confirm the positive rapid test result;
            - Applicants that propose to provide confirmatory HIV testing through a linkage agreement are expected to have documented working relationships with agencies that provide these services at the time of engagement with the priority population. Collaboration Agreements, as described in **Attachment 2 – AIDS Institute's Cross Sector Collaborations Requirements** section should specify how clients will be directly **linked to confirmatory testing services within 72 hours of receiving their rapid reactive result** and how the applicant agency will obtain results regarding the outcome of the linkage. Applicants are required to document that the referred client(s) received HIV confirmatory testing and obtain test results.

        b). Report confirmed cases of HIV to the NYSDOH within 14 days of diagnosis;

- Note: NYS Public Health Law (PHL) Article 21 (Chapter 163 of the Laws of 1998) requires the reporting of persons living with HIV as well as AIDS to the NYSDOH. The Medical Provider Report Form (PRF) (DOH-4189) must be completed within 14 days of diagnosis. The PRF can be completed electronically using the Provider Portal on the NYSDOH Health Commerce System at https://commerce.health.ny.gov. Information regarding electronic reporting or paper forms is available from the NYSDOH by calling 518-474-4284; contractors located in NYC should call 212-442-3388.
- Note: Applicants that propose to refer/link to another entity for confirmatory testing: it is the responsibility of the provider conducting the confirmatory testing to report the diagnosis to the NYSDOH within 14 days of diagnosis.

c). Link individuals to HIV medical care with CD4 or viral load tests performed within 30 days of date of diagnosis;

- A formalized collaboration agreement with local public health providers and appropriate medical care providers is required. More information on collaboration agreements is described in **Attachment 2 – AIDS Institute's Cross Sector Collaborations Requirements section**.

d). Link individuals to Partner Services; For more information on Partner Services, visit www.health.ny.gov/diseases/communicable/STI/partner_services; and

e). Provide follow up for persons who are confirmed HIV positive to ensure linkage to HIV medical care and Partner Services.

4. As appropriate, individuals should be linked to essential support services and offered screening or referred for screening for STI and HCV.

Applicants directly providing HIV testing are required to have the following:

- Prior experience conducting HIV testing services or can demonstrate the capacity to provide testing activities;
- Successful history engaging and working with the priority population(s);
- Medical provider (i.e., MD, NP, PA) of record under whose license specimens are collected and processed (Note: The provider can be an employee or any medical provider with whom the agency has a contractual or referral relationship.);
- A valid CLIA permit and limited service laboratory registration with the NYSDOH Wadsworth Center, Clinical Laboratory Evaluation Program (CLEP);
- An approved laboratory quality assurance protocol describing in detail how laboratory testing will be performed.
- Appropriate liability insurance;
- Procedures for contacting persons tested with results and linkage to treatment; and
- Ability to meet disease reporting requirements as part of the point-of-service testing protocols.

Funded applicants providing HIV testing must develop protocols specific to their intervention and site(s) and submit them for approval to the NYSDOH ***prior*** to initiating testing services. Agency protocols must include guidance for activities that are carried out prior to, during and after HIV testing. Required protocols include:

- Staff training;
- Management of biohazardous waste and sharps;
- Client risk assessment for testing;
- Completion of required documentation for client intake;
- Testing logs for tracking purposes;
- Requisitions for HIV clinical laboratory testing;
- Specimen collection and handling procedures;
- Transport of specimens for laboratory processing services;
- Result tracking and medical records maintenance;
- Interpretation and delivery of results to clients (posttest);
- Facilitation of immediate access to medical treatment;
- Referral and facilitation of partner services for partner notification;

- Disease reporting to the NYSDOH AI within 14 business days;
- Blood borne pathogens, OSHA requirements, and medical waste disposal; and
- A process to insure culturally and linguistically appropriate services.

HIV testing should also be used as an access point for linking persons who engage in high-risk behaviors who test HIV negative to needed behavioral, health, and supportive services. HIV negative test results provide an opportunity to expand the menu of prevention offerings to populations already identified as being at high risk for HIV/STI/HCV acquisition. Individuals should be engaged in prevention interventions as long as they continue to engage in behaviors that put them at risk for HIV infection. This includes linkage to high impact behavioral interventions and strategies, STI and HCV screening, essential support services, etc. Linkage to affordable health insurance and culturally affirming and responsive care is a priority for those who test HIV positive as well as those who test negative but remain at risk for infection. Assessments for medical care, social services, and insurance coverage should be integrated into prevention activities.

In March of 2016, the Centers for Disease Control and Prevention released program guidance for HIV testing providers called *Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers* that contractors can use as a resource.

HIV Home/Self-Test Kit Requirements Guidance

HIV home/self-testing can be an important part of a comprehensive HIV/STI/HCV testing and screening program and may provide an accessible option for persons who are uncomfortable or unable to come to an office or mobile site for testing. Prior to including home/self-testing as part of your current HIV/STI/HCV testing and screening program, agencies need to consider the pros and cons of home/self-testing and whether home/self-testing is a good option for the populations to be prioritized. Those seeking to add home/self-testing to their testing program need to negotiate this with their contract manager and have the following systems and protocols in place.

Policy & Procedure Requirements

Contractors proposing to provide HIV home/self-test (HIVST) kits with AIDS Institute contract funds must develop protocols specific to their program, intervention and site(s), and submit for approval to the Division of HIV/STD/HCV Prevention prior to initiating this service.

Protocols must address the provision of HIVST kits; the defined priority population(s) to be tested; and how those services will be carried out in regards to: client confidentiality; registering and screening clients; delivering kits to clients; documenting tests distributed; risk assessment; follow up to ensure test kits were used and results received; provision of or linkage to confirmatory testing (when indicated), and HIV medical care and treatment. As appropriate, referrals to behavioral and biomedical (i.e., Pre- Exposure Prophylaxis or PrEP, Post Exposure Prophylaxis or PEP) prevention services must also be provided.

Agency policies and procedures must include guidance for activities that are conducted prior to, during, and after the provision of an HIVST kit.

These must include:

- Staff training;
- Confidentiality specific to HIVST kit program including virtual interactions (e.g. texting, FaceTime, Zoom, WhatsApp, etc.);
- Client recruitment;
- Client risk assessment for screening *(please note, the OraQuick home test is not FDA approved for persons under the age of 17 the AIDS Institute will not support the provision of HIVST to persons under 17)*;
- Counseling messages, including messaging regarding the window period for OraQuick;
- Prevention messages;
- Completion of required documentation for client registration;
- Purchasing of kits;
- Confidential distribution of kits;
- Information provided with the HIVST kit or as part of the home/self-testing process (e.g. PrEP/PEP, STI screening, safer sex supplies);
- Result tracking and records maintenance;
- Facilitation of immediate access to confirmatory testing and HIV medical treatment as appropriate;
- Referral and facilitation of Partner Services for partner notification for confirmed positive tests;
- Referral to supportive services, as appropriate;

Interested in making HIVST kits available as part of your HIV testing program? Reach out to your contract manager to inquire about initiating services.

in- and

- A process to ensure culturally/linguistically appropriate services; and
- Documentation of HIVST test kits in the AIDS Institute Reporting System (AIRS) as per the AIRS guidance.

Agency Requirements

- Successful history engaging and working with the priority population(s);

******IMPORTANT INFORMATION ON THE WINDOW PERIOD******
Clients must be informed that the OraQuick in-home HIV Test is designed to detect infections resulting from exposures that occurred 3 months or more prior to the test. Clients reporting more recent risk exposures with signs and symptoms of acute HIV infection should be directed to immediately contact a medical provider.

- Procedures for ensuring client uses the HIVST kit and linkage to treatment and supportive services as appropriate;
- Have collaboration agreements with medical providers for direct linkage to medical evaluation and treatment

Agencies do not need to update their Limited Service Laboratory Registration to reflect the addition/provision of HIVST kits. HIVST kits are FDA approved for commercial use and are not considered a CLIA-waived point of care test.

Agencies should recognize that not all clients will want/need counseling or assistance when taking the test and are cautioned not to make the requirements to get a test overly restrictive.

HIVST Resources

- OraQuick in-home test kit can be purchased at CustomerCare@orasure.com or 1- 800-OraSure **(1-800-672-7873)**
- OraSure website: http://www.oraquick.com/
- Centers for Disease Control resource: https://www.cdc.gov/hiv/testing/self-testing.html

Attachment 5
NYSDOH AI's STI and HCV Screening Requirements

High Impact Prevention and Services that Address Social Determinants of Health and Reduce Health Disparities within Communities of Color
RFA #20407
Internal Program #23-0004

The direct provision of STI and HCV screening services is limited to healthcare providers and non-healthcare providers who have at least two (2) years of experience successfully providing these services or can demonstrate the capacity to provide integrated screening activities on-site.

Non-healthcare providers who do not have a history of providing STI and HCV screening services or have not demonstrated the capacity are required to refer and link clients who engage in high-risk behaviors to medical providers for these services. Applicants are expected to have documented working relationships with agencies that provide STI and HCV screening at the time of engagement with the priority population. Collaboration agreements should specify how clients will be directly linked to screening services and how the applicant agency will obtain test results and outcomes of referral and linkage services, where appropriate.

Applicants proposing to directly provide STI and HCV screening are required to have the following:

- Prior experience conducting these services or can demonstrate the capacity to provide integrated screening activities on-site;
- Successful history engaging and working with the priority population;
- Medical provider (i.e., MD, NP, PA) of record under whose license specimens are collected and processed;
- A valid CLIA permit and limited service laboratory registration with the Wadsworth Center, Clinical Laboratory Evaluation Program (CLEP);
- An approved laboratory quality assurance protocol describing in detail how laboratory testing will be performed;
- Staff who can perform venipuncture and supervise the collection and handling of urine specimens and client-collected vaginal/cervical, rectal and pharyngeal swabs;
- Appropriate liability insurance;
- A collaboration/contract with a NYS-licensed laboratory to process specimens;
    - Agencies performing Extra-Genital NAAT testing must collaborate with laboratories approved by NYSDOH Wadsworth Center.
- Procedures for contacting persons tested with results and linkage to treatment;
- Ability to meet disease reporting requirements as part of the point-of-service testing protocols; and
- Collaboration agreements with medical providers and/or Sexual Health Centers/STI Clinics to provide medical evaluation and treatment.
    - STI positive clients: Collaboration agreements should specify how clients will be directly linked to services **within three (3) business days of receiving their STI positive results** and how the applicant agency will obtain results regarding the outcome of the linkage. Funded applicants must document that the referred clients receive treatment and/or medical evaluation and obtain test/treatment results. More information on collaboration agreements is described in **Attachment 2– NYSDOH AI's Cross Sector Collaborations Requirements**.
    - HCV rapid reactive and/or HCV RNA detectable clients: Collaboration agreements should specify how clients will be directly linked to medical services and how the applicant agency will obtain results regarding the outcome of the linkage. Funded applicants are required to be able to document that the referred clients receive treatment and/or medical evaluation and obtain test/treatment results. More information on collaboration agreements is described in **Attachment 2 – NYSDOH AI's Cross Sector Collaborations Requirements.**

Contractors with the capacity to provide integrated screening activities are highly encouraged to provide

extragenital nucleic acid amplification testing (NAAT). Urine-based screening alone has been shown to miss a significant proportion of extragenital chlamydial and gonococcal infections. Because extragenital (oropharyngeal and/or rectal) infections are common in men who engage in high-risk behaviors and the majority are asymptomatic, routine extragenital screening of this population is recommended. It is recommended that applicants and/or referral agencies establish relationships with laboratories approved by the NYSDOH CLEP to provide high quality, comprehensive STI services that include extragenital testing for chlamydia and gonorrhea. Applicants can search for approved laboratories by visiting the CLEP website or by calling (518) 485-5378.

Other STI screening and testing should be conducted in accordance with current guidelines and standards of care for the detection and treatment of chlamydia, gonorrhea, and/or syphilis as outlined in 2021 CDC STI Treatment Guidelines, MMWR on recommendations for providing STD Quality Clinical Care, and HIV Clinical Care Guidelines for STI care.

Clients who engage in sexual intercourse and who accept the offer for the screenings should be screened using the following:

1. Syphilis serology, with a confirmatory test to establish whether persons with reactive serologies have incident untreated syphilis, have partially treated syphilis, or are manifesting a slow serologic response to appropriate prior therapy;
2. A test for urethral infection with gonorrhea and chlamydia in clients who have had insertive intercourse during the preceding year; testing of the urine or vaginal/cervical swab using NAAT is the preferred approach;
3. A test for rectal infection with gonorrhea and chlamydia in clients who have had receptive anal intercourse during the preceding year; NAAT of rectal swabs is the preferred approach; and
4. A test for oral infection with gonorrhea and chlamydia in clients who have had performed oral intercourse during the preceding year; NAAT of pharyngeal swabs is the preferred approach.

Funded applicants electing to provide direct STI and/or HCV screening need to develop protocols specific to their intervention and site(s) and submit for approval to NYSDOH AI prior to initiating screening services.

Protocols must address the provision of confidential HCV and STI screening for syphilis, gonorrhea and chlamydia and other STIs as appropriate; the defined priority population(s) to be tested; and, the settings where access to testing services and how those services will be carried out with regard to: registering clients; documenting tests performed; rationale/risk assessments; follow- up appointments for receipt of results; and, direct linkage to medical care and treatment when indicated. Protocols must be specific to the testing model that is developed. The NYSDOH AI regulates medical HCV and STI screening.

Funded applicants who conduct testing directly with agency staff must have a medical provider (i.e., MD, NP, PA) of record under whose license staff are authorized to collect (or direct clients to collect) urine, rectal and/or pharyngeal specimens from client(s) being screened for STIs. Screenings for syphilis, gonorrhea and chlamydia, must adhere to NYS Sanitary Code (10NYCRR §2.12) concerning the reporting requirements of communicable diseases to the appropriate authorities..

Funded applicant's agency policies and procedures must include guidance for activities that are carried out prior to, during and after STI testing and HCV screening. These must include:

- Staff training;
- Management of biohazardous waste and sharps;
- Client risk assessment for screening;
- HCV testing of minors (< 18 years of age);
- Completion of required documentation for client registration;
- Determination of client insurance status;
- Testing logs for tracking purposes;
- Requisitions for clinical laboratory testing;

- Specimen collection and handling of blood, urine, and client-collected vaginal/cervical, rectal and/or pharyngeal swabs;
- Transport of specimens for laboratory processing services;
- Result tracking and medical records maintenance;
- Interpretation and delivery of results to clients (posttest);
    - Note: For reactive syphilis tests, testing providers must contact the patient's local health department to request a syphilis serology search in order to interpret test results before notifying the client. The testing provider must initiate this communication, therefore funded applicants choosing to offer syphilis testing via subcontract and/or referral must coordinate communication with the appropriate provider.
- Facilitation of immediate access to medical treatment;
- Referral and facilitation of partner services for partner notification;
- Disease reporting to the local health department as required by statute based on the patient's residence;
- Blood borne pathogens, OSHA requirements and medical waste disposal; and
- A process to insure culturally/linguistically appropriate services.

Revised September 2020

Attachment 6
Health Equity Definitions and Examples

RFA #20407

SOCIAL DETERMINANTS OF HEALTH (SDOH): Social determinants of health (SDOH) are the overarchingfactors in society that impact health. SDOH include:

- Secure employment, safe, bias-free working conditions and equitable living wages;
- Healthy environment, including clean water and air;
- Safe neighborhoods and housing;
- Food security and access to healthy food;
- Access to comprehensive, quality health care services;
- Access to transportation;
- Quality education; and
- Access to a social support network.

Inequities in access to SDOH are a result of structural racism, sexism, homophobia, transphobia, poverty, stigma, and other forms of oppression that are perpetuated by current social structures and institutions.

STRUCTURAL RACISM: The combination of public policies, institutional practices, social and economic forces that systematically privilege White people and disadvantage Black, Indigenous and other people of color. This term underscores that current racial inequities within society are not the result of personal prejudice held by individuals. Adapted from Aspen Institute and Bailey, Feldman, Bassett.

HEALTH DISPARITIES: The statistical difference in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States. USDHHS.

HEALTH INEQUITIES: Disparities in health that result from social or policy conditions that are unfair or unjust.

HEALTH EQUITY: Health equity is achieved when no one is limited in achieving good health because of theirsocial position or any other SDOH. The goal of health equity is to eliminate health inequities that are avoidable and unjust through proactive and inclusive processes.

Examples of how social and structural determinants can impact our health include: (note: this is not anexhaustive list)

- Stigma and discrimination are pervasive within healthcare and social support service delivery systems and exacerbate health inequities. Explicit and implicit biases persist among health and social service providers related to HIV status, race/ethnicity, sexual orientation, gender identity and expression, age, mental health, socioeconomic status, immigration status, substance use, criminal justice involvement, and the exchange of sex for money, drugs, housing, or other resources; these result in stigma and discrimination in healthcareand are demonstrated barriers to uptake and sustained engagement in HIV prevention and care services.
- Other overlapping social and structural determinants of heath further exacerbate health inequities includinghousing status, food insecurity, poverty, unemployment, neighborhood conditions, mental health issues, domestic violence, sexism, homophobia, transphobia, ableism, agism, racism, and other complex and integrated systems of oppression. These social and structural determinants of health are barriers to achieving positive health outcomes.
- Culturally and linguistically appropriate services are one way to improve the quality of services provided toall individuals, which will ultimately help reduce disparities and inequities and achieve health equity. The provision of services that are responsive to the individuals first or preferred language, health beliefs, practices and needs of diverse populations, individuals and clients can help close the gaps in health outcomes. What is CLAS? - Think Cultural Health

Attachment 13: Work Plan - Component A
SUMMARY

PROJECT NAME: Prevention and Essential Support Services for Men within Communities of Color
CONTRACTOR SFS PAYEE NAME:
CONTRACT PERIOD From: May 1, 2024 To: April 30, 2029

Project Summary

This initiative supports a high impact approach to prevention and essential support services to achieve Ending the Epidemic (ETE) and Beyond Initiative goals and reduce/eliminate disparities and inequities in HIV incidence in men of color (e.g., Black, Latino/Latinx, Indigenous people and Asian populations). Funding supports programs that provide HIV/STI/HCV prevention interventions and essential support services for men within communities of color that seek to address Social Determinants of Health (SDOH) and promote health equity.

The overall goals are to:

- Prevent new HIV/STI/HCV infections by increasing access to comprehensive sexual health information, behavioral, and biomedical interventions such as PrEP/PEP, and essential supportive services; and
- Identify individuals who are living with HIV/STI/HCV and unaware of their status and ensure access to early, high-quality medical care and prevention services.

Prevention interventions and client services address the prevention and support needs of men within communities of color living with HIV as well men who will benefit from prevention interventions/services within communities of color (e.g., Black, Latino/Latinx, Indigenous people and Asian populations). The expected outcomes are to: reduce disease incidence; decrease the rate of HIV/STI/HCV transmission; promote sexual and drug user health; increase the number of persons living with HIV/STI/HCV who are aware of their status; and increase the number of persons living with HIV/STI/HCV who are linked to prevention, partner services (PS), and treatment/medical care.

Funding will support the provision of Client Recruitment/Engagement; HIV Prevention Community Collaboration; Condom Promotion, Education, and Distribution; direct provision of HIV Testing; direct provision of, or documented referral to, STD and HCV Screening; HIV Navigation Services; and delivery of High Impact Prevention Public Health Strategies, Evidence Based Behavioral Interventions (EBI), and/or Locally Developed Interventions.

The initiative aims to impact the New York State Department of Health (NYSDOH) AIDS Institute (AI) efforts to:

- Reduce disease incidence;
- Decrease risk of sexual and drug using behaviors among persons living with HIV and persons who engage in behaviors that put them at risk of HIV/STI/HCV infection;
- Increase the number of persons living with HIV/STI/HCV who are aware of their status; and
- Increase the number of persons living with HIV/STI/HCV who are linked to prevention, partner services, and treatment/medical care.

This funding will support two program models.

Indicate Program Model Selected
_____ Program Model 1
_____ Program Model 2

Sections of the work plan
HIV Testing and Linkage to Prevention & HIV Care Services (REQUIRED PROGRAM MODEL 1) – Objectives 1-9
Referral for HIV Testing (REQUIRED PROGRAM MODEL 2) – Objective 10
STI and HCV Screening* (REQUIRED FOR PROGRAM MODEL 1 AND 2) – Objectives 11-15 (If your agency is not conducting STI & HCV Screening, please follow Objective 15)
Social Determinants of Health Intervention (REQUIRED) – Objective 16
HIV Navigation Services -- Staff and/or Peer Led (IF APPLICABLE) – Objective 17
Condom Promotion, Education and Distribution (REQUIRED) – Objective 18
Health Promotion Activities/Prevention/Supportive Interventions and Peer Training (REQUIRED) – Objectives 19-21
PrEP/PEP(REQUIRED) – Objective 22
High Impact Public Health Strategy, Evidence Based Effective Intervention, and/or Locally Developed Interventions (IF APPLICABLE) – Objective 23
Evaluation and Reporting (REQUIRED) – Objectives 24-27

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Instructions: For the Grants Gateway **Work Plan Project Summary**, applicants are instructed to include the Program Model selected and insert the Project Summary as it is listed above. In the Grants Gateway **Work Plan Organizational Capacity** section, applicants are instructed to list this as “not applicable.” Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Attachment 13: Component A Work Plan. Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.

HIV Testing and Linkage to Prevention & HIV Care Services			
Objective		**Tasks (Activities)**	**Performance Measures**
1. Meet key performance indicators and monitor service delivery.		1.1 Monitor service delivery and data to ensure targeted testing is achieving program goals. 1.2 Conduct confidential HIV testing in accordance with NYS Public Health Law (PHL) as well as contractual obligations.	1.1.1 At least 85% of HIV tests will be conducted relative to the number projected (projected vs. actual). 1.2.1 100% of HIV testing will be conducted as per NYS PHL and contract obligations.
2. Increase the number individuals who are aware of their HIV status.		2.1 Develop a recruitment strategy with appropriate messaging that is responsive to the needs of the priority population. Strategies may include: Outreach (Street based, Venue based, Internet); Internal or External referrals; and Collaborations with PS. 2.2 Conduct client recruitment activities and engage individuals who will benefit from this intervention. 2.3 Identify individuals who have never tested for HIV and engage them in this intervention.	2.1.1 90% of clients tested in non-clinical settings will be members of the identified priority population. 2.2.1 90% of clients recruited for testing could benefit from this intervention. 2.3.1 At least 25% of clients recruited will be first time testers.
3. Identify newly HIV diagnosed individuals based on annual service targets.		3.1 Implement effective strategies to locate individuals who are living with HIV and are not aware of their status.	3.1.1 As identified in the Annual Program Service Targets for Component A - Program Model 2 Interventions table of the Communities of Color RFA, the minimum number of clients tested will be identified as living with HIV for the first time.
4. Ensure 100% of individuals tested for HIV receive their test results.		4.1 Provide client with a confirmed test result in accordance with NYS public health law. 4.2 Have a protocol in place to follow-up with clients if clients do not return for their test results. Utilize NYS and/or local health department Partner Services (PS) staff to help locate clients where possible.	4.1.1 100% of individuals with an HIV positive/reactive test will be given their test results. 4.2.1 Protocol will be implemented with all clients in need of follow up.
5. Link newly identified HIV positive clients to medical care and PS.		5.1 Have a protocol in place that aligns with the Director of the AIDS Institute's Call to Action for intra-agency or external referrals which ensures rapid access to HIV treatment.	5.1.1 90% of individual newly diagnosed with HIV who receive their test result will be linked to HIV medical care with HIV-related lab work and the offer of treatment initiation within 3 days of HIV diagnosis.

		5.2 Follow up with medical providers (intra-agency and external) to verify that the client has attended their medical appointment with HIV-related lab work (e.g., viral load, CD4, genotype) and determine if treatment was initiated. 5.3 Establish collaboration agreements with regional and/or local partner services staff to accept referrals for partner services. Inform clients about Partner Services and provide linkage/referral.	5.2.1 100% of client referrals to medical providers will be verified. 5.3.1 100% of newly identified individuals living with HIV will receive information about, and referral to, PS.
6. Report all individuals newly diagnosed with HIV to the NYSDOH AI.		6.1 Utilize the Medical Provider Report Form (PRF) (DOH-4189) [or complete electronically (ePRF) using the Provider Portal on the NYSDOH Health Commerce System], to report confirmed cases of HIV to NYSDOH within 7 days of diagnosis.	6.1.1 100% of individuals newly diagnosed with HIV will have a PRF or ePRF completed and submitted to NYSDOH within 7 days of diagnosis.
7. Link individuals newly diagnosed with HIV to HIV prevention services.		7.1 Discuss action plan with client and address barriers preventing the client from implementing behavior change. 7.2 Refer individuals newly diagnosed with HIV to prevention services (e.g., navigation/peer support, individual/group interventions, etc.). 7.3 Establish collaboration agreements with providers to accept referrals for HIV prevention interventions and other related services not provided by your program/agency.	7.1.1 100% of individuals newly diagnosed with HIV who receive their test results will be screened for risk reduction intervention needs. 7.2.1 At least 90% of individuals newly diagnosed with HIV who are screened and identified as needing risk reduction intervention will be provided an intervention and will be linked to prevention services within 30 days of receiving test result. 7.3.1 N/A
8. Refer, test &/or screen clients testing for HIV for STI & HCV services.		8.1 Engage in Program Collaboration/Service Integration. Ensure comprehensive risk assessments address client risks for STIs & HCV in addition to HIV. Provide information & documented linkage to testing & treatment for STI/HCV (as appropriate).	8.1.1 100% of individuals newly diagnosed with HIV who receive their test results will be offered testing/screening or referred for testing/screening for STIs and HCV.
9. Increase the number of individuals who are linked to PrEP/PEP.		9.1 Establish collaboration agreements with PrEP/PEP prescribers to accept linkages/referrals for PrEP/PEP. 9.2 Link HIV-negative clients with prevention services, including non-occupational Post-Exposure Prophylaxis (PEP) and/or Pre-Exposure Prophylaxis (PrEP).	9.1.1 100% of clients not already on PrEP at the time of HIV testing will be screened for PrEP. 9.2.1 65% of clients who are screened and identified as eligible for PrEP will be referred to a PrEP prescriber.

If your agency is not contracted to conduct HIV testing, please follow the guidance provided below			
10. Refer eligible clients to HIV testing.		10.1 Ensure the comprehensive risk assessment conducted also addresses client risks for STIs and HCV. 10.2 Refer for HIV testing in accordance with public health law and contractual obligations.	10.1.1 65% will accept the referral for HIV testing. 10.2.1 N/A

STI and HCV Screening			
Objective		**Tasks (Activities)**	**Performance Measures**
11. Meet key performance indicators and monitor service delivery.		11.1 Conduct STI and HCV screening and linkage to services in accordance with NYS PHL and contractual obligations.	11.1.1 At least 85% of STI and HCV screenings conducted relative to the number projected (projected vs. actual).
12. 100% of persons with an STI positive result receive their test results.		12.1 Provide client with a confirmed test result in accordance with NYS public health law.	12.1.1 100% of persons with an STI positive test result will be given their results.
13. Link clients diagnosed with a STI to medical care and PS and report to LHD.		13.1. Have a protocol in place for external or intra-agency referrals which ensures linkage to treatment and medical care within 3 business days of receiving their results. 13.2 Follow up with medical providers (intra-agency and external) to verify that the client has attended medical appointment and received treatment. 13.3 Utilize the Confidential Case Report Form (DOH-389) for ROS Providers (non-NYC based providers) or the Universal Report Form (URF) for NYC-based providers, to report confirmed STI cases to the local health department within 24 hours of diagnosis.	13.1.1 100% of clients with a STI positive result that receive their test result will be referred to treatment and medical care within 3 business days of receiving their test result. 13.2.1 100% of client referrals to medical providers will be verified. 13.3.1 100% of clients diagnosed with a STI will have a DOH 389 or URF submitted to the local health department within 24 hours of diagnosis. A phone call must be made to the local health department immediately following a new confirmed case of early syphilis.

14. Ensure 100% of HCV reactive clients receive their test result.		14.1 Provide client with results of HCV screening. If providing diagnostic HCV testing directly, provide client with test result in accordance with NYS PHL. 14.2 If providing diagnostic HCV testing directly: Utilize the Confidential Case Report Form (DOH-389) to report HCV RNA results to the local health department within 24 hours of diagnosis.	14.1.1 100% of HCV reactive test results will be returned to clients. 14.2.1 100% of HCV RNA tests will have a DOH 389 completed and submitted to the local health department within 24 hours of diagnosis.

If your agency is not conducting STI and HCV Screening, please follow the guidance provided below			
15. Refer eligible clients to STI and HCV screening.		15.1 Ensure the comprehensive risk assessment conducted also addresses client risks for STIs and HCV. 15.2 Refer for STI and HCV screening in accordance with public health law and contractual obligations.	15.1.1 100% of comprehensive risk assessments will integrate STI and HCV risk information. 15.2.1 65% will accept the referral for STI and HCV screening.

Social Determinants of Health Intervention (REQUIRED)			
Objective		**Task/Activities**	**Performance Measures**
16. Address at least one SDOH.		16.1 Ensure all clients (regardless of HIV status) are screened for SDOH. 16.2 Deliver interventions/ services that address SDOH.	16.1.1 100% of clients screened for SDOH. 16.2.1 100% of clients receive who are identified and screened for a SDOH will be provided with an SDOH intervention/service.

HIV Navigation Services (HNS) -- Staff and/or Peer Led (OPTIONAL)			
Objective		**Task/Activities**	**Performance Measures**
17. Link persons in need, to care, prevention, and support services.		17.1 Deliver **HIV Navigation Services (**HNS) as per intervention and program guidance. 17.2 Ensure all clients living with HIV are linked to medical care and essential support services. Partners/network associates should be informed of available interventions (e.g., PrEP/PEP, EBI) and be provided with referrals. 17.3 Ensure clients living with HIV in need of medication adherence are linked to treatment adherence services and monitor with the goal of viral suppression.	17.1.1 HNS are delivered as per guidance. 17.2.1 100% of individuals living with HIV will be linked to medical care and essential support services. 17.3.1 80% of all individuals living with HIV who are screened and identified as needing ART medication adherence support services will be provided/linked to these services and will be monitored for treatment adherence - goal of viral

HIV Navigation Services (HNS) -- Staff and/or Peer Led (OPTIONAL)			
Objective		**Task/Activities**	**Performance Measures**
			suppression.
		17.4 Link clients to HIV testing, STI and/or HCV screening as per assessment and action plan.	17.4.1 90% of clients with unknown HIV, STI, and/or HCV status will be linked to testing or screening.
		17.5 Link clients to prevention interventions as per assessment and action plan.	17.5.1 90% of clients who are screened and identified as needing risk reduction intervention will be provided an intervention within 30 days.
		17.6 Link clients to essential support services as per assessment and action plan.	17.6.1 90% of clients in HNS will be linked to essential support services as per action plan.
		17.7 Make clients aware of PrEP/PEP, and ensure clients who will benefit from PrEP and are not already on PrEP at the time of enrollment are screened and are linked to PrEP prescriber.	17.7.1 100% of clients will be made aware of, screened for, and linked to PrEP/PEP.

Condom Promotion, Education and Distribution (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
18. Increase correct and consistent condom use.		18.1. Promote and/or distribute condoms during each client level encounter with persons living with HIV and populations at highest risk. As appropriate, provide condom education as needed when distributing condoms.	18.1.1 85% of clients will be provided condoms at each client level encounter.

Health Promotion Activities/Prevention/Supportive Interventions and Peer Training (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
19. Implement prevention interventions.		19.1 Implement prevention interventions as per program guidance. 19.2 Implement public health strategies or EBIs that are applicable and respond to the prevention needs of the priority population.	19.1.1 At least 90% of clients who are enrolled in each funded intervention(s) will be from the identified priority population. 19.2.1 At least 90% clients enrolled relative to the number projected (projected vs. actual).
20. Deliver prevention support interventions.		20.1 Implement supportive interventions as per program guidance. 20.2 Implement supportive interventions that are applicable and respond to the service needs of the priority population. Interventions supported include employment, education, healthcare, housing and sexual health education.	20.1.1 At least 90% of clients who are enrolled in each funded intervention(s) will be from the identified priority population. 20.2.1 At least 90% clients enrolled relative to the number projected (projected vs. actual).
21. Implement a Peer Training Program.		21.1 Follow a structured peer training curriculum, which includes initial and on-going training of peers (this may be a CDC approved EBI or locally developed intervention). 21.2 Integrate peers (including hiring of peers/certified peers) in the implementation of funded program interventions and services and provide ongoing supervision and support.	21.1.1 Train 10-20 peers through a minimum of 2 multi-session group cycles annually. 21.2.1 100% of trained peers will be provided with ongoing supervision and support.

PrEP/PEP (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
22. Increase awareness of PrEP and PEP among clients.		22.1 Raise awareness and educate clients about PrEP, screen and assess the priority population for PrEP, and link appropriate clients to medical providers for PrEP assessment and possible PrEP initiation. 22.2 Ensure that all clients are made aware that they can seek PEP within 36 hours of condomless sex. 22.3 Develop and implement social media and other campaigns to raise community awareness about PrEP/PEP.	22.1.1 100% of HIV negative clients not already on PrEP will be screened for PrEP. 22.2.1 100% of HIV negative clients not on PEP will be informed of PEP services. 22.3.1 100% of social media used will be relevant to the priority population in the geographic area selected.

High Impact Public Health Strategy, Evidence Based Effective Intervention, and/or Locally Developed Interventions (OPTIONAL)			
Objective		**Tasks (Activities)**	**Performance Measures**
23. Implement a strategy, EBI, or locally developed intervention.		23.**1 I**mplement at least 1 high impact public health strategy; EBI; and/or locally developed intervention. Locally developed interventions (LDIs) must adhere to the AI's 15 Common Factors of Effective Interventions.	23.1.1 At least 90% clients enrolled relative to the number projected (projected vs. actual).

Evaluation, Reporting and Program Management (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
24. Submit timely data, narrative, and fiscal reports/documents.		24.1 Collect and submit data and create narrative reports in accordance with Division and AI protocols. 24.2 Submit monthly AIRS extracts to the AIDS Institute via the Health Commerce System. 24.3 Create and submit fiscal reports/documents (e.g., voucher claims, budget modifications, etc.) in accordance with Division/AI protocols and the State Master Contract. 24.4 Monitor contract expenditures quarterly and address underspending accordingly.	24.1.1 100% of monthly AIRS extracts will be submitted by the established deadline. 24.2.1 100% of data and narrative reports submitted will be up to date (within 30 days of last service). 24.3.1 100% of fiscal documents will be submitted by the established deadlines. 24.4.1 100% of contract dollars will be spent annually.

Evaluation, Reporting and Program Management (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
25. Ensure funded staff receive appropriate training annually.		25.1 Provide funded staff with appropriate training.	25.1.1 Funded staff will receive 24 hours of training annually.
26. Address emerging community issues/service gaps.		26.1 Develop and coordinate a rapid response to emerging issues (e.g., new HIV infections, increases in Syphilis) as identified by the AI/DOH and or regional planning bodies. 26.2 Work closely with the AI /DOH to take action on HIV/STI/HCV related issues for communities not served by targeted funding. Contract manager must approve changes to the scope of work. 26.3 Provide updates to the AI/DOH on actions and outcomes.	26.1.1 100% of emerging issues identified will be addressed by agency. 26.2.1 Action will be taken on HIV/STI/HCV related issues faced by communities not served by targeted funding. 26.3.1 Updates on activities will be provided to the AI via email/monthly reports.
27. Ensure flexibility in programming.		27.1 Flexibility in programming to ensure that resources are effectively directed to the populations and communities most in need. 27.2Contract activities and deliverables may be modified at any point in this contract upon direction of the AI to address emerging needs or disparities, emerging HIV/STI/HCV epidemiologic patterns, or to accommodate advances in best practice. 27.3 Assist with other priority public health issues if/when they arise (e.g., local STI case increases, outbreaks, emergency situations, etc.). The contract manager must approve non-work plan work.	27.1.1 N/A 27.2.1 Aid with non-workplan public health issues if/when they arise. 27.3.1 100% of emerging issues identified will be coordinated as per AIDS Institute guidance.

Attachment 14: Work Plan - Component B
SUMMARY

PROJECT NAME: Prevention and Essential Support Services for Transgender and Gender Non-Conforming Individuals particularly in Communities of Color
CONTRACTOR SFS PAYEE NAME:
CONTRACT PERIOD From: May 1, 2024 To: April 30, 2029

Project Summary

This initiative supports a high impact approach to prevention and essential support services to achieve ETE and Beyond Initiative goals and reduce/eliminate disparities and inequities in HIV incidence transgender and gender non-conforming individuals particularly in communities of color (e.g., Black, Hispanic/Latinx, Indigenous people, and Asian/Pacific Islander populations). Funding supports programs that provide HIV/STI/HCV prevention interventions and essential support services for transgender and gender non-conforming individuals particularly in communities of color that seek to address Social Determinants of Health (SDOH) and promote health equity.

The overall goals are to:

- Prevent new HIV/STI/HCV infections by increasing access to comprehensive sexual health information, behavioral, and biomedical interventions such as PrEP/PEP, and essential supportive services; and
- Identify individuals who are living with HIV/STI/HCV and unaware of their status and ensure access to early, high quality medical care and prevention services.

Prevention interventions and client services address the prevention and support needs of transgender and gender non-conforming individuals living with HIV as well transgender and gender non-conforming individuals who will benefit from prevention interventions/services particularly in communities of color (e.g., Black/African American, Latinx, Asian American/Native Hawaiian/Other Pacific Islander, and American Indian/Alaska Native). The expected outcomes are to: reduce disease incidence; decrease the rate of HIV/STI/HCV transmission; promote sexual and drug user health; increase the proportion of persons living with HIV/STI/HCV who are aware of their status; and increase the proportion of persons living with HIV/STI/HCV who are linked to prevention, partner services (PS), and treatment/medical care.

Funding will support the provision of Client Recruitment/Engagement; HIV Prevention Community Collaboration; Condom Promotion, Education, and Distribution; direct provision of HIV Testing; direct provision of, or documented referral to, STD and HCV Screening; HIV Navigation Services; and delivery of High Impact Prevention Public Health Strategies, Evidence Based Behavioral Interventions (EBI), and/or Locally Developed Interventions.

The initiative aims to impact the New York State Department of Health (NYSDOH) AIDS Institute (AI) efforts to:

- Reduce disease incidence;

- Decrease risk of sexual and drug using behaviors among persons living with HIV and persons who engage in behaviors that put them at risk of HIV/STI/HCV infection;
- Increase the number of persons living with HIV/STI/HCV who are aware of their status; and
- Increase the number of persons living with HIV/STI/HCV who are linked to prevention, partner services, and treatment/medical care.

This funding will support two program models.

Indicate Program Model Selected
_____ Program Model 1
_____ Program Model 2

Sections of the work plan
HIV Testing and Linkage to Prevention & HIV Care Services (REQUIRED PROGRAM MODEL 1) – Objectives 1-9
Referral for HIV Testing (REQUIRED PROGRAM MODEL 2) – Objective 10
STI and HCV Screening* (REQUIRED FOR PROGRAM MODEL 1 AND 2) – Objectives 11-15 (If your agency is not conducting STI & HCV Screening, please follow Objective 15)
Social Determinants of Health Intervention (REQUIRED) – Objective 16
HIV Navigation Services -- Staff and/or Peer Led (IF APPLICABLE) – Objective 17
Condom Promotion, Education and Distribution (REQUIRED) – Objective 18
Health Promotion Activities/Prevention/Supportive Interventions and Peer Training (REQUIRED) – Objectives 19-21
PrEP/PEP (REQUIRED) – Objective 22
High Impact Public Health Strategy, Evidence Based Effective Intervention, and/or Locally Developed Interventions (IF APPLICABLE) – Objective 23
Evaluation and Reporting (REQUIRED) – Objectives 24-27

Instructions: For the Grants Gateway **Work Plan Project Summary**, applicants are instructed to insert the Program Model selected and insert the Project Summary as it is listed above. In the Grants Gateway **Work Plan Organizational Capacity** section, applicants are instructed to list this as "not applicable." Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Attachment 14: Component B Work Plan. Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.

HIV Testing and Linkage to Prevention & HIV Care Services			
Objective		**Tasks (Activities)**	**Performance Measures**
1. Meet key performance indicators and monitor service delivery.		1.1 Monitor service delivery and data to ensure targeted testing is achieving program goals. 1.2 Conduct confidential HIV testing in accordance with NYS Public Health Law (PHL) as well as contractual obligations.	1.1.1 At least 85% of HIV tests will be conducted relative to the number projected (projected vs. actual). 1.2.1 100% of HIV testing will be conducted as per NYS PHL and contract obligations.
2. Increase the number individuals who are aware of their HIV status.		2.1 Develop a recruitment strategy with appropriate messaging that is responsive to the needs of the priority population. Strategies may include: Outreach (Street based, Venue based, Internet); Internal or External referrals; and Collaborations with PS. 2.2 Conduct client recruitment activities and engage individuals who will benefit from this intervention. 2.3 Identify individuals who have never tested for HIV and engage them in this intervention.	2.2.1 90% of clients tested in non-clinical settings will be members of the identified priority population. 2.2.1 90% of clients recruited for testing could benefit from this intervention. 2.3.1 At least 25% of clients recruited will be first time testers.
3. Identify newly HIV diagnosed individuals based on annual service targets.		3.1 Implement effective strategies to locate individuals who are living with HIV and are not aware of their status.	3.1.1 As identified in the Annual Program Service Targets for Component B - Program Model 1 Interventions table of the Communities of Color RFA, the minimum number of clients tested will be identified as living with HIV for the first time.
4. Ensure 100% of individuals tested for HIV receive their test results.		4.1 Provide client with a confirmed test result in accordance with NYS Public Health Law. 4.2 Have a protocol in place to follow-up with clients if clients do not return for their test results. Utilize NYS and/or local health department Partner Services (PS) staff to help locate clients where possible.	4.1.1 100% of individuals with an HIV positive/reactive test will be given their test results. 4.2.1 Protocol will be implemented with all clients in need of follow up.
5. Link newly identified HIV positive clients to medical care and PS.	NA	5.1 Have a protocol in place that aligns with the Director of the AIDS Institute's Call to Action for intra-agency or external referrals which ensures rapid access to HIV treatment. 5.2 Follow up with medical providers (intra-agency and	5.1.1 90% of individuals newly diagnosed with HIV who receive their test result will be linked to HIV medical care with HIV-related lab work and the offer of treatment initiation within 3 days of HIV diagnosis. 5.2.1 100% of client referrals to

		external) to verify that the client has attended their medical appointment with HIV-related lab work (e.g., viral load, CD4, genotype) and determine if treatment was initiated. 5.3 Establish collaboration agreements with regional and/or local partner services staff to accept referrals for partner services. Inform clients about Partner Services and provide linkage/referral.	medical providers will be verified. 5.3.1 100% of newly identified individuals living with HIV will receive information about, and referral to, PS.
6. Report all individuals newly diagnosed with HIV to the NYSDOH.		6.1 Utilize the Medical Provider Report Form (PRF) (DOH-4189) [or complete electronically (ePRF) using the Provider Portal on the NYSDOH Health Commerce System], to report confirmed cases of HIV to NYSDOH within 14 days of diagnosis.	6.1.1 100% of individuals newly diagnosed with HIV will have a PRF or ePRF completed and submitted to NYSDOH within 14 days of diagnosis.
7. Link individuals newly diagnosed with HIV to HIV prevention services.		7.1 Discuss action plan with client to address barriers preventing the client from implementing behavior change. 7.2 Refer individuals newly diagnosed with HIV to prevention services (e.g., navigation/peer support, individual/group interventions, etc.). 7.3 Establish collaboration agreements with providers to accept referrals for HIV prevention interventions and other related services not provided by your program/agency.	7.1.1 100% of individuals newly diagnosed with HIV who receive their test results will be screened for risk reduction intervention needs. 7.2.1 At least 90% of individuals newly diagnosed with HIV who are screened and identified as needing risk reduction intervention will be provided an intervention and linked to prevention services within 30 days of receiving test result. 7.3.1 N/A
8. Refer, test &/or screen clients testing for HIV for STI & HCV services.		8.1 Engage in Program Collaboration/Service Integration. Ensure comprehensive risk assessments and address client risks for STIs & HCV in addition to HIV. Provide information & documented linkage to testing & treatment for STI/HCV (as appropriate).	8.1.1 100% of individuals newly diagnosed with HIV who receive their test results will be offered testing/screening or referred for testing/screening for STIs and HCV.
9. Increase the number of individuals who are linked to PrEP/PEP.		9.1 Establish collaboration agreements with PrEP/PEP prescribers to accept linkages/referrals for PrEP/PEP. 9.2 Link HIV-negative clients with prevention services, including non-occupational Post-Exposure Prophylaxis (PEP) and/or Pre-Exposure Prophylaxis (PrEP).	9.1.1 100% of clients not already on PrEP at the time of HIV testing will be screened for PrEP. 9.2.1 65% of clients who are screened and identified as eligible for PrEP will be referred to a PrEP prescriber.

If your agency is not contracted to conduct HIV testing, please follow the guidance provided below			
10. Refer eligible clients to HIV testing.		10.1 Ensure the comprehensive risk assessment conducted also addresses client risks for STIs and HCV. 10.2 Refer for HIV testing in accordance with public health law and contractual obligations.	10.1.1 65% will accept the referral for HIV testing. 10.2.1 N/A

STI and HCV Screening			
Objective		**Tasks (Activities)**	**Performance Measures**
11. Meet key performance indicators and monitor service delivery.		11.1 Conduct STI and HCV screening and linkage to services in accordance with NYS PHL and contractual obligations.	11.1.1 At least 85% of STI and HCV screenings conducted relative to the number projected (projected vs. actual).
12. 100% of persons with a STI positive result receive their test results.		12.1 Provide client with a confirmed test result in accordance with NYS public health law.	12.1.1 100% of persons with a STI positive test result will be given their results.
13. Link clients diagnosed with a STI to medical care and PS and report to LHD.		13.1. Have a protocol in place for external or intra-agency referrals which ensures linkage to treatment and medical care within 3 business days of receiving their results. 13.2 Follow up with medical providers (intra-agency and external) to verify that the client has attended medical appointment and received treatment. 13.3 Utilize the Confidential Case Report Form (DOH-389) for Rest of State (ROS) Providers (non-NYC based providers) or the Universal Report Form (URF) for NYC-based providers, to report confirmed STI cases to the local health department within 24 hours of diagnosis.	13.1.1 100% of clients with a STI positive result and receive their test result will be referred to treatment and medical care within 3 business days of receiving their test result. 13.2.1 100% of client referrals to medical providers will be verified. 13.3.1 100% of clients diagnosed with a STI will have a DOH 389 or URF submitted to the local health department within 24 hours of diagnosis. A phone call must be made to the local health department immediately following a new confirmed case of early syphilis.
14. Ensure 100% of HCV reactive clients receive their test result.		**14.1** Provide client with results of HCV screening. If providing diagnostic HCV testing directly, provide client with test result in accordance with NYS PHL. **14.2** If providing diagnostic HCV testing directly: Utilize the Confidential Case Report Form (DOH-389) to report	**14.1.1 100%** of HCV reactive test results will be returned to clients. **14.2.1 100%** of HCV RNA tests will have a DOH 389 completed and

		HCV RNA results to the local health department within 24 hours of diagnosis.	submitted to the local health department within 24 hours of diagnosis.

If your agency is not conducting STI and HCV Screening, please follow the guidance provided below			
15. Refer eligible clients to STI and HCV screening.		15.1 Ensure the comprehensive risk assessment conducted also addresses client risks for STIs and HCV. 15.2 Refer for STI and HCV screening in accordance with public health law and contractual obligations.	15.1.1 100% of comprehensive risk assessments will integrate STI and HCV risk information. 15.2.1 65% will accept the referral for STI and HCV screening.

Social Determinants of Health Intervention (REQUIRED)			
Objective		**Task/Activities**	**Performance Measures**
16. Address at least one SDOH.		16.1 Ensure all clients (regardless of HIV status) are screened for SDOH. 16.2 Deliver interventions/ services that address SDOH.	16.1.1 100% of clients screened for SDOH. 16.2.1 100% of clients who are identified and screened for a SDOH will be provided with an SDOH intervention/service.

HIV Navigation Services (HNS) -- Staff and/or Peer Led (OPTIONAL)			
Objective		**Task/Activities**	**Performance Measures**
17. Link persons in need to care, prevention, and support services.		17.1 Deliver HNS as per intervention and program guidance. 17.2 Ensure all clients living with HIV are linked to medical care and essential support services. Partners/network associates should be informed of available interventions (e.g., PrEP/PEP, EBI) and be provided with referrals. 17.3 Ensure clients living with HIV in need of medication adherence are linked to treatment adherence services and monitor with the goal of viral suppression. 17.4 Link clients to HIV testing, STI and/or HCV screening as per assessment and action plan. 17.5 Link clients to prevention interventions as per	17.1.1 HNS are delivered as per guidance. 17.2.1 100% of individuals living with HIV will be linked to medical care and essential support services. 17.3.1 80% of all individuals living with HIV who are screened and identified as needing ART medication adherence support services will be provided/linked to these services and will be monitored for treatment adherence - goal of viral suppression. 17.4.1 90% of clients with unknown HIV, STI, and/or HCV status will be linked to testing or screening. 17.5.1 90% of clients who are screened

HIV Navigation Services (HNS) -- Staff and/or Peer Led (OPTIONAL)			
Objective		**Task/Activities**	**Performance Measures**
		assessment and action plan. 17.6 Link clients to essential support services as per assessment and action plan. 17.7 Make clients aware of PrEP/PEP, and ensure clients who will benefit from PrEP and are not already on PrEP at the time of enrollment are screened and are linked to PrEP prescriber.	and identified as needing risk reduction intervention will be provided an intervention within 30 days. 17.6.1 90% of clients in HNS will be linked to essential support services as per action plan. 17.7.1 100% of clients will be made aware of PrEP/PEP, screened, and linked to PrEP.

Condom Promotion, Education and Distribution (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
18. Increase correct and consistent condom use.		18.1. Promote and/or distribute condoms during each client-level encounter with persons living with HIV and populations at highest risk. As appropriate, provide condom education as needed when distributing condoms.	18.1.1 85% of clients will be provided condoms at each client level encounter.

Health Promotion Activities/Prevention/Supportive Interventions and Peer Training (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
19. Implement prevention interventions.		19.1 Implement prevention interventions as per program guidance. 19.2 Implement public health strategies or EBIs that are applicable and respond to the prevention needs of the priority population.	19.1.1 At least 90% of clients who are enrolled in each funded intervention(s) will be from the identified priority population. 19.2.1 At least 90% clients enrolled relative to the number projected (projected vs. actual).
20. Deliver prevention support interventions.		20.1 Implement supportive interventions as per program guidance. 20.2 Implement supportive interventions that are applicable and respond to the service needs of the priority population. Interventions supported include employment, education, healthcare, housing and sexual health education.	20.1.1 At least 90% of clients who are enrolled in each funded intervention(s) will be from the identified priority population. 20.2.1 At least 90% clients enrolled relative to the number projected (projected vs. actual).
21. Implement a Peer Training Program.		21.1 Follow a structured peer training curriculum, which includes initial and on-going training of peers (this may be a CDC approved EBI or locally developed intervention). 21.2 Integrate peers (including hiring of peers/certified peers) in the implementation of funded program interventions and services and provide ongoing supervision and support.	21.1.1 Train 10-20 peers through a minimum of 2 multi-session group cycles annually. 21.2.1 100% of trained peers will be provided with ongoing supervision and support.

PrEP/PEP (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
22. Increase awareness of PrEP and PEP among clients.		22.1 Raise awareness and educate clients about PrEP, screen and assess the priority population for PrEP, and link appropriate clients to medical providers for PrEP assessment and possible PrEP initiation. 22.2 Ensure that all clients are made aware that they can seek PEP within 36 hours of condomless sex. 22.3 Develop and implement social media and other campaigns to raise community awareness about PrEP/PEP.	22.1.1 100% of HIV negative clients not already on PrEP will be screened for PrEP. 22.2.1 100% of HIV negative clients not on PEP will be informed of PEP services. 22.3.1 100% of social media used will be relevant to the priority population in the geographic area selected.

High Impact Public Health Strategy, Evidence Based Effective Intervention, and/or Locally Developed Interventions (OPTIONAL)			
Objective		**Tasks (Activities)**	**Performance Measures**
23. Implement a strategy, EBI, or locally developed intervention.		23.1 Implement at least 1 high impact public health strategy; EBI; and/or locally developed intervention. Locally developed interventions (LDIs) must adhere to the AI's 15 Common Factors of Effective Interventions.	23.1.1 At least 90% clients enrolled relative to the number projected (projected vs. actual).

Evaluation, Reporting and Program Management (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
24. Submit timely data, narrative, and fiscal reports/documents.		24.1 Collect and submit data and create narrative reports in accordance with Division and AI protocols. 24.2 Submit monthly AIRS extracts to the AIDS Institute via the Health Commerce System. 24.3 Create and submit fiscal reports/documents (e.g., voucher claims, budget modifications, etc.) in accordance with Division/AI protocols and the State Master Contract. 24.4 Monitor contract expenditures quarterly and address underspending accordingly.	24.1.1 100% of monthly AIRS extracts will be submitted by the established deadline. 24.2.1 100% of data and narrative reports submitted will be up to date (within 30 days of last service). 24.3.1 100% of fiscal documents will be submitted by the established deadlines. 24.4.1 100% of contract dollars will be spent annually.

Evaluation, Reporting and Program Management (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
25. Ensure funded staff receive appropriate training annually.		25.1 Provide funded staff with appropriate training.	25.1.1 Funded staff will receive 24 hours of training annually.
26. Address emerging community issues/service gaps.		26.1 Develop and coordinate a rapid response to emerging issues (e.g., new HIV infections, increases in Syphilis) as identified by the AI/DOH and or regional planning bodies. 26.2 Work closely with the AI /DOH to take action on HIV/STI/HCV-related issues for communities not served by targeted funding. Contract manager must approve changes to the scope of work. 26.3 Provide updates to the AI/DOH on actions and outcomes.	26.1.1 100% of emerging issues identified will be addressed by agency. 26.2.1 Action will be taken on HIV/STI/HCV related issues faced by communities not served by targeted funding. 26.3.1 Updates on activities will be provided to the AI via email/monthly reports.
27. Ensure flexibility in programming.		27.1 Flexibility in programming to ensure that resources are effectively directed to the populations and communities most in need. 27.2 Contract activities and deliverables may be modified at any point in this contract upon direction of the AIDS Institute to address emerging needs or disparities, emerging HIV/STI/HCV epidemiologic patterns, or to accommodate advances in best practice. 27.3 Assist with other priority public health issues if/when they arise (e.g., local STI case increases, outbreaks, emergency situations, etc.). The contract manager must approve non-work plan work.	27.1.1 N/A 27.2.1 Aid with non-workplan public health issues if/when they arise. 27.3.1 100% of emerging issues identified will be coordinated as per AIDS Institute guidance.

Attachment 15: Work Plan - Component C
SUMMARY

PROJECT NAME: Prevention and Essential Support Services for Women and Young Women within Communities of Color
CONTRACTOR SFS PAYEE NAME:
CONTRACT PERIOD From: May 1, 2024 To: April 30, 2029

Project Summary

This initiative supports a high impact approach to prevention and essential support services to achieve ETE and Beyond Initiative goals and reduce/eliminate disparities and inequities in HIV incidence in women and young women of color (e.g., Black, Latina/Latinx, Indigenous people and Asian populations). Funding supports programs that provide HIV/STI/HCV prevention interventions and essential support services for women and young women of color that seek to address Social Determinants of Health (SDOH) and promote health equity.

The overall goals are to:

- Prevent new HIV/STI/HCV infections by increasing access to comprehensive sexual health information, behavioral, and biomedical interventions such as PrEP/PEP, and essential supportive services; and
- Identify individuals who are living with HIV/STI/HCV and unaware of their status and ensure access to early, high quality medical care and prevention services.

Prevention interventions and client services address the prevention and support needs of women and young women within communities of color living with HIV as well women and young women who will benefit from prevention interventions/services (ex. women and young women in sexual relationships with partners whose status is unknown or who are in sero-discordant relationships; partners of men who have sex with men (MSM); women and young women with a history of trauma, sexual, emotional, and physical abuse; women and young women involved in sex work; women and young women who have sex with women; women and young women with a history of incarceration or other forms of institutionalization within communities of color (e.g., Black, Latina/Latinx, Indigenous people and Asian). The expected outcomes are to: reduce disease incidence; decrease the rate of HIV/STI/HCV transmission; promote sexual and drug user health; increase the proportion of persons living with HIV/STI/HCV who are aware of their status; and increase the proportion of persons living with HIV/STI/HCV who are linked to prevention, partner services (PS), and treatment/medical care.

Funding will support the provision of Client Recruitment/Engagement; HIV Prevention Community Collaboration; Condom Promotion, Education, and Distribution; SDOH interventions, direct provision of HIV Testing; direct provision of, or documented referral to, STI and HCV Screening; HIV Navigation Services; and delivery of High Impact Prevention Public Health Strategies, Evidence Based Behavioral Interventions (EBI), and/or Locally Developed Interventions.

The initiative aims to impact the New York State Department of Health (NYSDOH) AIDS Institute (AI) efforts to:

- Reduce disease incidence;
- Decrease risk of sexual and drug using behaviors among persons living with HIV and persons who engage in behaviors that put them at risk of HIV/STI/HCV infection;
- Increase the number of persons living with HIV/STI/HCV who are aware of their status; and
- Increase the number of persons living with HIV/STI/HCV who are linked to prevention, partner services, and treatment/medical care.

This funding will support two program models.

Indicate Program Model Selected
_____ Program Model 1
_____ Program Model 2

Sections of the work plan
HIV Testing and Linkage to Prevention & HIV Care Services (REQUIRED PROGRAM MODEL 1) – Objectives 1-9
Referral for HIV Testing (REQUIRED PROGRAM MODEL 2) – Objective 10
STI and HCV Screening* (REQUIRED FOR PROGRAM MODEL 1 AND 2) – Objectives 11-15 (If your agency is not conducting STI & HCV Screening, please follow Objective 15)
Social Determinants of Health Intervention (REQUIRED) – Objective 16
HIV Navigation Services -- Staff and/or Peer Led (IF APPLICABLE) – Objective 17
Condom Promotion, Education and Distribution (REQUIRED) – Objective 18
Health Promotion Activities/Prevention/Supportive Interventions and Peer Training (REQUIRED) – Objectives 19-21
PrEP/PEP (REQUIRED) – Objective 22
High Impact Public Health Strategy, Evidence Based Effective Intervention, and/or Locally Developed Interventions (IF APPLICABLE) – Objective 23
Evaluation and Reporting (REQUIRED) – Objectives 24-27

Instructions: For the Grants Gateway **Work Plan Project Summary**, applicants are instructed to indicate the Program Model selected and the Project Summary as it is listed above. In the Grants Gateway **Work Plan Organizational Capacity** section, applicants are instructed to list this as "not applicable." Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Attachment 15: Component C Work Plan. Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.

HIV Testing and Linkage to Prevention & HIV Care Services			
Objective		**Tasks (Activities)**	**Performance Measures**
1. Meet key performance indicators and monitor service delivery.		1.1 Monitor service delivery and data to ensure targeted testing is achieving program goals. 1.2 Conduct confidential HIV testing in accordance with NYS Public Health Law (PHL) as well as contractual obligations.	1.1.1 At least 85% of HIV tests will be conducted relative to the number projected (projected vs. actual). 1.2.1 100% of HIV testing will be conducted as per NYS PHL and contract obligations.
2. Increase the number individuals who are aware of their HIV status.		2.1 Develop a recruitment strategy with appropriate messaging that is responsive to the needs of the priority population. Strategies may include: Outreach (Street based, Venue based, Internet); Internal or External referrals; and Collaborations with PS. 2.2 Conduct client recruitment activities and engage individuals who will benefit from this intervention. 2.3 Identify individuals who have never tested for HIV and engage them in this intervention.	2.1.1 90% of clients tested in non-clinical settings will be members of the identified priority population. 2.2.1 90% of clients recruited for testing could benefit from this intervention. 2.3.1 At least 25% of clients recruited will be first time testers.
3. Identify newly HIV diagnosed individuals based on annual service targets.		3.1 Implement effective strategies to locate individuals who are living with HIV and are not aware of their status.	3.1.1 As identified in the Annual Program Service Targets for Component C- Program Model Interventions table of the Communities of Color RFA, the minimum number of clients tested will be identified as living with HIV for the first time.
4. Ensure 100% of individuals tested for HIV receive their test results.		4.1 Provide client with a confirmed test result in accordance with NYS Public Health Law. 4.2 Have a protocol in place to follow-up with clients if clients do not return for their test results. Utilize NYS and/or local health department Partner Services (PS) staff to help locate clients where possible.	4.1.1 100% of individuals with an HIV positive/reactive test will be given their test results . 4.2.1 Protocol will be implemented with all clients in need of follow up.
5. Link newly identified HIV positive clients to medical care and PS.		5.1 Have a protocol in place that aligns with the Director of the AIDS Institute's Call to Action for intra-agency or external referrals which ensures rapid access to HIV treatment. 5.2 Follow up with medical providers (intra-agency and external) to verify that the client has attended their medical appointment with HIV-related lab work (e.g.,	5.1.1 90% of individuals newly diagnosed with HIV who receive their test result will be linked to HIV medical care with HIV-related lab work and the offer of treatment initiation within 3 days of HIV diagnosis. 5.2.1 100% of client referrals to medical providers will be verified.

		viral load, CD4, genotype) and determine if treatment was initiated. 5.3 Establish collaboration agreements with regional and/or local partner services staff to accept referrals for partner services. Inform clients about Partner Services and provide linkage/referral.	5.3.1 100% of newly identified individuals living with HIV will receive information about, and referral to, PS.
6. Report all individuals newly diagnosed with HIV to the NYSDOH.		6.1 Utilize the Medical Provider Report Form (PRF) (DOH-4189) [or complete electronically (ePRF) using the Provider Portal on the NYSDOH Health Commerce System], to report confirmed cases of HIV to NYSDOH within 14 days of diagnosis.	6.1.1 100% of individuals newly diagnosed with HIV will have a PRF or ePRF completed and submitted to NYSDOH within 14 days of diagnosis.
7. Link individuals newly diagnosed with HIV to HIV prevention services.		7.1 Discuss action plan with client to address barriers preventing the client from implementing behavior change. 7.2 Refer individuals newly diagnosed with HIV to prevention services (e.g., navigation/peer support, individual/group interventions, etc.). 7.3 Establish collaboration agreements with providers to accept referrals for HIV prevention interventions and other related services not provided by your program/agency.	7.1.1 100% of individuals newly diagnosed with HIV who receive their test results will be screened for risk reduction intervention needs 7.2.1 At least 90% of individuals newly diagnosed with HIV who are screened and identified as needing risk reduction intervention will be provided an intervention and linked to prevention services within 30 days of receiving test result 7.3.1 N/A
8. Refer, test &/or screen clients testing for HIV for STI & HCV services.		8.1 Engage in Program Collaboration/Service Integration. Ensure comprehensive risk assessments and address client risks for STIs & HCV in addition to HIV. Provide information & documented linkage to testing & treatment for STI/HCV (as appropriate).	8.1.1 100% of newly individuals newly diagnosed with HIV who receive their test results will be offered testing/screening or referred for testing/screening for STIs and HCV .
9. Increase the number of individuals who are linked to PrEP/PEP.		9.1 Establish collaboration agreements with PrEP/PEP prescribers to accept linkages/referrals for PrEP/PEP. 9.2 Link HIV-negative clients with prevention services, including non-occupational Post-Exposure Prophylaxis (PEP) and/or Pre-Exposure Prophylaxis (PrEP).	9.1.1 100% of clients not already on PrEP at the time of HIV testing will be screened for PrEP. 9.2.1 65% of clients who are screened and identified as eligible for PrEP will be referred to a PrEP prescriber.
If your agency is not contracted to conduct HIV testing, please follow the guidance provided below			
10. Refer eligible clients to HIV testing.		10.1 Ensure the comprehensive risk assessment conducted also addresses client risks for STIs and HCV.	10.1.1 65% will accept the referral for HIV testing.

		10.2 Refer for HIV testing in accordance with public health law and contractual obligations.	10.2.1 N/A

STI and HCV Screening			
Objective		**Tasks (Activities)**	**Performance Measures**
11. Meet key performance indicators and monitor service delivery.		11.1 Conduct STI and HCV screening and linkage to services in accordance with NYS PHL and contractual obligations.	11.1.1 At least 85% of STI and HCV screenings conducted relative to the number projected (projected vs. actual).
12. 100% of persons with an STI positive result receive their test results.		12.1 Provide client with a confirmed test result in accordance with NYS Public Health Law.	12.1.1 100% of persons with an STI positive test result will be given their results.
13. Link clients diagnosed with a STI to medical care and PS and report to LHD.		13.1. Have a protocol in place for external or intra-agency referrals which ensures linkage to treatment and medical care within 3 business days of receiving their results. 13.2 Follow up with medical providers (intra-agency and external) to verify that the client has attended medical appointment and received treatment 13.3 Utilize the Confidential Case Report Form (DOH-389) for Rest of State Providers (non-NYC based providers) or the Universal Report Form(URF) for NYC-based providers, to report confirmed STI cases to the local health department within 24 hours of dx.	13.1.1 100% of clients with a STI positive result that receive their test result will be referred to treatment and medical care within 3 business days of receiving their test result 13.2.1 100% of client referrals to medical providers will be verified. 13.3.1 100% of clients dx with a STI will have a DOH 389 or URF submitted to the local health department within 24 hours of dx. A phone call must be made to the local health department immediately following a new confirmed case of early syphilis.
14. Ensure 100% of HCV reactive clients receive their test result.		14.1 Provide client with results of HCV screening. If providing diagnostic HCV testing directly, provide client with test result in accordance with NYS PHL. 14.2 If providing diagnostic HCV testing directly: Utilize the Confidential Case Report Form (DOH-389) to report HCV RNA results to the local health department within 24 hours of diagnosis.	14.1.1 100% of HCV reactive test results will be returned to clients. 14.2.1 100% of HCV RNA tests will have a DOH 389 completed and submitted to the local health department within 24 hours of diagnosis.

If your agency is not conducting STI and HCV Screening, please follow the guidance provided below			
15. Refer eligible clients to STI and HCV screening.		15.1 Ensure the comprehensive risk assessment conducted also addresses client risks for STIs and HCV. 15.2 Refer for STI and HCV screening in accordance with public health law and contractual obligations.	15.1.1 100% of comprehensive risk assessments will integrate STI and HCV risk information. 15.2.1 65% will accept the referral for STI and HCV screening.

Social Determinants of Health Intervention (REQUIRED)			
Objective		Task/Activities	Performance Measures
16. Address at least one SDOH.		16.1 Ensure all clients (regardless of HIV status) are screened for SDOH. 16.2 Deliver interventions/ services that address SDOH	16.1.1 100% of clients screened for SDOH. 16.2.1 100% of clients who are identified and screened for a SDOH will be provided with an SDOH intervention/service.

HIV Navigation Services (HNS) -- Staff and/or Peer Led (OPTIONAL)			
Objective		**Task/Activities**	**Performance Measures**
17. Link persons in need to care, prevention, and support services.		**17.1** Deliver HNS as per intervention and program guidance.	**17.1.1** HNS are delivered as per guidance
		17.2 Ensure all clients living with HIV are linked to medical care and essential support services. Partners/network associates should be informed of available interventions (e.g., PrEP/PEP, EBI) and be provided with referrals	**17.2.1 100%** of individuals living with HIV will be linked to medical care and essential support services.
		17.3 Ensure clients living with HIV in need of medication adherence are linked to treatment adherence services and monitor with the goal of viral suppression.	**17.3.1 80%** of all individuals living with HIV who are screened and identified as needing ART medication adherence support services will be provided/linked to these services and will be monitored for treatment adherence - goal of viral suppression.
		17.4 Link clients to HIV testing, STI and/or HCV screening as per assessment and action plan.	**17.4.1 90%** of clients with unknown HIV, STI, and/or HCV status will be linked to testing or screening
		17.5 Link clients to prevention interventions as per assessment and action plan.	**17.5.1 90%** of clients who are screened and identified as needing risk reduction intervention will be provided an intervention within 30 days.
		17.6 Link clients to essential support services as per assessment and action plan.	**17.6.1 90%** of clients in HNS will be linked to essential support services as per action plan.
		17.7 Make clients aware of PrEP/PEP, and ensure clients who will benefit from PrEP and are not already on PrEP at the time of enrollment are screened and are linked to PrEP prescriber.	**17.7.1 100%** of clients will be made aware of, screened, and linked to PrEP/PEP.

Condom Promotion, Education and Distribution (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
18. Increase correct and consistent condom use.		18.1. Promote and/or distribute condoms during each client level encounter with persons living with and populations at highest risk. As appropriate, provide condom education as needed when distributing condoms.	18.1.1 85% of clients will be provided condoms at each client level encounter.

Health Promotion Activities/Prevention/Supportive Interventions and Peer Training (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
19. Implement prevention interventions.		19.1 Implement prevention interventions as per program guidance. 19.2 Implement public health strategies or EBIs that are applicable and respond to the prevention needs of the priority population.	19.1.1 At least 90% of clients who are enrolled in each funded intervention(s) will be from the identified priority population. 19.2.1 At least 90% clients enrolled relative to the number projected (projected vs. actual).
20. Deliver prevention support interventions.		20.1 Implement supportive interventions as per program guidance. 20.2 Implement supportive interventions that are applicable and respond to the service needs of the priority population. Interventions supported include employment, education, healthcare, housing and sexual health education.	20.1.1 At least 90% of clients who are enrolled in each funded intervention(s) will be from the identified priority population. 20.2.1 At least 90% clients enrolled relative to the number projected (projected vs. actual).
21. Implement a Peer Training Program/		21.1 Follow a structured peer training curriculum, which includes initial and on-going training of peers (this may be a CDC approved EBI or locally developed intervention). 21.2 Integrate peers (including hiring of peers/certified peers) in the implementation of funded program interventions and services and provide ongoing supervision and support.	21.1.1 Train 10-20 peers through a minimum of 2 multi-session group cycles annually. 21.2.1 100% of trained peers will be provided with ongoing supervision and support.

PrEP/PEP (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
22. Increase awareness of PrEP and PEP among clients.		22.1 Raise awareness and educate clients about PrEP screen and assess the priority population for PrEP, and link appropriate clients to medical providers for PrEP assessment and possible PrEP initiation. 22.2 Ensure that all clients are made aware that they can seek PEP within 36 hours of condomless sex. 22.3 Develop and implement social media and other campaigns to raise community awareness about PrEP/PEP.	22.1.1 100% of HIV negative clients not already on PrEP will be screened for PrEP. 22.2.1 100% of HIV negative clients not on PEP will be informed of PEP services. 22.3.1 100% of social media used will be relevant to the priority population in the geographic area selected.

High Impact Public Health Strategy, Evidence Based Effective Intervention, and/or Locally Developed Interventions (OPTIONAL)			
Objective		**Tasks (Activities)**	**Performance Measures**
23. Implement a strategy, EBI, or locally developed intervention.		**23.1** Implement at least 1 high impact public health strategy; EBI; and/or locally developed intervention. Locally developed interventions (LDIs) must adhere to the AI's 15 Common Factors of Effective Interventions.	**23.1.1** At least **90%** clients enrolled relative to the number projected (projected vs. actual).

Evaluation, Reporting and Program Management (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
24. Submit timely data, narrative, and fiscal reports/documents.		24.1 Collect and submit data and create narrative reports in accordance with Division and AI protocols. 24.2 Submit monthly AIRS extracts to the AIDS Institute via the Health Commerce System. 24.3 Create and submit fiscal reports/documents (e.g., voucher claims, budget modifications, etc.) in accordance with Division/AI protocols and the State Master Contract. 24.4 Monitor contract expenditures quarterly and address underspending accordingly.	24.1.1 100% of monthly AIRS extracts will be submitted by the established deadline. 24.2.1 100% of data and narrative reports submitted will be up to date (within 30 days of last service). 24.3.1 100% of fiscal documents will be submitted by the established deadlines. 24.4.1 100% of contract dollars will be spent annually.

Evaluation, Reporting and Program Management (REQUIRED)			
Objective		**Tasks (Activities)**	**Performance Measures**
25. Ensure funded staff receive appropriate training annually.		25.1 Provide funded staff with appropriate training.	25.1.1 Funded staff will receive 24 hours of training annually.
26. Address emerging community issues/service gaps.		26.1 Develop and coordinate a rapid response to emerging issues (e.g., new HIV infections, increases in Syphilis) as identified by the AI/DOH and or regional planning bodies. 26.2 Work closely with the AI /DOH to take action on HIV/STI/HCV related issues for communities not served by targeted funding. Contract manager must approve changes to the scope of work. 26.3 Provide updates to the AI/DOH on actions and outcomes.	26.1.1 100% of emerging issues identified will be addressed by agency. 26.2.1 Action will be taken on HIV/STI/HCV related issues faced by communities not served by targeted funding. 26.3.1 Updates on activities will be provided to the AI via email/monthly reports.
27. Ensure flexibility in programming.		27.1 Flexibility in programming to ensure that resources are effectively directed to the populations and communities most in need. 27.2 Contract activities and deliverables may be modified at any point in this contract upon direction of the AIDS Institute to address emerging needs or disparities, emerging HIV/STI/HCV epidemiologic patterns, or to accommodate advances in best practice. 27.3 Assist with other priority public health issues if/when they arise (e.g., local STI case increases, outbreaks, emergency situations, etc.). The contract manager must approve non-work plan work.	27.1.1 N/A 27.2.1 Aide with non-workplan public health issues if/when they arise. 27.3.1 100% of emerging issues identified will be coordinated as per AIDS Institute guidance

Attachment 18
Grants Gateway Expenditure Budget Instructions

This guidance document is intended to help applicants with understanding the types and level of detail required in Grants Gateway for each individual budget line. For Grantee questions and instructions about entering an application in the Grants Gateway, please go to Resources for Grant Applicants | Grants Management (ny.gov) for more training and guidance resources.

Please be aware of the following:

- AIDS Institute Program Managers may require additional information or clarification necessary for approval of requested amounts on funded applications; and
- The allowability of costs are subject to the OMB Uniform Guidance. (https://www.cfo.gov/financial-assistance/resources/uniform-guidance.html)

Grants Gateway Categories of Expense

There are two major Budget Categories, Personal Services and Non-Personal Services. Each of these categories include individual sub-categories for more specific budget items that can be requested in a budget. Each line requires different information.

1. Personal Services
    a. Salary (including peers who receive W2s)
    b. Fringe

2. Non-Personal Services
    a. Contractual (subcontractors, peers who receive 1099s, etc.)
    b. Travel
    c. Equipment
    d. Space/Property & Utilities
    e. Operating Expenses (supplies, audit expenses, postage, etc.)
    f. Other (indirect costs only)

Guidance on allowable expenditures can be found in the "Basic Considerations for Allowability of Costs" document. This document can be found here: http://www.ecfr.gov/cgi-bin/text-idx?SID=1728c16d0aca3b9aabbd3c25d38d5483&mc=true&node=pt2.1.200&rgn=div5.

> Title 2 → Subtitle A → Chapter II → Part 200 — UNIFORM ADMINISTRATIVE REQUIREMENTS, COST PRINCIPLES, AND AUDIT REQUIREMENTS FOR FEDERAL AWARDS, Subpart E - ***Basic Considerations, §200.402 - §200.475***

PERSONAL SERVICES – SALARY

For each salary position funded on the proposed contract, provide the following:

Details:

- **Position/Title:** Enter the title and the incumbent's name. If the position is yet to be filled, enter "TBH" (to be hired.)

- **Role/Responsibility:** Enter the position description, including the duties supported by the contract.

Financial:

- **Annualized Salary Per Position:** Enter the full salary for 12 months regardless of funding source.
- **STD Work Week (hrs):** Enter the standard work week for this position regardless of funding. If it is a full-time position, this is often either 35, 37.5 or 40 hours per week. If it is a part-time position, enter the expected number of hours per week the person will work.
- **% Funded:** Enter the percent of effort to be funded on this proposed contract.
- **# of Months Funded:** Enter number of months this position will be funded during the proposed contract period. Use months only; do not use pay periods.
- **Total Grant Funds:** Enter the total amount for this position requested during the proposed contract period. **Grants Gateway will not automatically calculate this. Please check your calculation for accuracy.**

Items to Note:

- The Total Match Funds and Total Other Funds lines are not used. You will not be able to enter information on those lines.
- While Grants Gateway does not calculate the Line Total, it does calculate the cumulative Category Total.

PERSONAL SERVICES - FRINGE

Details:

- **Fringe – Type/Description:** Enter a description (examples, fringe rate, union fringe rate, nonunion fringe rate, part-time fringe rate, full-time fringe rate) and the percentage.

- **Justification:** Specify whether fringe is based on federally approved rate, audited financials or actual costs.

Financial:

- **Total Grant Funds:** Enter the total amount of fringe requested for this proposed contract period.

CONTRACTUAL

Details:

- **Contractual – Type/Description:** Enter the name of the agency, consultant or TBA (if not yet selected). Use a separate Contractual line for each subcontractor or consultant. Include an estimated cost for these services.

- **Justification:** Briefly describe the services to be provided.

Financial:

- **Total Grant Funds:** Enter the total amount requested for the subcontractor.

TRAVEL

Details:

- **Travel – Type/Description:** Describe the type of travel cost and/or related expenses.

- **Justification:** Briefly describe how the travel relates to the proposed contract.

Financial:

- **Total Grant Funds:** Enter the total amount requested for the Travel item.

EQUIPMENT

Details:

- **Equipment – Type/Description:** Describe the equipment and who it is for.

- **Justification:** Briefly describe how this equipment relates to the proposed contract and why it is necessary.

Financial:

- **Total Grant Funds:** Enter the total amount requested for this Equipment item.

Items to Note:

- Equipment is defined as any item costing $1,000 or more.
- Rental equipment (if applicable) can be included in this section.

SPACE/PROPERTY RENT or Own

Details:

- **Space/Property: Rent or Own – Type/Description:** Describe the property, whether it is the agency's main site or satellite and provide the address. Use a separate Space line for each different location.

- **Justification:** Explain why this proposed contract is paying for the space costs at this location.

Financial:

- **Total Grant Funds:** Enter the total amount requested for this Space/Property item.

UTILITY

Details:

- **Utility – Type/Description:** Describe the utility expense.

- **Justification:** Indicate the property address for which this expense will be incurred.

Financial:

- **Total Grant Funds:** Enter the total amount requested for this Utility item.

OPERATING EXPENSES

This section is used to itemize costs associated with the operation of the program, including but not limited to insurance/bonding, photocopying, advertising, and supplies.

Details:

- **Operating Expenses – Type/Description:** Describe what is being purchased.

1. Supplies – Briefly describe items being purchased.

2. Equipment – Include all items with a total cost under $1,000, including computer software. Use a separate line for each group of items.

3. Telecommunications – Include costs for all telephone lines funded by this proposed contract, fax and modem lines, telecommunications installation costs, hotlines, long distance, cell phones, and internet expenses.

4. Miscellaneous – Includes postage, printing, insurance, equipment maintenance, stipends, media advertising, recruitment, or other appropriate costs.
    - For incentives, briefly detail the types of incentives to be purchased and what they will be used for.

- **Justification:** Describe how this item relates to the contract and why it is necessary.

Financial:

- **Total Grant Funds:** Enter the total amount requested for this Operating Expense item.

Items to Note:

- Participant Support and Incentives – the following chart is in accordance with AIDS Institute policy:

Type	Allowable using State Funding?
Participant Support	
Food Vouchers	YES
Pharmacy Cards	YES
Metro Cards	YES
Gasoline Cards	YES
Bus Passes	YES
Incentives	
Gift Card – non-cash	YES
Cash or Cash equivalent (e.g., VISA Card)	NO
Movie Tickets	NO
Theater Tickets	NO
Promotional Items *	YES*

*Promotional items must be promoting a specific program or intervention, such as Ending the Epidemic, or HIV testing, or Know your Status, rather than generically promoting the organization.

- Reimbursement for employee parking at regular work site or transportation costs to and from work is not allowable on AI contracts, unless the employee is in travel status as defined by agency's Policies and Procedures.
- Reimbursement for refreshment for employee or the Board of Directors (BOD) is not allowable. This includes food, coffee, tea, and water for staff meetings, staff break areas, or BOD meetings.

OTHER

Details:

- **Other Expenses – Type/Description:** This section will **only** be used to document Indirect Costs. Enter the words “Indirect Cost rate” and the rate being requested.

- **Justification:** Enter whether or not this rate is based on a federally approved rate agreement.

Financial:

- **Total Grant Funds:** Enter the total amount requested for this Expense item.

Items to Note:

- An indirect cost rate of up to 10% of modified total direct costs can be requested.
- If your organization has a federally approved rate, an indirect cost rate of up to 20% of modified total direct costs can be requested. If your agency has a federally approved rate of less than 20%, the maximum indirect rate that can be requested is the federally approved rate.
- No cost that is billed directly to this contract can be part of the indirect rate.

Attachment 22: Work Plan - Component D
SUMMARY

PROJECT NAME: NYS Hotline Services and Social Media Based Outreach for English and Spanish Speakers
CONTRACTOR SFS PAYEE NAME:
CONTRACT PERIOD **From:** May 1, 2024 To: April 30, 2029

Project Summary

This initiative supports a statewide hotline for English and Spanish speakers. Funding will support the operation of a toll-free telephone hotline and social media outreach services to provide information, referrals, and support services to residents of New York State. Grantees are expected to develop a mechanism to respond to telephone and social media inquiries and provide comprehensive HIV/STI/HCV and Drug User Health information as well as referral source information for prevention, support, and care-related services throughout New York State. Hotline services and social media-based outreach activities must be made available in English and Spanish.

The initiative overall goals are to:

- Provide clear, accurate and science-based education about HIV/STI and HCV related topics (e.g., sexual and reproductive health, COVID-19, MPOX, etc.);
- Promote awareness and educate the public about HIV/STI/HCV scientific advances which prevent the transmission of including Treatment as Prevention (TasP), referred to as Undetectable = Untransmittable (U=U); Pre-Exposure Prophylaxis (PrEP); and Post Exposure Prophylaxis (PEP);
- Share information about prevention campaign efforts and promote sites such as HIV Stops with Me, Act Against AIDS, Undetectable = Untransmittable (U=U), and PrEP for Sex;
- Promote Drug User Health Services and provide referrals to Opioid Overdose Prevention Programs, Syringe Exchange and Expanded Syringe Access Programs (ESAP);
- Promote LGBTQ Health and Wellness;
- Facilitate access to early, high-quality medical care and essential support and prevention services; and
- Facilitate access to behavioral and biomedical prevention services; including HIV testing, Partner Services, STI/HCV screening and effective behavioral interventions, PEP, PrEP, and TasP, and Expanded Partner Therapy (EPT).

Funding allows for the provision of a toll-free Statewide Hotline and Social Media Based Outreach for English and Spanish Speakers and supports the following:

- Mechanisms to receive and respond to telephone and social media inquiries in English and Spanish and provide comprehensive information and referral source contacts for HIV/STI/HCV prevention, support, and care-related services throughout New York State;

- Program staff who provide information and referral services and have knowledge of Ending the Epidemic Initiative goals, harm reduction strategies, PrEP and PEP interventions, Expanded Partner Therapy (EPT) and understand the ethnic/cultural norms that influence HIV risk; and
- Collaboration with State and local health departments, community-based organizations, health homes and medical providers to facilitate delivery of comprehensive Hotline Services and Social Media Based Outreach across the care continuum.

Instructions: For the Grants Gateway **Work Plan Project Summary**, applicants are instructed to insert the Project Summary as it is listed above. In the Grants Gateway **Work Plan Organizational Capacity** section, applicants are instructed to list this as "not applicable." Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Attachment 22: Component D Work Plan. Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.

Statewide Hotline Services in English and Spanish			
Objective		**Tasks (Activities)**	**Performance Measures**
1. Operate a Statewide Hotline and implement social media outreach.		1.1 Establish hours of operation that accommodate the needs of the community and optimize opportunities for individuals to receive information/education and referrals. 1.2 Offer a minimum of 40 hours per week of hotline services and social media activity. 1.3 Conduct engagement events targeted to community-based organizations, health homes and medical providers that seek to promote the hotline number and social media presence. 1.4 Distribute hotline marketing materials, promote NYSDOH AIDS Institute (AI) HIV/STI/HCV, LGBTQ health and wellness, and drug user health (Opioid Overdose Prevention/ESAP)-related educational campaigns. Provide educational materials. 1.5 Expand audience reach via the use of social media sites to advertise the hotline number/services and promote community-based activities led by partner agencies (e.g., post information about Pride events).	1.1.1 100% of program staff will be hired as per RFA requirements. 1.2.1 Hours of operation will be established to optimize opportunities for callers to receive clear, accurate/science-based education, and appropriate referrals. 1.3.1 100% of engagement events will seek to promote the hotline number and social media activities. 1.4.1 100% of hotline related material distributed will promote NYSDOH AIDS Institute-related educational campaigns and provide educational materials. 1.5.1 100% of all social media activities will incorporate advertising of hotline number and will promote community events.
2. Increase awareness on HIV/STI/HCV and related topics. Provide needed referrals.		2.1 Respond to telephone and social media inquiries and provide comprehensive HIV/STI/HCV information. 2.2 Provide callers with accurate answers and reliable information in a friendly, non-threatening, non-judgmental manner. 2.3 Dedicate time to dialogue and increase the individual's knowledge, build health protective skills, promote prevention behaviors, and provide support as appropriate.	2.1.1 Respond to 100% of calls and social media inquiries. 2.2.1 100% of callers will be provided with accurate and reliable information in a friendly, non-threatening, non-judgmental manner. 2.3.1 100% of callers will be given sufficient time for dialogue about HIV/STI/HCV-related

Statewide Hotline Services in English and Spanish			
Objective		**Tasks (Activities)**	**Performance Measures**
		2.4 Provide referrals and information for prevention, support, and care-related services throughout New York State. 2.5 Disseminate free printed materials to individuals on HIV/STI/HCV and other health related topics (upon request). 2.6 Expand audience reach via the use of social media sites (e.g., Twitter, Facebook, Instagram) to address misinformation, and provide credible, science-based health information regarding HIV/STI/HCV and other health-related topics. 2.7 Educate and provide facts via the use of social media sites to increase knowledge of HIV-related topics such as HIV testing, PEP and PrEP access, Syphilis and other STIs, Drug User Health, and LGBTQ Health and Wellness. 2.8 Use social media to educate, raise public awareness, and promote public health messaging and annual observances (e.g., U=U, TasP & PrEP awareness, EPT, STD Awareness, National HIV Testing Day, Opioid Overdose Awareness Day, World AIDS Day, etc.) 2.9 Evaluate hotline and social media staff to ensure information provided is clear, accurate/science based and provided in a non-discriminatory, culturally affirming and non-judgmental manner.	concerns. 2.4.1 100% of hotline and social media callers asking for referrals and information will be provided current linkage information/resources. 2.5.1 100% of hotline and social media clients requesting materials will be provided with materials. 2.6.1 100% of social media activities will address one of the following: Misinformation/stigma; Lack of knowledge; Public health messaging / promotion of national observances. 2.7.1 100% of hotline and social media staff will receive training and on-going staff development. 2.8.1 100% of social media posts will provide education/awareness and promote public health messaging and annual observances. 2.9.1 100% of hotline and social media staff will be evaluated to verify that the information provided is clear, accurate/science-based and provided in a non-discriminatory, culturally affirming, and non-judgmental manner.
3. Conduct condom promotion, education, and distribution activities.		3.1 Provide callers with condoms and other safer sex supplies upon request (at no cost to the caller). 3.2 Use social media sites (e.g., Twitter, Facebook, Instagram)	3.1.1 100% of callers requesting condoms or other safer sex supplies will be provided with condoms/safer sex supplies. 3.2.1 30% of social media posts will include a

Statewide Hotline Services in English and Spanish			
Objective		**Tasks (Activities)**	**Performance Measures**
		to promote condom access and education.	condom access/education message.

Evaluation, Reporting, and Program Management			
Objective		**Tasks (Activities)**	**Performance Measures**
4. Submit timely data, narrative, and fiscal reports/documents.		4.1 Collect and submit data and create narrative reports in accordance with Division and AI protocols. 4.2 Submit monthly AIRS extracts to the AIDS Institute via the Health Commerce System. 4.3 Create and submit fiscal reports/documents (e.g., voucher claims, budget modifications, etc.) in accordance with Division/AI protocols and the State Master Contract. 4.4 Monitor contract expenditures quarterly and address underspending accordingly.	4.1.1 100% of monthly AIRS extracts will be submitted by the established deadline. 4.2.1 100% of data and narrative reports submitted will be up to date (within 30 days of last service). 4.3.1 100% of fiscal documents will be submitted by the established deadlines. 4.4.1 100% of contract dollars will be spent annually.
5. Ensure funded staff receive appropriate training annually.		5.1 Provide funded staff with appropriate training.	5.1.1 Funded staff will receive 24 hours of training annually
6. Address emerging community issues/service gaps .		6.1 Develop and coordinate a rapid response to emerging issues (e.g., new HIV infections, increases in Syphilis) as identified by the AI/DOH and or regional planning bodies. 6.2 Work closely with the AI /DOH to take action on HIV/STI/HCV related issues for communities not served by targeted funding. Contract manager must approve changes to the scope of work. 6.3 Provide updates to the AI/DOH on actions and outcomes.	6.1.1 100% of emerging issues identified will be addressed by agency. 6.2.1 Action will be taken on HIV/STI/HCV-related issues faced by communities not served by targeted funding. 6.3.1 Updates on activities will be provided to the AI via email/monthly reports.
7. Ensure flexibility in programming.		7.1 Flexibility in programming to ensure that resources are effectively directed to the populations and communities most in need. 7.2 Contract activities and deliverables may be modified at any point in this contract upon direction of the AIDS Institute to address emerging needs or disparities, emerging HIV/STI/HCV epidemiologic patterns, or to accommodate advances in best practice. 7.3 Assist with other priority public health issues if/when they arise (e.g., local STI case increases, outbreaks, emergency situations, etc.). The contract manager must	7.1.1 N/A 7.1.2 Aide with non-workplan public health issues if/when they arise. 7.1.3 100% of emerging issues identified will be coordinated as per AIDS Institute guidance

Evaluation, Reporting, and Program Management			
Objective		**Tasks (Activities)**	**Performance Measures**
		approve non-work plan work.	

Attachment 23: Work Plan - Component E
SUMMARY

PROJECT NAME: Training and Technical Assistance on HIV-Related Violence Targeting LGBTQ Individuals
CONTRACTOR SFS PAYEE NAME:
CONTRACT PERIOD **From: May 1, 2024** **To: April 30,2029**

Project Summary

This initiative supports the provision of services that address the intersection of HIV/AIDS and HIV-related violence impacting the lives of LGBTQ individuals living with HIV and individuals affected by HIV, particularly LGBTQ individuals of color.

The overall goals are to:

- Increase access to services for LGBTQ individuals who are victims of violence, victimization, hate, assault, and/or sexual intimate partner violence;
- Raise awareness of HIV-related violence;
- Increase provider skills and knowledge to provide culturally responsive/sensitive services to LGBTQ populations; and
- Increase provider skills and knowledge to provide competent post-victimization services for LGBTQ individuals who have experienced violence.

Instructions:
For the Grants Gateway **Work Plan Project Summary**, applicants are instructed to insert the Project Summary as it is listed above. In the Grants Gateway **Work Plan Organizational Capacity** section, applicants are instructed to list this as "not applicable." Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Attachment 23: Component E Work Plan. Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.
***For Performance measure (8.2.1): *This number will be determined/negotiated once the contract is awarded. The agency's performance will be assessed based on the actual number of performance measures achieved based on the contract deliverables.**

Objective		Tasks (Activities)	Performance Measures
1. Engage LGBTQ individuals in violence and post-victimization services.		1.1 Conduct program promotion, client engagement and recruitment activities to engage LGBTQ individuals in violence and post-victimization services (e.g.: Outreach; Internal/External Referrals; Social Networking; Social Media/Marketing campaigns).	1.1.1 Increase the number of individuals who access agency services as a result of recruitment and engagement activities. 1.1.2 Meet work plan projections regarding the number of activities to be conducted.

Objective		Tasks (Activities)	Performance Measures
2. Increase and/or enhance crisis intervention and supportive services.		2.1 Assess clients for crisis intervention and support service needs.	2.1.1 100% of clients will be assessed for immediate and long-term post-victimization needs.
		2.2 Provide crisis intervention services to LGBTQ victims of hate, assault, sexual and/or intimate partner violence.	2.2.1 100% of clients will be linked and navigated to post-victimization services.
		2.3 Ensure all clients (regardless of HIV status) are screened for SDOH.	2.3.1 100% of clients will be screened for SDOH.
		2.4 Complete an action plan to reduce barriers and increase/facilitate access to essential services and update action plan as needed.	2.4.1 85% of clients will complete an initial action plan; updates will occur as needed.
		2.5 Provide HIV/STI/HCV risk reduction and violence avoidance strategies, education and skills building to reduce and/or eliminate sexual and substance use behaviors that place individuals at risk for acquiring or transmitting HIV/STI/HCV.	2.5.1 100% of clients will receive risk reduction education, prevention and safety strategies and linkage to SDOH services.
		2.6 Link and navigate LGBTQ victims of violence to medical care, prevention and essential support services based on client need.	2.6.1 100% of clients will be linked to needed services based on the action plan.
		2.7 Develop written agreements with healthcare, behavioral health and social	2.7.1 100% of identified healthcare, behavioral health and social service providers will

		service providers to facilitate linkage to needed services or programs. 2.8 Train staff to: use a client-centered, culturally/linguistically affirming approach; engage client in HIV/STI/HCV prevention services; assist client in achieving self-sufficiency based on action plan; and comply with patient confidentiality reqs. 2.9 Document all services provided, referrals and linkage outcomes in the AIDS Institute Reporting System (AIRS).	accept client linkage/referrals. 2.8.1 100% of contract staff will be trained to provide funded services based on workplan requirements. 2.9.1 100% of monthly AIRS extracts will be submitted by the established deadline.
3. Increase the # of victims of violence who know their HIV/STI/HCV status.		3.1 Assess client HIV, STI and HCV risk. 3.2 Refer and link at risk clients for HIV/STI and/or HCV testing in accordance with public health law and contractual obligations as appropriate. 3.3 Establish collaboration agreements with providers to accept referrals for HIV/STI/HCV testing.	3.1.1 100% of clients with an unknown HIV, STI and/or HCV status will be assessed for risk and referred to HIV, STI and/or HCV testing as appropriate. 3.2.1 At least 65% of clients will accept a referral for HIV/STI/HCV testing. 3.3.1 100% of identified HIV/STI/HCV testing providers will accept client linkage/referrals.
4. Increase the # of at-risk clients screened for PrEP or PEP and referred.		4.1 Provide clients with PrEP/PEP information. 4.2 Link high-risk HIV negative clients to prevention services, including PrEP/PEP. 4.3 Establish collaboration agreements with PrEP/PEP prescribers to accept linkage/referrals for PrEP/PEP.	4.1.1 100% of clients not already on PrEP at the time of program enrollment will be screened for PrEP. 4.1.2 100% of clients will receive information on PEP availability. 4.2.1 65% of high-risk HIV negative clients who are screened and identified as eligible for PrEP will be referred to a PrEP prescriber. 4.3.1 100% of identified PrEP/PEP providers will accept client linkage/referrals.

5. Enhance capacity to deliver affirming services to LGBTQ individuals.		5.1 Conduct provider education and training on the provision of culturally affirming services to LGBTQ populations, particularly within communities of color. 5.2 Conduct training topics that include but are not limited to: creating safe environments for LGBTQ clients; offering effective referrals; and provision of competent post-victimization services for LGBTQ individuals that have experienced violence.	5.1.1 Establish a cadre of LGBTQ culturally affirming providers who can offer appropriate services to LGBTQ individuals 5.2.1 Increase knowledge by at least 50% as measured by pre/post knowledge assessments/scales.
6. Increase correct and consistent condom use among those at highest risk.		6.1 Promote and/or distribute condoms during each client level encounter with clients at high risk for HIV/STI/HCV and unintended pregnancy. 6.2 Provide condom education as needed when distributing condoms.	6.1.1 85% of clients living with HIV and at high-risk negative clients will be provided condoms at each client level encounter. 6.2.1 Condom education will be provided to 100% of clients in need of information.
7. Submit timely data reports; narrative reports; and fiscal documents.		7.1 Collect and submit data in accordance with AIDS Institute (AI) protocols. 7.2. Submit timely monthly AIRS extracts to the AI via the Health Commerce System 7.3 Create and submit narrative reports in accordance with AI protocols. 7.4 Create and submit fiscal reports/documents (vouchers, budget modifications, audits) in accordance to AI protocols.	7.1.1 75% of monthly AIRS extracts will be submitted by the established deadline. 7.2.1 100% of data submitted will be up to date (within 30 days). 7.3.1 100% of monthly reports will be submitted by the established deadline. 7.4.1 100% of fiscal reports/documents will be submitted by the established deadlines.
8. Engage in CQI activities for all funded activities.		8.1 Routinely examine agency data using AI reports available through External Reporting Application (ERA); discuss data internally and with your Contract Manager; implement correct action plans to address programmatic and data-related deficiencies. 8.2 Use continuous quality improvement (CQI) activities to guide future programming and make modifications.	8.1.1 Participate in 4 quarterly calls per year with your Contract Manager to review data and assess progress in meeting contractual expectations. 8.2.1 Number and percent of programmatic changes made relative to the number.

			recommended by your contract manager.
9. Ensure funded staff receive appropriate training annually.		9.1 Provide funded staff with appropriate training.	9.1.1 Funded staff will receive 24 hours of training annually.
10. Ensure flexibility in programming.		10.1 Flexibility in programming to ensure that resources are effectively directed to the populations and communities most in need. 10.2 Contract activities and deliverables may be modified at any point in this contract upon direction of the AIDS Institute to address emerging needs or disparities, emerging HIV/STI/HCV epidemiologic patterns, or to accommodate advances in best practice. 10.3 Assist with other priority public health issues if/when they arise (e.g., local STI case increases, outbreaks, emergency situations, etc.). The Contract Manager must approve non-work plan work.	10.1.1 N/A 10.2.1 Aide with non-workplan public health issues if/when they arise. 10.3.1 100% of emerging issues identified will be coordinated as per AIDS Institute guidance.

Attachment 24: Work Plan - Component F
SUMMARY

PROJECT NAME: Capacity Building for High Impact Prevention for Hispanic/ Latino Gay/Men who have Sex with Men (MSM)
CONTRACTOR SFS PAYEE NAME:
CONTRACT PERIOD: From: May 1, 2024 To: April 30, 2029

Project Summary

This initiative will support events that will serve as forums for community-based organizations, policy makers and opinion leaders, local, state, and federal governments, professional groups, medical institutions, academia, faith groups, businesses, and members of the priority population an opportunity to discuss innovative approaches to address health, social and environmental issues that intersect with HIV prevention and care and impact the priority population including health equity, the role of social justice in ending the HIV and Hepatitis C (HCV) epidemics, and core competencies of HIV programming (e.g., PEP and PrEP access). Applicants are expected to provide capacity building and training/technical assistance to providers funded through the AIDS Institute (AI) to serve Hispanic/Latino Gay Men/Men who have Sex with Men (MSM).

The grantee will also engage in individualized/agency-specific technical assistance and capacity building for providers on an as-needed basis with AIDS Institute approval. The capacity building/technical assistance may cover the following areas: organizational development and sustainability, fiscal management, board development, staff recruitment, program development, and data management/evaluation.

In developing, coordinating, and implementing activities, the grantee is required to:

- Work with existing coordinating and community planning bodies such as ETE regional committees, NY Links and New York Knows to plan, promote, and implement events, and leverage resources;
- Establish relationships with other organizations (e.g., academic, faith, health centers/hospitals, prevention and support services, immigration, substance use, behavioral health, housing, employment, etc.) and local health departments to address various domains of wellness for Hispanic/Latino gay men/MSM and help identify innovative strategies to achieve collective impact;
- Use community assets and strengths-based approaches to identify needs and promote access and use of sexual and other health services by Hispanic/Latino gay men/MSM;
- Include Hispanic/Latino gay men /MSM in the planning and evaluation process to gain input and gain a better understanding of barriers, effective strategies, and available resources;
- Foster a spirit of community partnership among members of the priority population (both people living with HIV and those who could benefit from prevention) and the community-based organizations who serve them to achieve positive health outcomes and move closer to health equity;

- Enhance provider capacity to effectively serve Hispanic/Latino gay men/MSM and address cultural competency deficiencies that may prevent this community from accessing prevention and treatment; and
- Offer HIV testing, linkage to care, PEP and PrEP services, Partner Services, and sexual health information and tools (e.g., condoms) during meetings as appropriate. Interventions offered should meet the needs of the participants and must be grounded in anti-racist, anti-stigma, non-discriminatory, culturally affirming, trauma-informed approaches to service delivery. Use technology and social media platforms (e.g., Facebook, Twitter, YouTube, Grindr) to support event promotion, increase general awareness, provide accurate and science-based education and address misinformation. The applicant should consider existing social media efforts to enhance awareness/education. Applicants can develop their own campaign materials but are strongly encouraged to use existing campaign resources (with permission, as appropriate) such as those available from CDC, NYSDOH and NYC Department of Health and Mental Hygiene and tailor them to meet the needs of the priority population and geographic area.

Meetings and individualized agency technical assistance and trainings will offer an opportunity for participants to foster awareness about the priority health issues and concerns affecting Hispanic/Latino gay men/MSM. Meeting topics may include: understanding how disparities/SDOH can result in barriers to prevention/health care access, the role of social justice in ending the HIV and HCV epidemics, the importance of cultural communication, policy updates, the need for workforce development, innovative approaches to HIV programming (e.g., PEP and PrEP resources and access), the value of early diagnosis and treatment of HIV/STI/HCV, the benefits of navigation services, the need for accurate data collection and reporting, and program sustainability.

Instructions: For the Grants Gateway **Work Plan Project Summary**, applicants are instructed to insert the Project Summary as it is listed above. In the Grants Gateway **Work Plan Organizational Capacity** section, applicants are instructed to list this as "not applicable." Any additional Project Summary or Organizational Capacity entered in these areas will not be considered or scored by reviewers of your application.

Funded applicants will be held to the Objective, Tasks and Performance Measures as listed in Attachment 24: Component F Work Plan. Applicants are not required to enter any Objectives, Tasks or Performance Measures into the Grants Gateway Work Plan.

***For Performance measures (1.1.1, 1.2.1, 1.3.1, 2.1.1, 4.1.1, and 4.2.1): *This number will be determined/negotiated once the contract is awarded. The agency's performance will be assessed based on the actual number of performance measures achieved based on the contract deliverables.**

Objective	Tasks (Activities)	Performance Measures
1. Design and implement two (2) capacity building/technical assistance events.	1.1 Work with existing coordinating and community planning bodies such as ETE regional committees, NY Links, New York Knows to plan, promote and implement events, share resources and learn from one another. 1.2 Establish relationships with other organizations, entities, and local health departments to	1.1.1 Number of coordinating and community planning body meetings attended. 1.2.1 Number of relationships/ partnerships established to address various domains of

Objective	Tasks (Activities)	Performance Measures
	address various domains of wellness for the priority population and help identify innovative strategies to achieve collective impact. 1.3 Include members of the priority population in the planning process to gain input on barriers and facilitators to seeking prevention/sexual health services and medical care. 1.4 Foster a spirit of community partnership among members of the priority population and the community-based organizations who serve them to achieve both individual HIV prevention and care goals and Ending the Epidemic goals.	wellness for the priority population and help identify innovative strategies to achieve collective impact. 1.3.1 Number of members from the priority population involved in the planning process. 1.4.1 Partnerships endeavors will focus on activities to reach Ending the Epidemic goals.
2. Make HIV testing, care linkages, PEP/ PrEP info; and PS available.	2.1 Work with partner agencies to ensure participation at events. Partners should offer or facilitate access to direct services at events including HIV and STI testing, linkage to PrEP support program and PrEP prescriber, and linkage to care. 2.2 Make condoms and safer sex supplies available at events.	2.1.1 Number of partner agencies providing HIV and/or STI testing, linkage to care services, PrEP support, and safer sex supplies. 2.2.1 Condoms and safer sex supplies will be made available at all events.
3. Increase correct and consistent condom use in the priority population.	3.1 Promote and/or distribute condoms during community-wide events and related activities. 3.2 Provide condom education as needed when distributing condoms.	3.1.1 85% of members of the priority population are provided with condoms at each community wide event (2 total). 3.2.1 100% of individuals receiving condoms will receive educational information/materials about proper condom use.
4. Enhance provider capacity to effectively serve the priority population.	4.1 Work closely with direct service providers to identify gaps (via needs assessment) and conduct technical assistance to increase their capacity to effectively serve Hispanic/Latino gay men/MSM. 4.2 Collaborate with direct service providers to address cultural competency deficiencies that may prevent the population from accessing	4.1.1 Number of direct service providers that identify gaps and are provided with technical assistance to increase capacity. 4.2.1 Number of collaborations established to address cultural competency deficiencies. Activities may be integrated and be a

Objective	Tasks (Activities)	Performance Measures
	services such as PEP and PrEP, HIV/STI/HCV testing and screening and HIV medical care/treatment.	component part of the Capacity Building/Technical Assistance event (e.g., Workshop on cultural responsibility).
5. Use technology and social media for program promotion and education.	5.1 Use social media to support event promotion, increase awareness, provide accurate and science-based education, and address misinformation. All materials, promotional efforts, and related activities for these events are subject to NYSDOH AI review.	5.1.1 100% of social media use will be for promotion and targeted community education.

Objective	Tasks (Activities)	Performance Measures
6. Submit timely data, narrative, and fiscal reports/documents.	6.1 Collect and submit data and create narrative reports in accordance with Division and AI protocols. 6.2 Submit monthly AIRS extracts to the AIDS Institute via the Health Commerce System. 6.3 Create and submit fiscal reports/documents (e.g., voucher claims, budget modifications, etc.) in accordance with Division/AI protocols and the State Master Contract. 6.4 Monitor contract expenditures quarterly and address underspending accordingly.	6.1.1 100% of monthly AIRS extracts will be submitted by the established deadline. 6.2.1 100% of data and narrative reports submitted will be up to date (within 30 days of last service). 6.3.1 100% of fiscal documents will be submitted by the established deadlines. 6.4.1 100% of contract dollars will be spent annually.
7. Ensure funded staff receive appropriate training annually.	7.1 Provide funded staff with appropriate training.	7.1.1 Funded staff will receive 24 hours of training annually.
8. Address emerging community issues/service gaps.	8.1 Develop and coordinate a rapid response to emerging issues (e.g., new HIV infections, increases in Syphilis) as identified by the AI/NYSDOH and or regional planning bodies. 8.2 Work closely with the AI/NYSDOH to take action on HIV/STI/HCV-related issues for communities not served by targeted funding. Contract manager must approve changes to the scope of work. 8.3 Provide updates to the AI/NYSDOH on actions and outcomes.	8.1.1 100% of emerging issues identified will be addressed by agency. 8.2.1 Action will be taken on HIV/STI/HCV-related issues faced by communities not served by targeted funding. 8.3.1 Updates on activities will be provided to the AI via email/monthly reports.

Objective	Tasks (Activities)	Performance Measures
9. Ensure flexibility in programming.	9.1 Flexibility in programming to ensure that resources are effectively directed to the populations and communities most in need. 9.2 Contract activities and deliverables may be modified at any point in this contract upon direction of the AIDS Institute to address emerging needs or disparities, emerging HIV/STI/HCV epidemiologic patterns, or to accommodate advances in best practice. 9.3 Assist with other priority public health issues if/when they arise (e.g., local STI case increases, outbreaks, emergency situations, etc.). The contract manager must approve non-work plan work.	9.1.1 N/A 9.2.1 Aide with non-workplan public health issues if/when they arise. 9.3.1 100% of emerging issues identified will be coordinated as per AIDS Institute guidance