

**HIV Prevention Request for Applications (RFA)
RFA-18-001**

APPLICATION GUIDELINES

FY 2019

Florida Department of Health

Bureau of Communicable Diseases, HIV/AIDS Section, Prevention Program

August 3, 2018

Pre-Application Teleconference:

Friday, August 17, 2018
2:00 p.m.–4:00 p.m. (EST)

Dial-in Number: 888-670-3525
Participant code: 275 509 0568 #

Application Deadline:

September 4, 2018

THIS GRANT OPPORTUNITY IS NOT SUBJECT TO 120.57 (3) FLORIDA STATUTES

FUNDING ANNOUNCEMENT

The Florida Department of Health, HIV/AIDS Section, Prevention Program, announces the availability of funds for community-based HIV prevention programs and services.

Purpose: This Request for Applications (RFA) seeks to develop new and enhance existing strategies for community-based HIV prevention programs that aim to prevent new HIV infections and achieve viral suppression among persons living with HIV (PLWH) in Florida. Specifically, this RFA supports increasing the proportion of persons who are aware of their HIV status; preventing new HIV transmissions from occurring; engaging with priority populations for the purposes of education and awareness; and improving health outcomes for PLWH through achieving and sustaining viral suppression, and reducing health-related disparities by using a data driven approach for HIV prevention programs.

Eligibility: Non-profit entities with a 501(c)(3) designation

Estimated Funds Available: Approximately \$10 million

Anticipated Number of Awards: The number of awards will vary by Category and HIV/AIDS Service Area

Range of Awards: The initial amount of an award, per applicant, may vary. The maximum of each award is based on the ceiling funding level for each HIV/AIDS Service Area; however, the maximum award may not exceed \$400,000 for any one applicant. Budgets must be justified by proposal activities.

Type of Award: Grant

Budget Period: Twelve Months

Program Period: January 1, 2019–December 31, 2021

TABLE OF CONTENTS

Section 1.0 INTRODUCTION	5
1.1 Definitions	6
1.2 Program Authority.....	14
1.3 Notice and Disclaimer	14
1.4 Program Purpose	14
1.5 Available Funding	15
1.6 Matching Funds	16
Section 2.0 PROGRAM OVERVIEW.....	16
2.1 Background	16
2.2 Priority Populations.....	20
2.3 Program Expectations.....	24
2.4 Project Requirements	28
2.5 Current and Prior Funded Projects	35
Section 3.0 TERMS AND CONDITIONS OF SUPPORT.....	35
3.1 Eligible Applicants	35
3.2 Eligibility Criteria.....	36
3.3 Funding Period	36
3.4 Grant Renewals and Amendments	36
3.5 Use of Grant Funds.....	37
3.6 Invoicing and Payment of Invoice.....	40
Section 4.0 APPLICATION PREPARATION GUIDELINES	40
4.1 Application Content	40
4.2 Instructions for Formatting Applications	40
4.3 Order of Application Package	41
4.4 Cover Page	42
4.5 Table of Contents	42
4.6 Project Summary	42
4.7 Project Narrative.....	42
4.8 Proposed Budget Summary and Budget Justification Narrative	42

Section 5.0	REQUIRED CONTENT OF THE PROJECT NARRATIVE	43
5.1	Statement of Need	43
5.2	Organizational Capacity and Staffing	44
5.3	Program Proposal	44
5.4	Collaborations	44
5.5	Evaluation Plan.....	45
5.6	Work Plan.....	45
5.7	Appendices	45
Section 6.0	SUBMISSION OF APPLICATION	46
6.1	Application Deadline.....	46
6.2	Submission Methods	46
6.3	Authorized Signatory	46
Section 7.0	EVALUATION OF APPLICATONS	47
7.1	Receipt of Applications	47
7.2	How Applications are Scored	47
7.3	Grant Awards	50
7.4	Award Criteria.....	50
Section 8.0	REPORTING AND OTHER REQUIREMENTS	51
8.1	Post Award Requirements	51
8.2	Standard Contract	51
Section 9.0	REFERENCES.....	52

ATTACHMENTS

Attachment 1.....	54
Attachment 2.....	57
Attachment 3.....	59
Attachment 4.....	60
Attachment 5.....	61
Attachment 6.....	63
Attachment 7.....	64
Attachment 8.....	65
Attachment 9.....	67
Attachment 10.....	69

RFA TIMELINE

Schedule	Due Date	Location
Request for Applications released	Friday, August 3, 2018	Department of Health Grant Funding Opportunities Website http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/grant-funding-opportunities/index.html
Questions submitted via e-mail	Prior to 4:00 p.m. (EST), Friday, August 10, 2018	Submit to: Florida Department of Health HIV/AIDS Section, Prevention Program E-mail: Arlene.Manuel@flhealth.gov
Applicant conference call to answer questions	2:00 p.m.–4:00 p.m. (EST), Friday, August 17, 2018	The dial-in number is 1-888-670-3525. At the prompt, enter the following conference code: 275 509 0568#
Written answers to questions placed on website	On or before Thursday, August 23, 2018	Department of Health Grant Funding Opportunities Website http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/grant-funding-opportunities/index.html
Applications due	No later than 4:00 p.m. (EST), Tuesday, September 4, 2018	<u>Mailing Address:</u> Florida Department of Health Office of Contracts 4052 Bald Cypress Way, Bin B-08 Tallahassee, FL 32399-1715 <u>Physical Address:</u> Florida Department of Health Office of Contracts Attention: Janice Howard 4052 Bald Cypress Way, Front Desk Tallahassee, FL 32399
Anticipated negotiations begin	October 8, 2018	Negotiations and budget revisions for awards begin
Anticipated award date	December 3, 2018	Department of Health Grant Funding Opportunities Website http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/grant-funding-opportunities/index.html
Anticipated contract start date	January 1, 2019	

Section 1.0 INTRODUCTION

1.1 Definitions

Applicant: Entity applying for funding.

Awardee: Successful Applicant

Budget Period: The duration of each individual funding period within the project period. Traditionally, budget periods are 12 months or 1 year.

Contract Manager: A Department of Health employee designated to be responsible for enforcing the performance of contract terms and conditions and serving as a liaison with the provider for each contractual service contract, pursuant to section 287.057(14), Florida Statutes.

Department: The Florida Department of Health.

Effective: Demonstrating the desired effect when widely used in practice or under real-world conditions that are considerably less rigorous and controlled, rather than in environments that test efficacy but are still designed to ensure that the desired effect can be attributed to the intervention in question.

Evaluation: The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The RFA evaluation plan is used to describe how the awardee and/or the Department will determine whether activities are implemented appropriately and outcomes are achieved.

Grant Application: An application submitted by an entity to the Department in response to a Request for Application (RFA) for funding a project.

Grants: Financial assistance transferred, pursuant to written agreements between federal or state agencies and recipients, to carry out a public purpose.

HIV/AIDS Section: The organizational unit within the Department which will process grant awards to applicants.

Letter of Support: A letter from another organization, partner, or stakeholder stating their support for the proposed project.

Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA): Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

Performance measurement: Addresses the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A “program” may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

Service Area: The area in which the applicant’s services will be made available.

Work Plan: The summary of project period outcomes, objectives, strategies and activities, personnel and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

Program-Specific Definitions

Acquired Immunodeficiency Syndrome (AIDS): A condition that exists when a person has tested positive for HIV and has one or more of 26 listed opportunistic illnesses/infections and/or a T-cell count of 200 or less per micro-liter of blood.

Antiretroviral Treatment and Access to Services(ARTAS): This is a linkage intervention for case management based on the strengths and abilities of the client. The client has a maximum of five face-to-face contacts with the ARTAS Care Coordinator, with the ultimate goal of learning to independently navigate the medical care system.

Behavioral Interventions: The use of behavioral approaches designed to moderate intra- and interpersonal factors to prevent acquisition and transmission of HIV infection.

Biomedical Interventions: The use of medical, clinical, and public health approaches designed to moderate biological and physiological factors to prevent HIV infection, reduce susceptibility to HIV, and/or decrease HIV infectiousness (e.g., PrEP, nPEP).

Business Responds to AIDS (BRTA): Modeled after the CDC initiative by the same name, developed initially in 1992, BRTA programs support targeted HIV prevention efforts through partnerships with local businesses. BRTA programs mobilize businesses and labor organizations to respond to HIV/AIDS in the workplace and the community with subtle, noninvasive approaches to raise awareness, promote services, and break down stigma. BRTA activities involve the use of promotional and incentive items that businesses can use to generate conversations around HIV/AIDS with their customers.

Capacity Building: Activities that strengthen the core competencies of an organization and contribute to its ability to develop and implement an effective HIV prevention intervention and sustain the infrastructure and resource base necessary to support and maintain the intervention.

Community-Based Organization: A non-profit organization with a 501(c)(3) designation.

Community Mobilization: A process through which action is stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community’s individuals, groups, and organizations on a participatory and sustained basis to improve the health, hygiene and education levels so as to enhance the overall standard of living in the community.

Comprehensive HIV Prevention Plan: A plan that identifies prioritized target populations and describes what interventions will best meet the needs of each prioritized target population. The primary task of the

community planning process is developing a comprehensive HIV prevention plan through a participatory, science-based planning process. The contents of the plan are described in the HIV Prevention Planning Guidance, and key information necessary to develop the comprehensive HIV prevention plan is found in the epidemiologic profile and the community services assessment.

Condom Distribution: The means by which condoms are transferred, disseminated, or delivered from a community resource (e.g., health department, community-based organization, or health care organization).

Confidentiality: Ensuring that information is accessible only to those authorized to have access.

Confirmatory Testing: Additional testing performed to verify the results of an earlier (screening) test. For HIV diagnosis, a Western blot or, less commonly, an immunofluorescence assay (IFA) are typically used, though additional more sensitive tests may also be considered.

Coordination: Aligning processes, services, or systems to achieve increased efficiencies, benefits, or improved outcomes. Examples of coordination may include sharing information, such as progress reports, with state and local health offices or structuring prevention delivery systems to reduce duplication of effort.

Center for Disease Control and Prevention (CDC): A federal agency within the United States Department of Health and Human Services established to protect public health and safety through the control and prevention of disease.

Collaboration: Working with another person, organization, or group for mutual benefit by exchanging information, sharing resources, or enhancing the other's capacity, often to achieve a common goal or purpose.

Counseling, Testing and Linkage (CTL): Provision of counseling, testing and direct assistance in getting a client enrolled into the health and social service system.

Culturally Appropriate: Conforming to a culture's acceptable expressions and standards of behavior and thought. Interventions and educational materials are more likely to be culturally appropriate when representatives of the intended target audience are involved in planning, developing, and pilot testing them.

Epidemic: The occurrence of cases of an illness, specific health-related behavior, or other health-related events in a community or region in excess of normal expectancy.

Essential Support Services: Services designed to improve engagement in HIV prevention or care and improved health outcomes. Essential support services could include: Mental health counseling and services; substance abuse treatment and services; housing; transportation services (to and from HIV prevention and essential support services and HIV medical care appointments); employment services; basic education continuation and completion services; violence prevention services; educational services for hormone replacement therapy and sex reassignment procedures.

Ethnicity: The cultural characteristics that connect a particular group or groups of people to each other, such as people of Hispanic or Latinx origin.

EvaluationWeb: A web-based data collection system used by CDC to collect National HIV Prevention Program Monitoring and Evaluation data from CDC-funded community-based organizations and health departments.

Evidence-Based: Behavioral, social, and structural interventions relevant to HIV risk reduction that have been tested using a methodologically rigorous design, and have been shown to be effective in a research setting. These evidence-based (or science-based) interventions have been evaluated using behavioral or health outcomes; have been compared to a control/comparison group(s) (or pre-post data without a comparison group); had no apparent bias when assigning persons to intervention or control groups or were adjusted for any assignment bias; and produced significantly greater positive results when compared to the control/comparison group(s), while not producing adverse consequences.

Faith-Based Organization: A non-governmental agency owned by religiously affiliated entities such as (1) individual churches, mosques, synagogues, temples, or other places of worship or (2) a network or coalition of churches, mosques, synagogues, temples, or other places of worship.

Faith Responds to AIDS (FRTA): Built on the same framework as BRTA, FRTA is a Florida adaptation of the BRTA initiative but for faith-based organizations. FRTA programs are faith-based initiatives that mobilize churches and other faith-based institutions to raise awareness and reduce stigma around HIV/AIDS. FRTA programs are particularly effective at reaching minority communities. FRTA activities involve the use of promotional and incentive items that faith-based organizations can use to generate conversations around HIV/AIDS with their members.

Health Disparity: A particular type of health difference that is closely linked with social or economic disadvantage.

Health Education and Risk Reduction: Organized efforts to reach people at increased risk for becoming HIV infected or, if already infected, of transmitting the virus to others. The goal is to reduce the spread of infection. Activities range from individual HIV prevention counseling to broad, community-based interventions.

Health Equity: The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

High-Impact Prevention (HIP): Using combinations of scientifically-proven, cost-effective and scalable interventions targeted towards the highest risk populations in the right geographic areas to reduce new HIV infections.

Human Immunodeficiency Virus (HIV): The retrovirus virus can lead to AIDS, if not treated. The virus occurs in two types—HIV-1 and HIV-2. Both types are transmitted through direct contact (e.g., through sexual intercourse or sharing injection drug equipment) with HIV-infected body fluids, such as blood, semen, and genital secretions, or from an HIV-positive mother to her child during pregnancy, birth, or breastfeeding. can lead to AIDS, if not treated.

HIV Prevention Counseling: An interactive process between client and counselor aimed at reducing risky sex and drug injection behaviors related to HIV acquisition or transmission.

HIV Risk Behaviors: Specific behaviors or actions that increase a person's risk of acquiring or transmitting HIV. This includes unprotected anal or vaginal sex with a person living with HIV, injecting drugs with non-sterile, shared drug injection equipment, unprotected anal or vaginal sex in exchange for money or drugs, unprotected anal or vaginal sex with more than one sex partner since their most recent negative HIV test, having a sexually transmitted disease (STD), and unprotected anal or vaginal sex with anyone who had any of these risks.

HIV Risk Factors: Behaviors, activities and/or circumstances that may contribute to one's risk for acquiring HIV. Examples include substance abuse/use, poverty, mental health, low self-efficacy and esteem, and economic dependency.

HIV Testing Strategy: The approach an agency or a person uses when conducting HIV testing to decide who will be tested. Testing strategies include HIV screening that is population-based and targeted testing of subpopulations of persons at higher risk.

Incentive: A type of reward (e.g., food coupons or transportation vouchers) given to encourage healthy lifestyles, disease prevention behaviors, and/or patient compliance with medical treatment. If using food coupons, the monetary value cannot exceed per diem meal allowances each day per section 112.061(12), Florida Statutes.

Incidence: The number of new cases in a defined population within a certain time period (often a year). It is important to understand the difference between HIV incidence, which refers to new HIV infections, and new HIV diagnosis. New HIV diagnosis is a person who is newly diagnosed as HIV-infected, usually through HIV testing. These persons may have been infected recently or at some time in the past. *see also Prevalence*

Integrated Partner Services: An agreement between a county health department and a community-based organization to ensure that a disease intervention specialist (DIS) is readily available to provide partner services and linkages for those found to be HIV infected. This might include having a DIS embedded in the agency or having an on-call type arrangement with the DIS.

Internet/Virtual Outreach: A virtual interaction between an HIV prevention professional, such as an outreach worker, and a person or persons at risk for HIV for the purposes of providing HIV related health information and education, referrals and linkage to services, recruitment for testing and treatment, and support for reducing risk behaviors.

Intervention: A specific activity (or set of related activities) intended to reduce the risk of HIV transmission or acquisition. Interventions may be either biomedical or behavioral and have distinct process and outcome objectives and protocols outlining the steps for implementation.

Linkage: Actively assisting clients with accessing needed services through a time-limited professional relationship. The active assistance typically lasts a few days to a few weeks and includes a follow-up component to assess whether linkage has occurred. Linkage services can include assessment, supportive counseling, education, advocacy, and accompanying clients to initial appointments.

Linkage to Medical Care: This occurs when a patient is seen by a health care provider (e.g., physician, a physician's assistant, or nurse practitioner) to receive medical care for their HIV infection, usually within a specified time frame (i.e., 30 days for all newly diagnosed individuals). Linkage to medical care can

include specific referral to care service immediately after diagnosis and follow up until the person is linked to long-term case management.

Locally-Developed Intervention: An intervention that has been developed by a community for the community; a locally-developed intervention is driven by members (or organizations) of that community and is the result of a grass-roots effort. Locally-developed interventions must show minimal evidence of effectiveness within the specified target population in order to be implemented.

Logic Model: A visual representation showing the sequence of related events connecting the activities of a program with the program's desired outcomes and results.

Medication Adherence: The extent to which patients take their medication as prescribed by their doctors.

Men who have Sex with Men (MSM): Men who report sexual contact with other men and men who report sexual contact with both men and women (i.e., bisexual contact), whether or not they identify as gay.

Minority Organization: A minority-owned organization is a non-profit enterprise, regardless of size, physically located in the state of Florida, which is owned, operated, and controlled by racial/ethnic minority group members. Minority group members are United States citizens who are black, Hispanic, Asian, Native American, or Alaskan Native. Ownership by minority individuals means the business is at least 51% owned by such individuals, board of directors, or, in the case of a publicly-owned business, at least 51% of the stock is owned by one or more such individuals. Further, the management and daily operations are controlled by those minority group members.

Mobilization: *see Community Mobilization*

National HIV/AIDS Strategy for the United States: Updated to 2020 (NHAS): A comprehensive plan focused on reducing HIV incidence, increasing access to care and optimizing health outcomes, and reducing HIV-related health disparities.

Navigation Services: Patient navigation assistance is the process of helping a person obtain timely and appropriate medical or social services, given provider preferences, insurance status, scheduling issues, and other factors that may complicate access or utilization of services.

Navigator: Patient navigators are peers, volunteers, and staff members of clinics, health departments, and community-based organizations. Patient navigators may be lay persons, paraprofessionals, or medical professionals.

Non-Occupational Post-Exposure Prophylaxis (nPEP): *see Post-Exposure Prophylaxis (PEP)*

Non-profit Organization: Any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized for profit; and uses net proceeds to maintain, improve, or expand the operations of the organization. Nonprofit organizations include institutions of higher educations, hospitals, and tribal organizations (that is, Indian entities other than federally recognized Indian tribal governments).

Outcome: The results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, increased HIV testing, reduced morbidity and mortality.

Outreach: A process of engaging face-to-face with high-risk individuals in their own neighborhoods or venues where they typically congregate to provide HIV related testing and treatment, health information and education, referrals and linkage to services, and recruitment for other prevention interventions and/or services. Outreach is often conducted by peers, paraprofessional educators, and/or community health workers.

Partner Services: A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can be offered HIV testing and learn their status or, if already infected, prevent transmission to others. Partner Services helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Peers: Specially trained individuals from the community who are living with HIV/AIDS. As members of the health care team, peers promote treatment adherence and foster trust in the health care system.

Perinatal: Occurring during the period around birth (5 months before and 1 month after)

Post-Exposure Prophylaxis (PEP): The provision of antiretroviral medications to prevent transmission of HIV following an occupational or non-occupational exposure. Non-occupational post-exposure prophylaxis is referred to as nPEP.

Pre-Exposure Prophylaxis (PrEP): A once-daily pill, taken orally, in conjunction with prevention strategies to reduce the risk of acquiring HIV infection.

Prevalence: The total number of cases of a disease in a given population at a particular point in time. HIV/AIDS prevalence refers to persons living with HIV, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk that an individual will have a disease at a point in time. *see also Incidence*

Prevention Services: Any service or intervention directly aimed at reducing risk for transmitting or acquiring HIV infection (e.g., prevention counseling, behavioral interventions, risk reduction counseling, substance abuse and mental health services, and other services focused on social determinants of health). The goal is to provide a comprehensive health service to clients to reduce their risk of transmitting or

Previously Diagnosed HIV Infection: HIV infection in a person who meets either of the following criteria: 1) self-reports having previously tested HIV positive; or 2) has been previously reported to the health department's surveillance registry as being HIV positive.

Primary Medical Care (for HIV-negative persons at increased risk of acquiring HIV): Routine outpatient care that a patient receives at first contact with a health care provider.

Priority Populations: The primary groups of people or organizations that a program, strategy, or intervention is designed to affect.

Promotional Item: An item provided to members of a priority population which contains a health promotion message (e.g., hats, water bottles, T-shirts, etc.).

Rapid HIV Test: A point-of-care HIV screening test used in both clinical and non-clinical settings, usually with blood from a finger stick or with oral fluid.

Referral: Directing clients to a service in person or through telephone, written, or other form of communication. Generally, a one-time event. Referral may be made formally from one clinical provider to another, within a case management system by professional case managers, informally through support staff, or as part of an outreach services program.

Serostatus: Status with respect to being seropositive or seronegative for a particular antibody (the HIV antibody).

SMART: Specific, Measurable, Attainable, Relevant, and Time-Bound Objectives- Specific and quantifiable targets that measure the overall accomplishment of a goal over a specified period of time. They should describe actions that are distinct, able to be documented or quantified, feasible to execute, realistic to accomplish in the specified time frame and be linked to time-based milestones.

Social Determinants: The economic and social conditions that influence the health of persons, communities, and jurisdictions and include conditions for early childhood development; education, employment, and work; food security; health services; housing; income; and social exclusion.

Social Marketing: Social marketing applies to a wide range of commercial marketing strategies to promote public health. Strategies include those based on mass media; mediated (for example, through a healthcare provider), interpersonal, and other modes of communication; and marketing methods such as message placement (for example, in clinics), promotion, dissemination, and community level outreach.

Social Media: forms of electronic communication (such as websites for social networking and microblogging) through which users create online communities to share information, ideas, personal messages, and other content (such as videos).

Social Network: A map of the relationships between persons, indicating the ways in which they are connected through various social familiarities, ranging from casual acquaintance to close familial bonds. A collection of individuals and the links among, or ties between, them.

Social Networking Strategy (SNS): A recruitment strategy whereby public health services are disseminated through the community by taking advantage of the social networks of persons who are members of the community. The strategy is based on the notion that individuals are linked together to form large social networks, and that infectious diseases, and behaviors, often spread through these networks.

Structural interventions: Target factors outside the control of a single individual that impedes or facilitates personal efforts to avoid HIV infection (e.g., social, physical, cultural, economic, policy, etc.).

Surveillance: The ongoing and systematic collection, analysis, and interpretation of data about occurrences of a disease or health condition.

Technical Assistance: Advice, assistance, or training pertaining to program development, implementation, maintenance, or evaluation that is provided by the funding agency.

Test and Treat Program: A program that provides immediate linkage to HIV care and initiation of antiretroviral therapy (ART) at the time of HIV diagnosis and/or those patients with an HIV infection who have experienced a gap in treatment and are being re-engaged on ART.

Testing Together: A public health strategy for HIV testing in which two or more persons who are in, or are planning to be in a sexual relationship, receive HIV testing services together (including their HIV test results).

Transmission Risk: A behavior that places the priority population at potential risk for HIV infection or transmission.

1.2 Program Authority

The HIV Prevention Program is authorized by sections 381.003, 381.0038, 381.004, 381.0045, 381.0046, 384.31, and 402.41, Florida Statutes and Florida Administrative Code Rules 64D-2.002–2.006, and 3.042.

1.3 Notice and Disclaimer

Grant awards will be determined by the Department at its sole discretion based on the availability of funds and the quality of the application. The Department reserves the right to offer grant awards for less than the amount requested by applicants if deemed in the best interest of the state of Florida and the Department. The receipt of proposals in response to this publication does not imply or guarantee that any one or all proposals will be awarded a grant. The Department reserves the right to reject any and all applications. **Additionally, the Department reserves the right to negotiate services and funding with applicants prior to the final offer of the grant award.** See the timeline for when these negotiations will take place.

1.4 Program Purpose

The *National HIV/AIDS Strategy (NHAS) for the United States: Updated to 2020* (<http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/nhas.pdf>) is a comprehensive strategy that provides a roadmap for addressing HIV/AIDS in the United States. The strategy is intended to refocus existing HIV/AIDS prevention, care, and treatment efforts and deliver better results. The strategy outlines three goals: 1) reducing new HIV infections; 2) increasing access to care and improving health outcomes for people living with HIV/AIDS; and 3) reducing HIV-related health disparities. Since 2012, the CDC has pursued a high-impact prevention (HIP) approach to address HIV (http://www.cdc.gov/hiv/strategy/dhap/pdf/nhas_booklet.pdf) to maximize the effectiveness and reach of current HIV prevention efforts. The HIP approach is based on using combinations of scientifically proven, cost-effective, and scalable interventions and strategies targeted to priority populations in the right geographic areas to effect greater impact in reducing new HIV infections. The Department began implementing HIP programs and services in 2012 and since that time, has increased integration of HIV prevention, care, and surveillance activities to better address primary and secondary HIV prevention needs among Florida's priority populations.

To advance the prevention goals of the *National HIV/AIDS Strategy for the United States: Updated to 2020* and CDC's HIP approach, this RFA seeks to develop new and enhance existing strategies for community-based HIV prevention programs that aim to prevent new HIV infections and achieve viral suppression among persons living with HIV (PLWH) in Florida. Specifically, this RFA supports improving health outcomes for PLWH through sustaining viral suppression, and reducing health-related disparities by using a data driven approach for HIV prevention programs.

1.5 Available Funding

Annually, approximately \$10,000,000 in federal funds is available for high-impact HIV prevention projects. The number of grant awards will depend upon the amount of funds available and the number and quality of applications received. Subject to future availability of funds, there may be up to a 50% increase in individual funding amounts during the funding period to enhance high-impact HIV prevention projects. Applicants not initially funded that score high enough to be funded may be funded if additional money becomes available during the three-year funding period. The Department reserves the right to increase or reduce funding amounts for grants(s) resulting from this RFA.

To ensure that HIV prevention funding follows the epidemic, funds will be allocated by area based on the relative share of HIV-infected persons diagnosed, reported, or living in the area. The following table shows the distribution of funding by HIV/AIDS service region or area. See **Attachment 10** for Florida’s HIV/AIDS service area map. Anticipated funding levels to support HIV prevention programs are based on the proportionate share of each area to the number of people living with diagnosed HIV infection in 2016. A similar methodology (using year-end 2014 data) was used by CDC to calculate funding levels for all jurisdictions receiving funds from CDC PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments. The Department uses a formula that takes into account the proportion of persons living with HIV/AIDS (PLWHA), by county and area, as of year-end 2016. The distribution of funding was examined to identify areas which, under a strict proportionate funding approach, would receive less than the pre-determined floor of \$125,000. Two areas did not have a large enough share of the epidemic to reach the floor amount, so those amounts were raised to \$125,000. To review the data which support the funding allocations to each area, please see **Attachment 1: HIV Prevention Funding Allocation Detail**.

Table 1. HIV Prevention Funding Allocations by HIV/AIDS Service Area

Area	Annual Funding Allocation
1	\$186,000
2A	\$125,000
2B	\$176,000
3/13	\$390,000
4	\$640,000
5	\$506,000
6	\$755,000
7	\$1,150,000
8	\$430,000
9	\$740,000
10	\$1,775,000
11A	\$2,375,000
11B	\$125,000
12	\$175,000
14	\$236,000
15	\$216,000
Approximate Funds Available	\$10,000,000

*Minimum funding level for any area is \$125,000

Table 2. Available HIV Prevention Funding by Category

RFA Service Category	Total Funding Available (Annual)	Approximate Funding Ranges (Annual)	Anticipated Number of Awards
1. Community Outreach, Engagement, and Education	\$600,000	\$50,000–\$100,000	6–10
2. HIV Testing and Linkage to Prevention and Care Services	\$2 million	\$75,000–\$150,000	15–20
3. Comprehensive HIV Prevention Services	\$7.4 million	\$100,000–\$400,000	25–30

1.6 Matching Funds

There is no matching requirement.

Section 2.0 PROGRAM OVERVIEW

2.1 Background

The Department’s mission is to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts. Florida’s population in 2016 reached 20.2 million, (3rd in the Nation). Florida has a diverse population, substantial HIV/AIDS morbidity, and unique issues with respect to HIV/AIDS surveillance and prevention. A total of 114,772 persons were living with HIV in Florida through 2016, plus an additional estimate of 21,200 (15.6 percent, based on the CDC’s methodology for Florida’s population) who are unaware of their infection.

The Department has developed a Four Key Component Plan to eliminate HIV transmission and reduce HIV-related deaths which includes the following strategies:

- 1) Implement routine HIV and STD screening in health care settings and priority testing in non-health care settings;
- 2) Provide HIV testing, rapid access to treatment, and ensure retention in care (Test and Treat);
- 3) Improve access to antiretroviral pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP); and,
- 4) Increase HIV awareness and community response through outreach, engagement, and messaging.

In 2016, 4,972 persons were diagnosed with HIV, a six percent increase from 2015 and an eight percent increase since 2014. In 2016, 78 percent of the newly HIV diagnosed cases were male; this is up from 71 percent in 2007, but stable at 78 percent since 2014. By race and ethnicity, 42 percent were black, (down from 44 percent in 2014), 31 percent were Hispanic (up from 26 percent in 2014), and 24 percent were white (down from 26 percent in 2014). By age at HIV diagnosis, 35 percent were between the ages of 13-29, 44 percent were aged 30-49, and 21 percent were over the age of fifty. The majority (57%) of newly diagnosed HIV cases were men who have sex with men (MSM) (up from 56 percent in 2014), nearly one-third (30%) were heterosexual (down from 31 percent in 2014), and three percent were injecting drug users (IDU) (down from 4 percent in 2014).

Most of the counties in Florida (41 of 67) saw an increase in the number of newly diagnosed HIV cases from 2015 to 2016. An annual decrease was observed in three of the seven largest reporting counties:

Hillsborough (-1.8%); Pinellas (-4.4%); and Miami-Dade (-5.5%). The remaining four counties had an increase: Duval (4.4%); Palm Beach (8.1%); Orange (9.0%); and Broward (20.3%). From 2014 to 2016, five of the seven counties (Broward, Duval, Hillsborough, Miami-Dade, and Orange) saw the largest increase in new cases among Hispanics, compared to other race and ethnicity groups. Palm Beach saw the highest increase among blacks, whereas Pinellas saw the highest increase among whites. All seven counties saw increases among MSM cases over the three-year period, however, Duval and Pinellas had the highest increase among IDU (33 percent and 31 percent, respectively). Heterosexual contact increased in four of the seven counties (Broward, Duval, Miami-Dade, and Orange). In 2016, there were eight known perinatal infections born in Florida, down from nine in 2015.

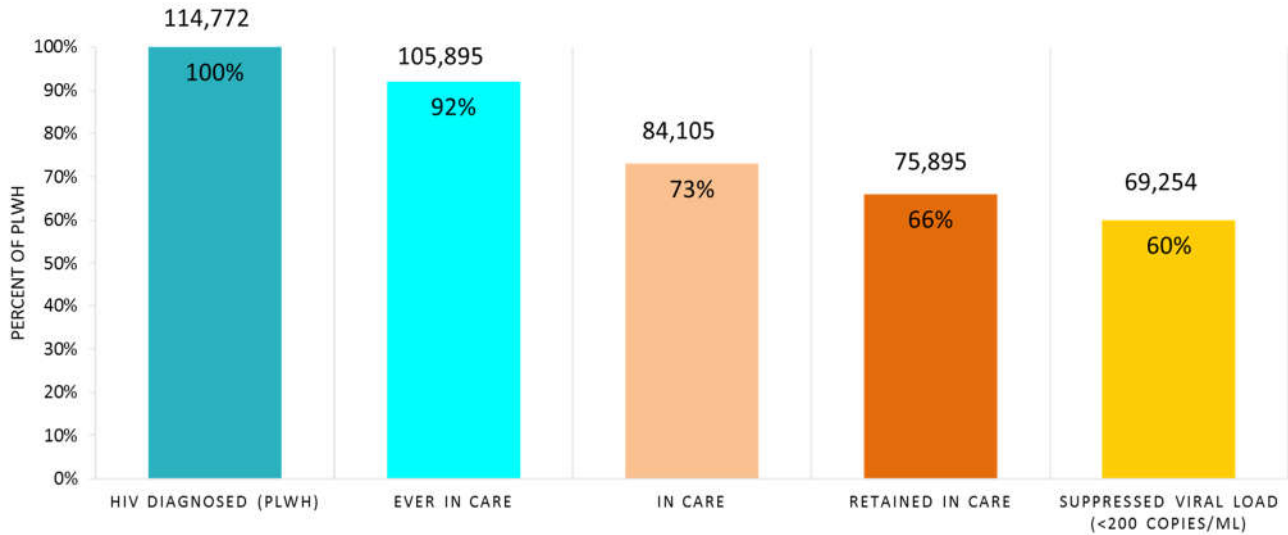
Statewide and local area epidemiological reports which depict ten-year and recent year trends are generated annually. These data are widely disseminated and used for targeted HIV testing and HIV programs and services, with an emphasis on preventing new infections and ensuring that comprehensive services promoting linkage to and re-engagement in HIV medical care are made available to all persons with a diagnosed HIV infection.

To reduce new HIV infections in Florida, it is critical to ensure that everyone with HIV is aware of their infection, linked to and retained in HIV medical care, and maintains viral suppression. Collaborative efforts from prevention and patient care programs at the state, and local efforts, including Local Health Offices, Ryan White (RW) Part A, C, and D partners, community-based organizations (CBOs), and health care providers are an integral part toward accomplishing this agenda. Of the 4,972 persons diagnosed with HIV in 2016, 85 percent were linked to care within three months (up from 83 percent in 2015). Of the 114,772 persons with a diagnosis of HIV and living in Florida through 2016, 73 percent engaged in care in 2016 at least once (same as in 2015), 66 percent were retained in care two or more times, at least three months apart in 2016, (same as in 2015), and 60 percent had evidence of viral suppression (up from 59 percent in 2015). Of those in care, 82 percent were virally suppressed and of those retained in care, 86 percent were virally suppressed.

The HIV Care Continuum provides a framework that depicts the series of stages a person with HIV engages in, from initial diagnosis through successful viral suppression. The HIV Care Continuum has five main “steps” or stages including: HIV diagnosis, linkage to care, retention in care, antiretroviral use, and viral suppression. It demonstrates the proportion of individuals living with HIV who are engaged at each stage. This model is used by federal, state, and local agencies to identify issues and opportunities related to improving the delivery of services to PLWH across the entire continuum.

Florida’s HIV Care Continuum (diagnosis-based model) allows Florida to display each step of the continuum as a percentage of the number of PLWH who have been diagnosed. The Florida model, like the federal and other models, represent persons living in Florida (regardless of where they were diagnosed) at the end of the current year being measured. The diagnosis-based continuum directs steps that can be taken to get individuals with HIV into care and virally suppressed (<200 copies/ml).

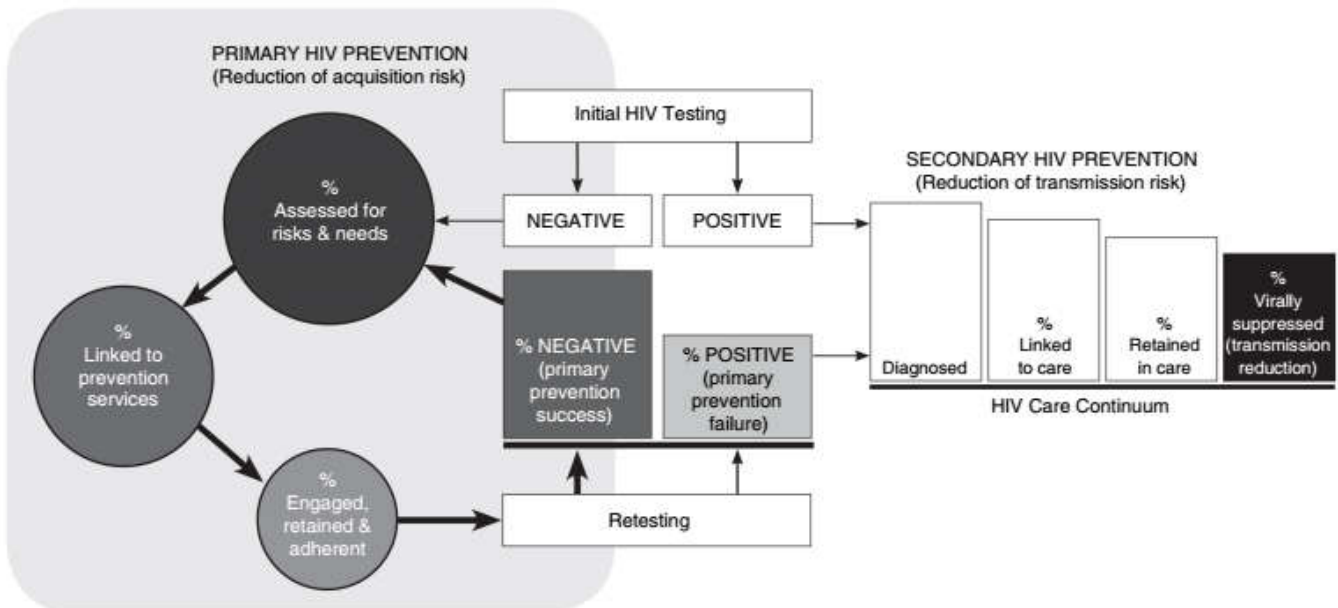
Figure 1. Florida’s diagnosis-based HIV Care Continuum for 2016



Source: Florida Department of Health, HIV/AIDS Section, Data as of 6/30/2017

HIV testing is the entry point in the HIV prevention cycle, as it generally provides a critical point of contact with the health care and service delivery systems for individuals who are HIV negative but are vulnerable to the infection, as well as being a gateway to treatment for people diagnosed with HIV.⁴ Below is a diagram illustrating the interplay between processes to halt both the acquisition and transmission of HIV. The primary HIV prevention cycle begins with HIV testing. Risk and needs assessments, linkage to prevention and support services, engagement in risk reduction prevention interventions and HIV testing are repeated for as long as an individual remains at risk for HIV acquisition.⁴

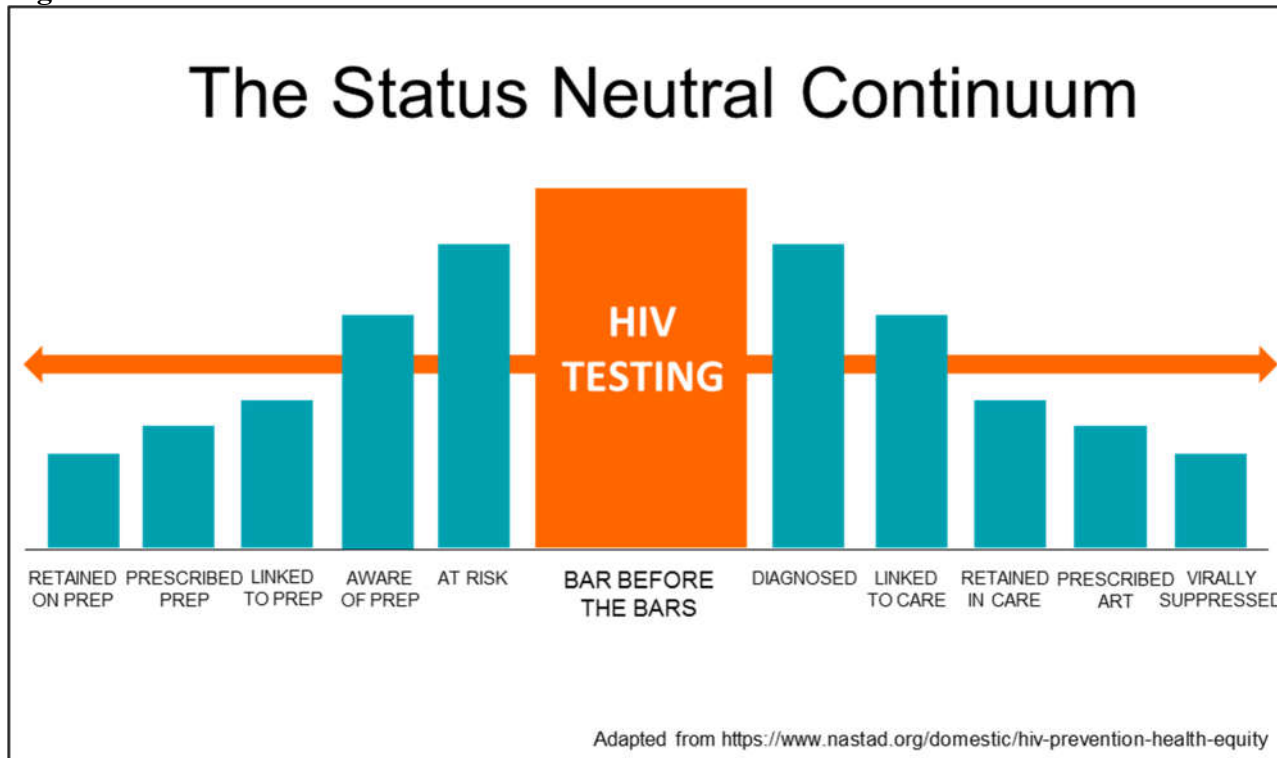
Figure 2. Comprehensive HIV Prevention Continuum



Source: Horn et al. *Journal of the International AIDS Society* 2016, 19:21263

Another depiction of an HIV prevention or status neutral continuum is below and also depicts two different pathways for individuals who are at risk for HIV acquisition (to the left of HIV testing) and those who are HIV positive (to the right of HIV testing), with the goal of having people retained on PrEP or retained in HIV treatment and therefore, virally suppressed.

Figure 3. The Status Neutral Continuum



Source: Hyman Scott, MD MPH, San Francisco Department of Public Health, CROI 2018

Integrated HIV Planning: In Florida, HIV planning is multi-faceted and conducted at the state and local level, with local planning bodies and representatives feeding information into the larger, statewide body—the Florida Comprehensive Planning Network, specifically the Patient Care and Prevention Planning Group. Florida’s statewide planning body became fully integrated in 2017. Within these groups are representatives from all parts of the RW Program, prevention providers, FQHCs, state and local government, academia, private sector, industry partners, service providers, health care professionals, substance abuse and mental health providers, consumers, and advocates. Florida’s *Statewide Integrated HIV Prevention and Care Plan, 2017–2021* (http://www.floridahealth.gov/diseases-and-conditions/aids/prevention/documents/State-of-Florida-Integrated-HIV-Prevention-and-Care-Plan-09-29-16_FINAL-Combined.pdf) was developed in late 2016 and sets statewide objectives for reducing new HIV infections, improving health outcomes for persons living with HIV, and addressing health disparities.⁵ Strategies and activities for HIV prevention and care are outlined under each objective. Priority populations for both primary and secondary prevention, as determined by the state’s priority population setting methodology, are contained within the plan. The Department seeks to advance the overarching statewide objectives for Florida’s Integrated HIV Prevention and Care Plan with this funding opportunity, as follows:

NHAS Goal 1: Reducing new HIV infections

Objective 1.1. By December 31, 2021, increase the proportion of HIV-infected persons who know their serostatus from 87.2 percent (2015) to at least 90 percent.

Objective 1.2. By December 31, 2021, reduce the annual number of newly diagnosed HIV infections in Florida from 4,613 (2014) to 4,004.

Objective 1.3. By December 31, 2021, reduce the annual number of HIV-infected babies born in Florida from 6 (2014) to less than 4.

NHAS Goal 2: Increasing access to care and improving health outcomes for persons living with HIV (PLWH)

Objective 2.1. By December 31, 2021, reduce the number of HIV-related resident deaths from 878 (2014) to 762.

Objective 2.2. By December 31, 2021, increase the proportion of PLWHs linked to care (ever in care) from 90 percent (2014) to 96 percent.

Objective 2.3. By December 31, 2021, increase the proportion of HIV-infected persons retained in care from 64 percent (2014) to 90 percent.

Objective 2.4. By December 31, 2021, increase the proportion of HIV-infected persons with a suppressed viral load (<200 copies/mL) from 58 percent (2014) to 80 percent.

Objective 2.5. By December 31, 2021, increase the proportion of AIDS Drug Assistance Program (ADAP) clients with a suppressed viral load (<200 copies/mL) from 89 percent (2014) to 94 percent.

NHAS Goal 3: Reducing HIV-related disparities and health inequities

Objective 3.1. By December 31, 2021, reduce the annual number of newly diagnosed HIV infections in Florida's black population from 2,024 (2014) to 1,757.

Objective 3.2. By December 31, 2021, reduce the annual number of newly diagnosed HIV infections in Florida's MSM population from 2,761 (2014) to 2,397.

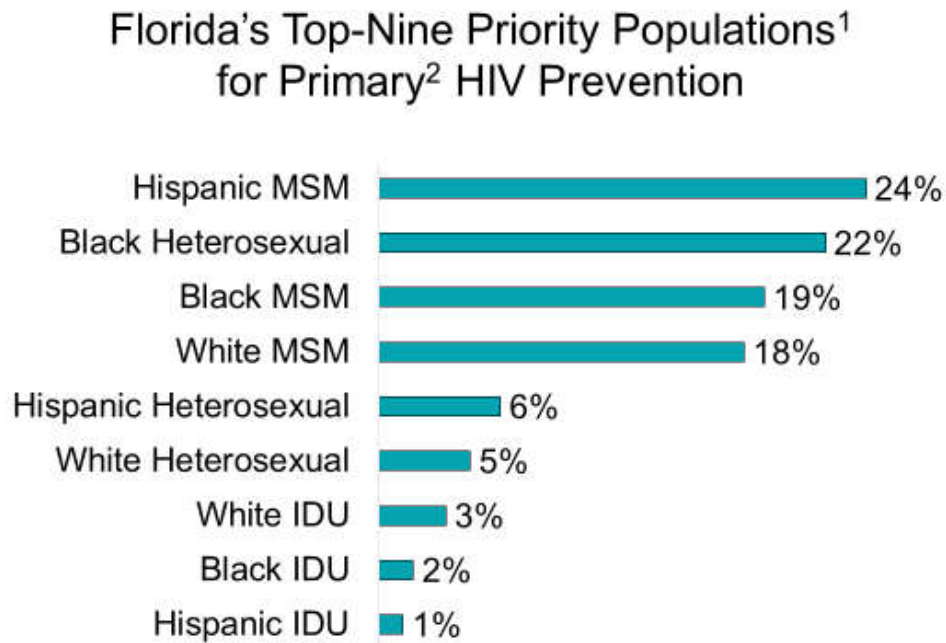
Objective 3.3. By December 31, 2021, reduce the rate of new HIV infections in Miami-Dade and Broward counties from 45.8 (2014) to 39.7 and 38.6 (2014) to 33.5, respectively so these counties will no longer be in the top three U.S. Metropolitan Statistical Areas/divisions with the highest rate of new HIV infections diagnosed.

Objective 3.4: By December 31, 2021, reduce the annual number of newly diagnosed HIV infections in Florida's Hispanic population from 1,281 (2014) to 1,112.

2.2 Priority Populations

Despite the best prevention efforts, some populations and communities are disproportionately affected by HIV. The NHAS identifies "Reducing HIV-Related Disparities and Health Inequities" as one of the strategy's three main overarching goals. Targeted HIV prevention efforts are needed for populations or communities that experience the highest rates of HIV and other STDs. To maximize the efficiency, effectiveness, and allocation of HIV prevention resources throughout the state, the HIV Surveillance Program uses a priority population setting methodology to prioritize population groups that require intensive HIV prevention efforts due to high rates of HIV infection and high incidence of risk behaviors. The tool takes an average of the HIV cases for the last three years by race and risk, and the living cases through the end of the most recent year by race and risk, and ranks them to determine the top nine risk groups. These top nine priority groups are individually identified for each partnership area and should be used to aid in the development and implementation of targeted prevention and care services in each area.

Figure 4. Florida’s Top-Nine Priority Populations for Primary HIV Prevention



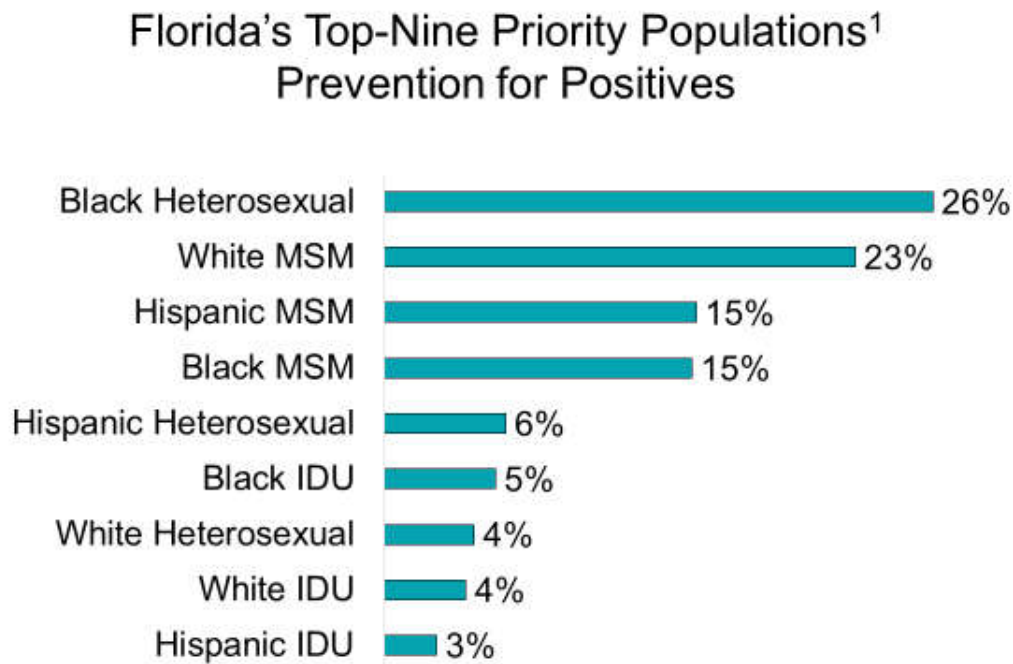
¹MSM=(MSM and MSM/IDU cases) and IDU=(IDU and MSM/IDU cases), therefore the data are not mutually exclusive.
²Priorities are based on the average on HIV cases diagnosed 2014–2016 (as of 6/30/2017). These priorities are used to target those not infected with HIV to reduce transmission among those with high risk for HIV.

73

The percentages above reflect the proportion each priority population comprised of HIV cases diagnosed from 2014–2016.

Populations are prioritized for both primary and secondary HIV prevention. Primary HIV prevention focuses on persons who are HIV negative or of an unknown status to reduce transmission among those at increased risk for HIV infection. Secondary HIV prevention strategies are used to intervene and reduce progression of the disease among PLWH to prevent further transmissions, also referred to as ‘prevention for positives.’

Figure 5. Florida’s Top-Nine Priority Populations for Prevention for Positives



¹MSM=(MSM and MSM/IDU cases) and IDU=(IDU and MSM/IDU cases), therefore the data are not mutually exclusive.
²Priorities are based on the number of cases living with HIV in Florida, year-end 2016 (as of 6/30/2017). These priorities are used to intervene and reduce progression of the disease among those known to be HIV-infected to prevent further infection in the community. 74

The percentages above reflect the proportion each priority population comprised of HIV cases diagnosed from 2014–2016.

In 2017, CDC released a Dear Colleague Letter in support of the latest scientific advances showing that PLWH who take antiretroviral therapy (ART) daily as prescribed and achieve and maintain an undetectable viral load (defined as less than 200 copies/ml) have effectively no risk of sexually transmitting the virus to an HIV-negative partner.⁶ Secondary HIV prevention strategies, or prevention for positives, work to ensure PLWH are linked to and retained in medical care, adherent to treatment, and subsequently virally suppressed.

Gay and bisexual men remain the population most severely affected by HIV in the United States. More than 26,500 gay and bisexual men received an HIV diagnosis in 2016, representing two-thirds of all new diagnoses in the United States, and diagnoses increased among Hispanic/Latino gay and bisexual men from 2011 to 2016.⁷ In Florida, 57 percent of newly diagnosed HIV cases were among MSM in 2016 (up from 56 percent in 2014). The HIV diagnosis rate among MSM is more than four times higher than heterosexual men.

Blacks/African Americans account for a higher proportion of new HIV diagnoses, those living with HIV, and those who have ever received an AIDS diagnosis, compared to other races/ethnicities. In 2016, African Americans accounted for 44 percent of HIV diagnoses, though they comprise 12 percent of the U.S. population.⁸ In Florida, 42 percent of newly diagnosed HIV infections in 2016 were among blacks/African Americans (down from 44 percent in 2014). The HIV diagnosis rate among black men in

Florida is more than five times higher than white men. For black women, the diagnosis rate is more than 13 times greater than for white women.

Latinx communities are also disproportionately affected by HIV. Latinx culture in the United States and in Florida is extremely diverse. Research shows that Hispanics born in different countries have different behavioral risk factors for HIV. For example, data suggest that Hispanics born in Puerto Rico are more likely than other Hispanics to contract HIV as a result of injection drug use (IDU) or from high-risk heterosexual contact. By contrast, sexual contact with other men is the primary cause of HIV infection among men born in places such as Mexico and the 50 U.S. states.⁹ In Florida, 31 percent of newly diagnosed HIV infections in 2016 were among Hispanics (up from 26 percent in 2014). The HIV diagnosis rate among Hispanic men in Florida is nearly three times greater than for white men. For Hispanic women, the diagnosis rate is almost twice that of white women.

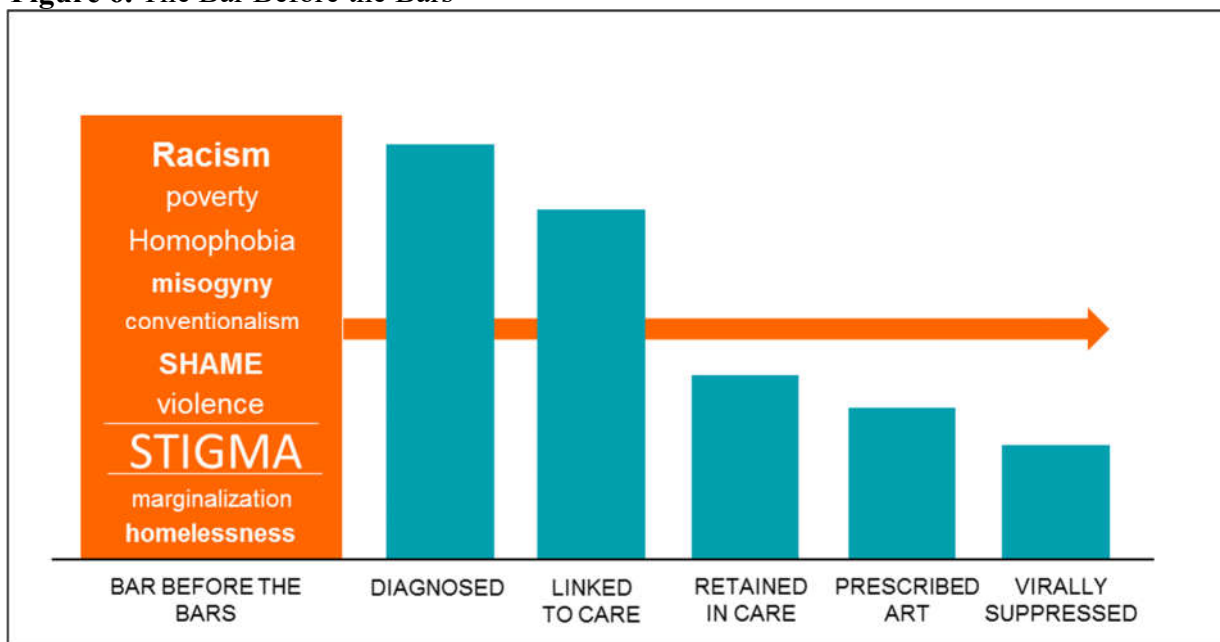
Transgender populations continue to be disproportionately affected by HIV. Between 2009 and 2014, 2,351 transgender persons received an HIV diagnosis in the U.S. Of these, 84 percent were transgender women, 15 percent were transgender men, and about half lived in the south.¹⁰ Among transgender adults living with HIV in Florida, the highest proportion of cases are among whites for female-to-male adults (50%) and are among blacks for male-to-female adults (51%). Half of the female-to-male adults are between the ages of 20 and 29. Meanwhile, the majority of male-to-female adults (34%) are aged 30-39. Among male-to-female adults, men who have sex with men (MSM) was the most common mode of exposure at 87 percent. In contrast, among female-to-male adults other risk (83%) contributed to the majority of cases (other risk includes hemophilia, transfusion, perinatal and other pediatric risks as well as other confirmed risks).

Health Disparities and Health Equity

Health disparities in HIV are tied to a mix of social determinants that impact populations most severely affected by this disease. Health equity is defined as the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities. Social determinants of health affect disparities in HIV, viral hepatitis, STD, and TB. Environmental factors such as housing conditions, social networks, and social support are also key indicators for infection with HIV, viral hepatitis, and STDs.

Factors driving the HIV epidemic within priority populations are as diverse as Florida's communities themselves. In all communities, lack of awareness of HIV status contributes to HIV risk. People who do not know they have HIV cannot take advantage of HIV care and treatment and may unknowingly pass HIV to others. The greater number of PLWH (prevalence) in these populations mean that sexual networks in these populations face greater risks of HIV infection. Some of these populations also experience higher rates of other STDs than other communities in Florida; having another STD can significantly increase a person's chance of acquiring or transmitting HIV. Stigma, fear, discrimination, and homophobia also place individuals from priority populations at higher risk for HIV. The socioeconomic issues associated with poverty—including limited access to high-quality health care, housing, and education—directly and indirectly increase the risk for HIV infection and affect the health of people living with and at risk for HIV. Stigma and other social determinants influence the HIV Care Continuum before a diagnosis is even made, hence why these factors appear in the 'bar before the bars' on the continuum.¹¹

Figure 6. The Bar Before the Bars



Source: Addressing Stigma: A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black and Latino Gay Men. National Association of State and Territorial AIDS Directors (NASTAD) and National Coalition of STD Directors (NCSD). May 2014. Accessed May 25, 2018

This RFA supports efforts to improve the health of populations disproportionately affected by HIV by maximizing the health impact of public health services, reducing disease prevalence, and promoting health equity. Applicants should use epidemiologic and social determinants data to identify communities within their jurisdictions disproportionately affected by HIV and related diseases and conditions. Likewise, applicants should use Florida Department of Health data describing the social determinants of diseases in their coverage areas to accurately focus activities for reducing health disparities and to identify strategies to promote health equity. In collaboration with partners and appropriate sectors of the community, applicants should consider social determinants of health in the development, implementation, and evaluation of program-specific efforts and use culturally appropriate prevention messages, strategies, and interventions that are tailored for the communities for which they are intended. Details of the health equity strategy and approach are outlined in the NCHHSTP Social Determinants of Health White Paper (<https://www.cdc.gov/nchhstp/socialdeterminants/docs/sdh-white-paper-2010.pdf>). Applicants can also review data from CDC’s HIV Surveillance Report, *Social Determinants of Health among Adults with Diagnosed HIV Infection in 13 States, the District of Columbia, and Puerto Rico, 2015* (<https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-22-3.pdf>).

2.3 Program Expectations

To reduce new HIV infections in Florida, it is critical to ensure that everyone with HIV is aware of their infection, linked to and retained in HIV medical care, and maintains viral suppression. Those at risk should be linked to HIV prevention services and, where applicable, PrEP. Using statewide and local area epidemiological reports, Florida can provide prioritized HIV testing and prevention services to ensure HIV infections are diagnosed and persons testing positive are linked and/or re-engaged into care and treatment, with the goal of achieving viral suppression.

In addition to the Department’s Four Key Component Plan, the *Florida Statewide Integrated HIV Prevention and Care Plan, 2017–2021* (<http://www.floridahealth.gov/diseases-and->

[conditions/aids/prevention/ documents/State-of-Florida-Integrated-HIV-Prevention-and-Care-Plan-09-29-16_FINAL-Combined.pdf](#)) contains statewide objectives, strategies, and activities, which correspond to each of the three NHAS goals.

Applicants are expected to use the strategies and components contained within the following Category Summary and Logic Model tables to deliver HIP programs and services to priority populations in high HIV incidence geographic areas. Long-term outcomes (i.e., greater than 5 years) which are expected to be achieved through implementation of the strategies are also listed in the tables.

Table 3. Category 1 Summary and Logic Model

Category 1: Community Outreach, Engagement, and Education		
Strategy:	Activities:	Long-term Outcomes and their Indicators:
Community-Level Prevention	<ul style="list-style-type: none"> - Condom distribution - Community outreach, engagement, and education - Social media and marketing - Referral to prevention and essential support services (see Section 2.4.A.1.d) 	<ul style="list-style-type: none"> - Increased availability of condoms among persons living with or at risk for HIV Infection Indicator: Number of condoms distributed to PLWH or those at increased risk for HIV infection - Increased awareness in affected communities at risk for transmitting or acquiring HIV infection and strategies for reducing these risks Indicator: Number of individuals exposed to HIV prevention messaging Indicator: Number of community partnerships established to promote awareness and prevention strategies, and to reduce stigma and discrimination Indicator: Number of individuals educated on HIV/STD prevention and care - Reduced stigma and discrimination for persons with diagnosed HIV infection - Increased use of social media platforms and dating apps to raise awareness through the use of approved marketing campaigns Indicator: Number of and types of platforms used to raise awareness Indicator: Number of posts, exposures, or contacts achieved through marketing campaign Indicator: Number of campaign components and/or concepts used to raise awareness - Increased referrals and access to HIV testing Indicator: Number of referrals made for HIV testing - Increased referrals and access to screening and treatment for STDs, viral hepatitis, and/or TB Indicator: Number of referrals made for partner services - Increased referrals of persons eligible for PrEP and nPEP Indicator: Number of individuals eligible for PrEP referred to PrEP services Indicator: Number of individuals eligible for nPEP referred to nPEP services

Table 4. Category 2 Summary and Logic Model

Category 2: HIV Testing and Linkage to Prevention and Care Services (includes HIV testing in health care and/or non-health care settings)		
Strategy:	Activities:	Long-term Outcomes and Indicators:
<p>HIV Testing Applicants can choose to implement routine and/or prioritized HIV testing based on their agency site type and organizational capacity.</p>	<ul style="list-style-type: none"> - Routine, opt-out HIV testing in health care settings <p>AND/OR</p> <ul style="list-style-type: none"> - Prioritized/targeted HIV testing in non-health care settings <p>OPTIONAL:</p> <ul style="list-style-type: none"> - Integrated screening activities 	<ul style="list-style-type: none"> - Increased number of individuals tested for HIV and who are aware of their status Indicator: Number of unduplicated HIV tests Indicator: Number of newly diagnosed HIV-positive tests Indicator: Number of other STD and HCV tests performed in conjunction with HIV screening
<p>Comprehensive Prevention for HIV-Positive Persons</p>	<ul style="list-style-type: none"> - Linkage to and re-engagement in HIV medical care - Partner services - Medication and treatment adherence services 	<ul style="list-style-type: none"> - Increased linkage to HIV medical care among PLWH Indicator: Percentage of newly diagnosed individuals linked to care within 30 days - Increased early initiation of ART among PLWH Indicator: Percentage of newly and/or previously diagnosed individuals successfully initiated on ART within 72 hours, or less (i.e., Test and Treat strategy) - Decreased risk behaviors among PLWH at risk of transmission Indicator: Percentage of PLWH successfully re-engaged to care and/or referred to re-engagement services - Increased participation in HIV partner services among persons with diagnosed HIV infection Indicator: Percentage of individuals eligible for partner services referred to partner services. Indicator: Number of individuals receiving partner services. - Increased HIV viral load suppression among PLWH Indicator: Percentage of newly diagnosed HIV-positive persons provided or referred to medication adherence services Indicator: Percentage of previously diagnosed PLWH provided or referred to medication adherence services
<p>Referral and Navigation to Prevention and Essential Support Services</p>	<ul style="list-style-type: none"> - Referrals and access to screening and treatment for STDs, viral hepatitis, and/or TB - PrEP - nPEP - Risk Reduction Counseling - Other Essential Support Services (see Section 2.4.A.1.d) 	<ul style="list-style-type: none"> - Increased referrals and access to screening and treatment for STDs, viral hepatitis, and/or TB Indicator: Number of individuals referred to screening and treatment for STDs, viral hepatitis, and/or TB - Increased referrals of persons eligible for PrEP and nPEP Indicator: Number of individuals eligible for PrEP referred to PrEP services. Indicator: Number of individuals eligible for nPEP referred to nPEP services - Increased referrals to support services Indicator: Number of individuals referred to essential support services

Table 5. Category 3 Summary and Logic Model

Category 3: Comprehensive HIV Prevention Services		
Strategy:	Activities:	Long-term Outcomes and Indicators:
<p>HIV Testing Applicants may choose to implement routine and/or prioritized HIV testing based on their site type and organizational capacity.</p>	<ul style="list-style-type: none"> - Routine, opt-out HIV testing in health care settings AND/OR - Prioritized/targeted HIV testing in non-health care settings OPTIONAL: - Integrated screening activities 	<ul style="list-style-type: none"> - Increased number of individuals tested for HIV and who are aware of their status Indicator: Number of unduplicated HIV tests Indicator: Number of newly diagnosed HIV-positive tests
<p>Comprehensive Prevention for HIV-Positive Persons</p>	<ul style="list-style-type: none"> - Linkage to and re-engagement in HIV medical care - Partner services - Medication and treatment adherence services - Risk Reduction Interventions for PLWH 	<ul style="list-style-type: none"> - Increased linkage to HIV medical care among PLWH Indicator: Percentage of newly diagnosed individuals linked to care within 30 days - Increased early initiation of ART among PLWH Indicator: Percentage of newly and/or previously diagnosed individuals successfully initiated on ART within 72 hours, or less (i.e., Test and Treat strategy) - Decreased risk behaviors among PLWH at risk of transmission Indicator: Percentage of PLWH successfully re-engaged to care and/or referred to re-engagement services Indicator: Number of individuals eligible for partner services referred to partner services. Indicator: Number of individuals receiving partner services. - Increased HIV viral load suppression among PLWH Indicator: Percentage of newly diagnosed HIV-positive persons provided or referred to medication adherence services Indicator: Percentage of previously diagnosed PLWH provided or referred to medication adherence services - Decreased risk behaviors among PLWH at risk of transmission Indicator: Number of PLWH receiving risk reduction interventions
<p>Prevention for HIV-Negative Persons at Increased Risk for HIV Infection</p>	<ul style="list-style-type: none"> - PrEP - nPEP - Risk Reduction Interventions 	<ul style="list-style-type: none"> - Increased provision of PrEP to persons for whom PrEP is indicated Indicator: Number of HIV-negative persons at risk for HIV infection who are screened for PrEP - Increased provision of nPEP to persons for whom nPEP is indicated Indicator: Number of HIV-negative persons at risk for HIV infection who are screened for nPEP - Increased referral of persons eligible for PrEP and nPEP Indicator: Number of individuals eligible for PrEP referred to PrEP services Indicator: Number of individuals eligible for nPEP referred to nPEP services - Increased linkage of persons eligible for PrEP to PrEP services Indicator: Number of individuals receiving PrEP

		<ul style="list-style-type: none"> - Increased linkage of persons eligible for nPEP to nPEP services Indicator: Number of individuals receiving nPEP - Decreased risk behaviors among HIV-negative persons at risk of HIV acquisition Indicator: Number of HIV-negative persons receiving risk reduction interventions
Community-Level Prevention	<ul style="list-style-type: none"> - Condom distribution - Community outreach, engagement, and education - Social media and marketing 	<ul style="list-style-type: none"> - Increase availability of condoms among persons living with or at risk for HIV Infection Indicator: Number of condoms distributed to persons living with HIV (PLWH) or at risk for HIV infection - Increased awareness in affected communities at risk for transmitting or acquiring HIV infection and strategies for reducing these risks - Reduced stigma and discrimination for persons with diagnosed HIV infection Indicator: Number of individuals exposed to HIV prevention messaging Indicator: Number of community partnerships established to promote awareness and prevention strategies, and to reduce stigma and discrimination Indicator: Number of individuals educated on HIV/STD prevention and care - Increased use of social media platforms and dating apps to raise awareness through the use of approved marketing campaigns Indicator: Number of and types of platforms used to raise awareness Indicator: Number of posts, exposures, or contacts achieved through marketing campaign Indicator: Number of campaign components and/or concepts used to raise awareness
Referral and Navigation to Prevention and Essential Support Services	<ul style="list-style-type: none"> - Referral and navigation to screening and treatment for STDs, viral hepatitis, and/or TB; and - Referrals and navigation to essential support services (see Section 2.4.A.1.d) 	<ul style="list-style-type: none"> - Increased referrals and access to screening and treatment for STDs, viral hepatitis, and/or TB - Increased referrals to essential support services Indicator: Percentage of individuals referred to prevention and essential support services

2.4 Project Requirements

A. **Category 1: Community Outreach, Engagement, and Education**

Applicants submitting proposals for Category 1 are required to implement Community-Level Prevention, as outlined below.

1. Community-Level Prevention

- a. Condom Distribution: Implement condom distribution as a structural intervention to increase access and use of condoms by persons living with HIV, HIV-negative persons at high risk of acquiring HIV, and persons of unknown HIV status. Effective condom distribution programs must provide condoms free of charge; implement social marketing efforts to promote condom use by increasing awareness of condom benefits and normalizing condom use within communities; and conduct both promotion and distribution activities at the individual, organizational, and community levels. Organizations must use local HIV/AIDS data (down to the ZIP code level) to assess current condom distribution patterns and ensure availability in high HIV incidence areas. For additional information and guidance, please visit <https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/StructuralInterventions.aspx>.
- b. Community outreach, engagement, and education: Applicants must develop and use innovative strategies, as well as traditional outreach strategies, the Internet, social media, and surveillance data (to support mapping of areas of highest morbidity) to establish a comprehensive outreach, mobilization, engagement, and recruitment program. Applicants may opt to implement Social Network Strategy (SNS) as a means to recruit high-risk members of the priority population(s) for strategic engagement and referral to prevention and support services. Applicants are required to conduct targeted outreach among priority populations and within high HIV incidence real or virtual venues.

Applicants must collaborate with other organizations that have an established history of working with and recruiting members of the priority population(s) at greatest risk for HIV acquisition or transmission. The program must seek input from community stakeholders to select the most appropriate program promotion and recruitment strategies to include determining the appropriate use of incentives and promotional items in the program.

Applicants must engage priority populations in high HIV incidence areas and provide culturally appropriate comprehensive sexual health education, including but not limited to topics of regular HIV/STD screenings, available HIV treatment options, and the importance of HIV treatment adherence and viral suppression for PLWH.

Additional activities required under this component include, but are not limited to:

- Identify key strategies to be used to reach and engage priority population(s).
- Identify locations for event-based outreach.
- Develop Business Responds to AIDS/Faith Responds to AIDS (BRTA/FRTA) partnerships.
- Distribute and market adapted campaign materials in both real and virtual venues.
- Engage priority populations in conversation about:
 - PrEP/nPEP basics, availability, and access;
 - Correct and consistent condom use;
 - Importance of frequent HIV testing;
 - Importance of seeking help for mental health and substance abuse issues; and,
 - Screening for STDs, viral hepatitis, and TB.
- Identify potential clients who may benefit from comprehensive prevention activities (i.e., risk behavior screening, risk reduction intervention, and comprehensive sexual health education).

- Conduct mobilization activities to address health disparities and health equity among priority populations and within high HIV incidence communities (including BRTA/FRTA).
 - Conduct community engagement sessions among selected priority population(s).
- c. Social media and marketing: All funded applicants must deliver strategic, culturally competent, community-based program marketing campaigns to increase public awareness of services available via the proposed program; destigmatize HIV and HIV medical care; empower disproportionately affected populations; promote HIV testing, linkage to, retention in, and re-engagement into HIV medical care; and promote navigation and referral to prevention and essential support services, including PrEP and nPEP.

Where appropriate, applicants must prioritize existing social marketing efforts that can be tailored to their jurisdiction’s specific requirements from the Department’s *Protect Yourself* campaign (www.knowyourhivstatus.com) or the CDC’s *Act Against AIDS* portfolio of social marketing campaigns (www.cdc.gov/actagainstaids/index.html). Applicants can also develop complementary social media efforts to disseminate information about HIV prevention; however, these efforts must be aligned with existing Department or CDC marketing and media campaigns.

- d. Referrals to Prevention and Essential Support Services: Applicants must facilitate referrals to prevention and essential support services which align with the goals and objectives of the *National HIV/AIDS Strategy for the United States: Updated to 2020* and the CDC’s HIP approach. Applicants are encouraged to train and develop navigators (e.g., community health workers, peer advocates, outreach workers) to help facilitate access to (linkage and re-engagement) and retention in HIV medical care and provide or refer prevention and essential support services. The Applicant’s client-centered program model must include a combination of high-impact HIV prevention strategies and activities to continually engage persons living with HIV. This will include referring individuals to prevention and essential support services as deemed appropriate and in compliance with the requirements of the RFA.

Prevention and essential support services include, but are not limited to the following:

- HIV testing;
- Screenings and treatment for STDs, viral hepatitis, and TB (as recommended by CDC);
- PrEP, as appropriate;
- nPEP, as appropriate;
- Partner Services;
- Mental health counseling and services;
- Substance abuse treatment and services;
- Housing;
- Transportation services (to and from HIV prevention and essential support services and HIV medical care appointments);
- Employment services;
- Basic education continuation and completion services;
- Comprehensive sexual health education, including HIV education (e.g., risk reduction programs, school-based HIV prevention providers);
- Violence prevention services; and,
- Educational services for hormone replacement therapy and sex reassignment procedures.

B. Category 2: HIV Testing and Linkage to Prevention and Medical Care Services

Applicants submitting proposals for Category 2 are required to implement the following strategies: HIV Testing; Comprehensive Prevention for HIV-Positive Persons; and Referral and Navigation to Prevention and Essential Support Services, as outlined below.

1. HIV Testing

- a. Routine, opt-out HIV screening in health care settings: Universal HIV screening by health care providers is a priority for Florida and is a key strategy for identifying undiagnosed infections and ensuring linkage to and retention in medical care for persons testing HIV positive. Persons who are aware of their HIV status, retained in care, and virally suppressed have effectively no risk of transmitting the virus to sexual partners. Applicants must adhere to section 381.004, Florida Statutes and Florida Administrative Code Rule 64D-2.004 which removes the need for separate informed consent prior to HIV testing in a health care setting. These changes were enacted to further increase routine HIV screening, which CDC highly recommends. There was no change in the law or rule regarding non-health care settings.

Applicants must implement strategies that align with the CDC *2006 Revised Recommendations for HIV Testing in Adults, Adolescents, and Pregnant Women* (<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>), and the U.S. Preventive Services Task Force (USPSTF) *2013 Updated Recommendation for HIV Screening* (<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening>). The USPSTF released an updated recommendation statement on screening for HIV, giving a Grade A recommendation for routine HIV screening in adolescents and adults 15–65 years old. The Grade A rating indicates that all primary payers including Medicaid and Medicare, are required to cover routine HIV screening. Model protocols for HIV testing in health care and non-health care settings are available on the Department’s HIV Prevention website at, www.floridahealth.gov/diseases-and-conditions/aids/prevention/testing-counseling.html.

Applicants are expected to explore billing opportunities for seeking reimbursement and to determine whether third-party reimbursement makes sense financially. Applicants with the capacity to bill and obtain reimbursement must use all available mechanisms to obtain reimbursement for eligible prevention and essential support services from third-party payers (e.g. Medicaid, Medicare, and private insurance). Applicants must also demonstrate experience and capacity to conduct high-volume HIV testing within the selected priority populations, in high HIV incidence areas. Applicants are encouraged to review the DOH Provider’s Guide to Reimbursement and Sustainability for HIV Testing in Florida Health Care Facilities (http://www.floridahealth.gov/diseases-and-conditions/aids/prevention/_documents/Counseling_testing/hiv-testingsustainabilityguide-dec2016-revisions.pdf) as well as the NASTAD’s Billing Coding Guide for HIV Prevention (<https://www.nastad.org/resource/billing-coding-guide-hiv-prevention>).

- b. Prioritized/targeted HIV testing in non-health care settings: Applicants may opt to use strategies such as Social Networking Strategies (SNS), Testing Together (formerly known as Couples HIV Testing and Counseling), and other existing HIV testing strategies implemented by the Applicant for the purposes of mobile outreach testing and other forms of prioritized or focused HIV testing in high incidence ZIP codes and neighborhoods.

Applicants must use the Department’s DH1628 form when conducting prioritized/targeted HIV testing within priority populations to conduct brief assessments to ascertain clients’ risks (e.g., sexual risk behaviors, drug use behaviors). Brief risk reduction education messaging must be conducted during post-test counseling and include factual HIV education (e.g., transmission, window period, and risk reduction methods). For more information regarding Florida’s HIV testing standards and guidelines, please visit the HIV Testing page on the HIV/AIDS Section website <http://www.floridahealth.gov/diseases-and-conditions/aids/prevention/testing-counseling.html> for access to the documents below:

- Model Protocol for HIV Counseling and Testing in Health Care Settings
- Model Protocol for HIV Counseling and Testing in Non-Health Care Settings
- Rapid HIV Testing Site Guidelines
- IOP 360-07-17: Minimum Standards for HIV Counselors, Trainers, and Early Intervention Consultants
- IOP 360-09-17: Provision of HIV Testing and Linkage

Applicants must identify a variety of settings where prioritized testing will be conducted and most effective in identifying members of the priority population(s) with undiagnosed HIV infection including, but not limited to on-site testing, venue-based testing, mobile and field testing, and home-based testing. If home-based testing is used, Applicants are required to provide specific protocols, which includes recruitment processes, follow-up, and linkage procedures at the time the application is submitted.

After HIV testing is completed, Applicants must refer (if services are not provided on-site) and link clients to appropriate HIP strategies and activities, as follows:

- a. For persons with a non-reactive HIV test result and who are at increased risk for HIV infection, referrals and/or linkage to PrEP and nPEP services; STD, viral hepatitis, and/or TB screenings; and other prevention and essential support services as described in **Section 2.4.A.1.d**.
- b. For persons with reactive HIV test results, if possible acute HIV infection is suspected based on risk assessment, staff must draw blood for 4th generation lab-based screening. If an organization is unable to draw blood on site, they must establish a referral relationship for the purposes of drawing blood for confirmatory HIV testing.
- c. Integrated screening activities (OPTIONAL): The Department will support collaboration between HIV, STD, viral hepatitis, and/or TB programs via the provision of integrated screening activities delivered in conjunction with HIV testing. Up to **5%** of funds from an applicant’s final award may be used for other screening tests, including those described below, only if these tests are provided in conjunction with HIV screening, are indicated by epidemiologic data, and are in accordance with current CDC guidelines and recommendations. Clinical services such as these are billable and therefore reimbursable by Medicaid, Medicare, and/or private insurers. Arrangements for these clinical services can also be made through collaborations with local health office’s STD, viral hepatitis, and/or TB programs or other clinical providers.

2. Comprehensive Prevention for HIV-Positive Persons

- a. Linkage to and Re-Engagement in Medical Care:
Under this component, applicants will be required to:

- Link newly diagnosed HIV-positive persons to HIV medical care within 30 days of diagnosis.
- Link or re-engage previously diagnosed out-of-care HIV-positive persons to HIV medical care.
- Link or re-engage newly or previously diagnosed, out-of-care HIV-positive pregnant women to HIV medical care and prenatal care (if not actively engaged).

Applicants may opt to implement a CDC-approved linkage to care intervention, i.e., Antiretroviral Treatment and Access to Services (ARTAS), Peer Navigation Programs, or the Applicant’s existing linkage to care services. Applicants must describe their linkage to HIV medical care process which details the following: staff responsible; organization linkage to care process and timeframes; providers associated with the linkage to care program; and a process for securing multiple communication methods to contact clients.

Applicants are not required to implement the Test and Treat model, but will be required to educate all newly-diagnosed individuals on the benefits and availability of immediate access to care, and provide referrals to Test and Treat sites if the client chooses this option. Applicants can choose to implement the Test and Treat model or may choose to establish an MOA/MOU with an established Test and Treat site(s) in their local area to expedite linkage to or re-engagement in care.

- b. Partner Services: Under this component, applicants are required to:
- Provide timely Partner Services for individuals **newly diagnosed** with HIV infection through referral agreements with the local health office’s Disease Intervention Specialists.
 - Provide timely Partner Services (through referral agreements with local health offices) for individuals with **previously diagnosed** HIV infection, presenting with a new STD diagnosis, or no evidence of viral suppression.

Applicants must demonstrate strong partnerships with local health department Partner Services programs and DIS, as evidenced by a letter of agreement, Memorandum of Understanding (MOU), or Memorandum of Agreement (MOA). Applicants may also choose to develop agreements with local health departments to embed DIS within their agencies for the provision of Partner Services for individuals newly diagnosed with HIV infection, as appropriate and available. Applicants must provide evidence of this collaboration through a letter of agreement, MOA, or MOU.

- c. Medication and Treatment Adherence Services: Applicants are required to implement on-site or make referrals to medication adherence services to support maintenance on antiretroviral therapy and overall achievement of viral suppression. Applicant organizations may opt to implement a CDC-approved medication adherence intervention, i.e., Partnership for Health [Medication adherence], HEART, Every Dose Every Day mobile application, SMART Couples, Peer Support/Navigation [with adherence and viral suppression strategies], or the applicant’s existing medication adherence services.

3. Referral and Navigation to Prevention and Essential Support Services: See **Section 2.4.A.1.d**

Category 3: Comprehensive HIV Prevention Services

Applicants submitting proposals for Category 3 are required to implement the following strategies: HIV Testing; Comprehensive Prevention for HIV-Positive Persons; Prevention for HIV-Negative Persons at

Increased Risk for HIV Infection; Community-Level Prevention; and Referral and Navigation to Prevention and Essential Support Services, as outlined below.

1. HIV Testing: See **Section 2.4.B.1**
2. Comprehensive Prevention for HIV-Positive Persons
 - a. Linkage and Re-engagement in Care: See **Section 2.4.B.2.a**
 - b. Medication and Treatment Adherence Services: See **Section 2.4.B.2.c**
 - c. Partner Services: See **Section 2.4.B.2.b**
 - d. Risk Reduction Interventions for PLWH: Applicants are required to conduct behavioral task screening for PLWH and provide risk reduction counseling or behavioral interventions for PLWH. For newly and previously diagnosed individuals, applicants may choose to implement behavioral interventions. Applicant may opt to implement a CDC-approved, evidence-based behavioral intervention for persons living with HIV/AIDS (e.g., CLEAR, Mpowerment, Partnership for Health (Safer Sex version), Healthy Relationships, CONNECT, Project START, or WILLOW). Applicants may also choose to implement a locally developed, evidence-based risk reduction intervention for persons living with HIV/AIDS. Applicants must describe in detail the activities and processes associated with existing risk reduction interventions for PLWH.
3. Prevention for HIV-Negative Persons at Increased Risk for HIV Infection:
 - a. PrEP and nPEP: Applicants are required to provide referral, navigation, and linkage to PrEP and nPEP services. For Applicants that have the ability to provide PrEP and nPEP on-site, please refer to **Attachment 2**, CDC’s PrEP Program Guidance for HIV Prevention Health Department Grantees (<https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS18-1802-AttachmentK-CDC-PrEP-Program-Guidance-for-HDs.pdf>) for details on allowable costs for PrEP and nPEP activities under this announcement. For Applicants that cannot perform PrEP or nPEP services on site, demonstrate a partnership with another local agency through MOUs/MOAs and describe the referral relationship in detail within the application. Required services include:
 1. Screening for PrEP and nPEP;
 2. Referral to PrEP and nPEP Services;
 3. Linkage to PrEP and nPEP services (on site or through collaborations with other partners); and,
 4. Provision of PrEP and nPEP (if services provided on site)

Applicants are also encouraged to review the latest update to CDC PrEP Guidelines—Pre-Exposure Prophylaxis for the Prevention of HIV Infection in the United States—2017 Update: A Clinical Practice Guideline (<https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf>), as well as the Department’s PrEP and nPEP Toolkits at the following link: <http://www.floridahealth.gov/diseases-and-conditions/aids/prevention/PrEP.html>.

- b. Risk Reduction Interventions for HIV-Negative Persons: Applicants will be required to conduct behavioral risk screening and provide risk reduction counseling or behavioral

interventions for HIV-negative persons at increased risk of acquiring HIV. Applicants may opt to implement a CDC-approved, evidence-based behavioral intervention for HIV-negative persons at increased risk for acquiring HIV (i.e., Mpowerment, PROMISE, VOICES/VOCES). Applicants may also opt to implement a home-grown or locally-developed, evidence-based risk reduction intervention for HIV-negative persons at increased risk for acquiring HIV. Applicants must describe in detail the activities and processes associated with existing risk reduction interventions.

4. Community-Level Prevention: See **Section 2.4.A.1**

5. Referral and Navigation to Prevention and Essential Support Services: See **Section 2.4.B.3**

2.5 Current and Prior Funded Projects

MOAs/MOUs for Prevention and Essential Support Services:

Applicants must submit at least one established MOA or MOU with a Prevention and Essential Support Service provider (internal or external to the organization), regardless of whether the services are being provided internally or externally. The agreements must be reflective of the services most commonly requested by the priority population(s). The Applicant should establish additional collaborations supported through similar agreements over the course of the three-year project period.

The MOAs/MOUs must include, but are not limited to, the following:

- a) Name and address of the provider(s). Name, title, and contact information (i.e., primary work address, email, and phone number) for the primary point of contact for the provider.
- b) Detailed description of the agreed-upon referral processes for prevention and essential support services between the applicant organization and the prevention and essential support service provider.
- c) Signatures from the Business Official for the Applicant and the prevention and essential support services provider.

Section 3.0 TERMS AND CONDITIONS OF SUPPORT

3.1 Eligible Applicants

Eligible applicants are limited to entities which have a 501(c)3 non-profit designation. Examples include: community-based organizations; community health centers; FQHCs; faith-based organizations; and other agencies that provide HIV prevention services.

Category 1: Smaller, non-profit 501(c)(3) organizations are encouraged to apply, including community-based organizations and/or faith-based organizations (e.g., organizations with limited staffing and resources, a workforce comprised primarily of individuals from the population served, and that provide services in high HIV incidence communities).

Category 2: Non-profit 501(c)(3) organizations, community-based organizations, community health centers, and/or FQHCs with HIV testing experience in non-health care or health care settings are encouraged to apply. Organizations previously funded through the Department's Expanded Testing Initiative (ETI) are encouraged to apply. Organizations must provide services in high HIV incidence communities and maintain the ability to conduct high volume HIV testing.

Category 3: Non-profit 501(c)(3) organizations (e.g., community-based organizations, community health centers, and/or FQHCs) with experience providing client-centered, comprehensive HIV prevention services are encouraged to apply. Organizations must provide services in high HIV incidence communities.

Applicants which meet the definition of a *minority organization* and produce documentation as verification of such status will be awarded additional points. See **Section 9.0: Definitions**.

3.2 Eligibility Criteria

Applicants must provide services and have a physical office located in the area where they are proposing to implement projects. In an effort not to duplicate services in any location and to ensure service delivery in the areas of greatest need, the Department reserves the sole discretion to negotiate awards based on geographic coverage, epidemiologic data, competence to achieve the stated goals of the program, and access to priority populations. Local Health Offices may be partners (unfunded) to applicants but cannot apply for grant funds. All entities submitting an application must be registered as a vendor in MyFloridaMarketPlace. For further information please visit:

http://dms.myflorida.com/business_operations/state_purchasing/myflorida_marketplace.

All Applicants are advised that in accepting federal dollars under this RFA, as a sub-recipient, they will be required to comply with all state laws, executive orders, regulations, and policies governing these funds. Applicants that have had contracts terminated or reduced by the Department for reasons other than a mutually agreed upon cause or are classified as a prohibited vendor may be ineligible for funding.

3.3 Funding Period

The funding period will be for a period of 36 months (three years) beginning January 1, 2019 and ending December 31, 2021. Contracts resulting from this RFA will be for a period of three years, based on the annual funding availability identified in **Section 1.5**. Applicants receiving a contract under this RFA will be required to submit an annual budget to the contract manager by November 1 of every year.

3.4 Grant Renewals and Amendments

Any contracts resulting from this RFA may be renewed. Contracts may be renewed for a period that may not exceed three years or the term of the original contract, whichever is longer. Renewals must be in writing, subject to the same terms and conditions set forth in the initial contract and any written amendments signed by the parties. Renewals are contingent upon satisfactory fiscal and programmatic performance evaluations as determined by the Department and are subject to the availability of funds. The renewal may not include any compensation for costs associated with the renewal.

Awardees and the Department may amend program activities during the funding period to ensure alignment with Department priorities, including: priority population(s) needs; agency capacity; and changes in HIV epidemiology or data trends. Amendment requests must be submitted, in writing, to the Contract Manager. Applicants must provide justification for the change in program activities and meet one of the following criteria:

- Change in HIV epidemiologic data requiring realignment with a geographical service area or priority population
- Saturation of services; meaning, an activity or intervention has reached a level of saturation within a specific community and requires a change in recruitment area or program delivery
- The area in which the Provider delivers services is part of an active HIV transmission cluster, as determined by the Florida Department of Health, HIV Surveillance Program.

3.5 Use of Grant Funds

Funds from this RFA may only be used to implement high-impact HIV prevention services and programs and the funds originate from the Department's Cooperative Agreement with the CDC for integrated HIV prevention and surveillance programs. As such, all applicants awarded funds under this RFA are considered federal subrecipients. A minimum of **75%** of funding (including personnel cost) must be allocated to required category components. Up to **15%** of funding may be allocated to recommended (optional) program components. **Administrative Costs** are limited to **10%** of the total budget amount.

Awardees will be required to attend HIV prevention trainings and workshops sponsored by the HIV/AIDS Section. Applicants' traveling to required meetings who fail to attend sessions or workshops will not be reimbursed for travel expenditures. Failure to attend the sessions will result in financial consequences as specified in resulting contract.

The provision of medical or clinical services **are not** permitted with this funding.

Within 10 days of award notification, applicants will be required to submit a copy of current W-9; copy of liability insurance, copy of lease agreement, and a letter of credit from a bank or certified statement from a financial institution indicating the availability of credit or cash to sustain the project for at least three months.

Subcontracts and consultants are allowed under this contract. However, they are accountable to the applicant for the management of any funds received. Applicants may not sub-contract any of the proposed services without prior written approval from the Contract Manager and Department.

DOH will not provide funds for the routine HIV tests themselves, but will provide funds for things such as: HIV testing staff; linkage navigators; linkage and re-engagement staff; HIV prevention education staff; PrEP navigators; electronic health record system enhancements; and billing and reimbursement system enhancements for the purposes of conducting routine, opt-out HIV screening in a health care setting.

Funds from this RFA may not be used for clinical services, such as the clinician's time for provision of PrEP and nPEP; treatment of HIV, STDs, viral hepatitis, and/or TB infection; vaccination against hepatitis A or hepatitis B; and vaccination against human papilloma virus (HPV).

Allowable and unallowable expenditures are defined by at least one of the following:

- Reference Guide for State Expenditures found at http://www.myfloridacfo.com/aadir/reference_guide/
- Florida Statutes (F.S.) (Section 112.061, Section 286.27)
- Florida Administrative Code (F.A.C.) (rule 3A-40.103)
- Office of Management and Budget (OMB) Circulars A-110-General Administrative Requirements
- A-133-Federal Single Audit
- A-122-Cost Principles for Not-For-Profits
- A-87-Cost Principles for State and Local Governments
- A-21-Cost Principles for Universities, Federal Public Laws
- Catalog of Federal Domestic Assistance (CFDA)
- Code of Federal Regulations (CFR)

Once federal funds are allocated to a state agency, the Florida Department of Financial Services considers the funding to be subject to the same standards and policies as funding allocated by the Florida legislature. Section 17.29, Florida Statutes, gives the Chief Financial Officer (CFO) the authority to prescribe any rule he considers necessary to fulfill his constitutional and statutory duties, which include, but are not limited to, procedures or policies related to the processing of payments from any applicable appropriation. The powers and duties of the CFO are set forth in Chapter 17, Florida Statutes. Section 17.03(1), Florida Statutes, requires that the CFO of the state of Florida, using generally accepted auditing procedures for testing or sampling, shall examine, audit, and settle all accounts, claims, and demands against the State.

In addition to following the Florida Department of Financial Services standards and policies, certain federal guidelines must also be followed (e.g., PrEP allowable costs).

With respect to PrEP, funds from this RFA may not be used for:

- PrEP medications (antiretrovirals)
- Laboratory testing related to PrEP (other than HIV tests or hepatitis screening)
- Personnel costs for the provision of PrEP medication and recommended clinical care associated with PrEP

To access CDC's PrEP Program Guidance (under CDC PS18-1802), see **Attachment 2** or visit <https://www.cdc.gov/hiv/pdf/funding/announcements/ps18-1802/CDC-HIV-PS18-1802-AttachmentK-CDC-PrEP-Program-Guidance-for-HDs.pdf>.

The following lists of allowable and unallowable costs were created solely to be used as a helpful guide for prospective applicants and grant awardees. These lists do not supersede the federal or state definitions of allowable and unallowable costs.

Allowable costs - must be reasonable and necessary and include, but are not limited to the following:

- Personnel salaries and fringe benefits;
- Travel in accordance with section 112.061, Florida Statutes and the Department's policies and procedures;
- Office space, furniture, and equipment;
- Program related expenses, such as office supplies, postage, copying, telephone, utilities, insurance, and advertising;
- Computer hardware and software, including electronic health record and billing system enhancements;
- Direct service provisions and activities;
- Program supplies and materials (e.g., HIV testing supplies, brochures, sexual health education items, condoms, lubricants, risk reduction intervention materials);
- Promotional activities;
- Client incentive and promotional items (as defined in DOHP250-18-18: Client Incentives and Promotional Items and in accordance with section 20.43, Florida Statutes);
- Food vouchers or coupons;
- Media and marketing activities and items (out-of-home, radio, television, and digital/Internet);
- Comprehensive sex education curricula and supporting materials;
- Financial compliance audit if required by Attachment VIII; and
- Level II background screening.

Unallowable costs - include, but are not limited to the following:

Pursuant to Florida Administrative Code Rule 3A-40.103, expenditures from state funds for items listed below are prohibited unless expressly provided by law:

- Telegrams
- Flowers
- Presentment of plaques for outstanding service
- Decorative items (globes, statues, potted plants, picture frames, etc.)
- Greeting cards (per section 286.27, Florida Statutes use of state funds for greeting cards is prohibited)

Unless specifically authorized by law, the expenditure of state funds for the following items related to professional and occupational licenses are not allowable:

- Florida or other bar dues
- Professional license fees
- Occupational license fees
- Driver license fees
- Other fees for licenses required for an individual to pass the examination for any of the above licenses, unless the training is directly related to the person's current official duties related to delivery of the program services
- Examination fees for professional occupational or other licenses for a person to perform his or her official duties

Other unallowable costs and expenditures include:

- Research;
- Clinical care;
- Lobbying;
- Cash awards to employees or ceremony expenditures;
- Entertainment costs, including food, drinks, decorations, amusement, diversion, and social activities and any expenditures directly related to such costs;
- Gift cards (e.g., Walmart, Publix, Winn-Dixie);
- Organizational affiliations, fund raising, and public relations;
- Deferred payments to employees as fringe benefit packages;
- Severance pay and unearned leave;
- Capital improvements, alterations or renovations;
- Lease or purchase of vehicles;
- Development of major software applications;
- Direct client assistance (monetary);
- Conference sponsorship;
- Personal cellular telephones;
- Meals not in accordance with section 112.061, Florida Statutes;
- Appliances for the personal convenience of staff, including microwave ovens, refrigerators, coffee pots, portable heaters, fans, etc.;
- Penalty on borrowed funds or statutory violations or penalty for late or nonpayment of taxes;
- Supplanting of other federal, state, and local public funds expended to provide HIV prevention program services and activities;

3.6 Invoicing and Payment of Invoice

The Department will disburse funds through a fixed price or cost reimbursement contract. All invoices will be due 10 days after the end of the billing period. A quarterly expenditure report must accompany the March, June, September, and December invoices, outlining the total funds expended to date.

Awardees will forfeit the funds expended in the final invoice if the invoice is submitted after 30 days of the end of the contract. The Department shall not honor any requests submitted after the aforesaid time period. Any payment due under the terms of the resulting contract may be withheld until any or all evaluations, statistical, and financial reports due from the awardee and necessary adjustments have been made and approved by the Department.

Awardees agree to refund to the Department any payments made by the Department for unexpended funds or those funds disallowed pursuant to the terms of the resulting contract. Such refunds shall be due within 45 days from the time the overpayment is discovered.

Payment Reductions and Financial Consequences: Contract deliverables and tasks will be assigned a dollar value during the negotiation phase and annually thereafter. The Department may withhold payment under the contract if the awardee fails to perform their contractual obligations.

Section 4.0 APPLICATION PREPARATION GUIDELINES

4.1 Application Content

Applications for funding must address all sections identified below in the order presented and in as much detail as requested. The provision of extraneous information should be avoided. Applicants must adhere to the page limits as identified below.

Applicants may submit only one application for consideration under this RFA. Each applicant can submit one application, for one category. Each application can propose to serve up to two service areas. Applicants must clearly specify which areas they plan to work in and list counties, down to the ZIP code-level, in which they will provide services.

4.2 Instructions for Formatting Applications

Applicants must submit all items as follows:

1. Font Size: 12 point (Arial or Times New Roman)
2. Page Margin Size: One inch
3. Complete and signed Cover Page (**Attachment 3**) submitted as the first page of the application.
4. Table of Contents must identify all major sections of the application in sequential order.
5. Project Narrative:
 - a. Single-spaced
 - b. Only the pages up to the maximum number of pages for each section outlined in **Section 5.0** will be considered.
6. Budget:
 - a. The budget summary information must be completed on **Attachment 4**.
 - b. Only the pages up to the maximum number of pages for the budget narrative outlined in **Section 4.8** will be considered.
 - c. The budget justification narrative must adhere to the format in **Attachment 5**.
7. The Work Plan must adhere to the template provided in **Attachment 7**.

8. Number and label all pages; not to exceed the maximum number of pages where applicable.
9. Headers should identify each section and footers should include: the name of the applicant and page number.
10. All required forms and content should be submitted in one packet in the order and format set forth in this RFA.

4.3 Order of Application Package

Applicants must submit all items in the following order:

First Page	Cover Page
Second Page	Table of Contents (1-page limit)–does not count towards Project Narrative page limit
Third Page	Project Summary (1-page limit)–does not count toward Project Narrative page limit
Pages 4–29	Project Narrative (25-page limit)-see Section 5.0 <ul style="list-style-type: none"> - Statement of Need - Organizational Capacity - Program Description - Collaborations - Evaluation Plan - Work Plan - Attachments (does not count toward Project Narrative page limit)
Budget Summary and Budget Narrative	Proposed Budget Summary (See Attachment 4) (1-page limit) Budget Justification Narrative (See Attachment 5) (3-page limit)
Appendix A–Organizational Capacity Documentation	A.1. An organizational chart A.2. Copy of current Certificate of Incorporation A.3. Documentation showing non-profit or 501(c)(3) designation A.3. Copies of key personnel’s resumes A.4. A current roster of the board of directors, including name, address, and telephone numbers
Appendix B–MOAs/MOUs	B.1. MOAs/MOUs with local health office(s) in the service areas within which the proposed project will occur

	B.2. MOAs/MOUs with other collaborative partners, identifying their role and contribution to the project
Appendix C–Letters of support	C.1. No more than 10 letters of support
Appendix D–Minority Organization Status	D.1. Applicants must submit documentation which verifies the Applicant’s status as a minority organization and meets the definition found in Section 1.0

4.4 Cover Page (1-Page Limit)

Each copy of the application must include a signed Cover Page (**Attachment 3**).

4.5 Table of Contents (1-Page Limit)

The application must contain a table of contents with page numbers identifying major sections of the application.

4.6 Project Summary (1-Page Limit)

Applicants shall provide a succinct one-page summary of the proposed project. The project summary should identify the main purpose of the project, the priority population(s) to be served, proposed category to be implemented, types of services offered, the area to be served, expected outcomes, and the total amount of grant funds requested.

4.7 Project Narrative (25-Page Limit)

The Project Narrative is limited to **25** single-spaced pages. Applicants should provide sufficient details for reviewers to be able to assess the project narrative’s appropriateness and merit. See **Section 5.0:**

Required Content of the Project Narrative Requirements

4.8 Proposed Budget Summary and Budget Justification Narrative

The Proposed Budget Summary and Budget Narrative must provide a computation and explanation of all requested cost items that will be incurred by the proposed project as they relate to the Project Narrative. All proposed costs for the project activities described in this RFA are required to be presented in a line-item budget format that is accompanied by a budget narrative that supports, justifies, and clarifies the various line items. Justification for all cost items contained in the Proposed Budget Summary must be described in a separate Budget Narrative, the format for which is contained in **Attachments 4 and 5**. Only cost allocations under the terms of the RFA and applicable federal and state cost principles may be included in the line item budget. All requested costs must be reasonable and necessary. **Administrative Costs are limited to 10%** of the total budget amount. Additional budget formatting instructions can be found in **Attachment 6**. Applicants should recognize that costs do not remain static. The budget should reflect the various phases and activities of planning, organizing, implementation, evaluation, and dissemination.

A. Proposed Budget Summary (1-Page Limit)

1. All costs contained in the Proposed Budget Summary must be directly related to the services and activities identified in the application. All costs must be presented in the format outlined in **Attachment 4**.

B. Budget Justification Narrative (3-Page Limit)

1. Provide a brief justification for each budget line item (see **Attachment 5**). Applicants should demonstrate how the proposed expenditures relate to the activities in the work plan or how the proposed expenditures will improve progress towards project objectives in a narrative format.
2. Include only expenses directly related to the project and necessary for program implementation using the standard headings listed on the budget form.
3. Participation in the 2019 Provider Orientation Meeting is mandatory and must be included in your budget. Applicants should budget travel for two to three staff to attend this meeting (date and location to be determined).
4. Applicants must demonstrate to the Department the procurement method used to secure all sub-contracts and consultant agreements. Consultant and sub-contract agreements will be restricted to no more than **15%** of the total final award. The intent to subcontract and all proposed sub-contracts must be identified in the applicant's proposal and the Department reserves the right to approve/deny any subcontracts and/or consultants.

Section 5.0 REQUIRED CONTENT OF THE PROJECT NARRATIVE

5.1 Statement of Need (2-Page Limit)

The Statement of Need shall be used to describe the need for the proposed project.

Applicants shall identify in narrative form the following information:

1. The applicant shall identify the specific area(s) served by the proposed project. Provide a description of the geographic area by ZIP code or neighborhood boundaries that the services and activities will cover and the sites where services will be provided, and indicate why those sites were chosen. The most current state and local HIV epidemiologic and surveillance data, CDC program data, Health Resources and Services Administration (HRSA) Ryan White program data, or HIV needs assessment data should be used to identify the service areas that are disproportionately affected by HIV and where people living with and at greatest risk for HIV infection reside or frequent.
2. The applicant shall identify the priority population(s) that the proposed project will target and provide epidemiologic data that supports the selection of the priority population(s) and use demographic and socioeconomic data to provide a description of the population(s). In addition, briefly describe the behaviors and social determinants that place the population(s) at risk for acquiring or transmitting HIV infection, including concurrent risk transmission with other diseases (i.e., STDs, viral hepatitis, and TB). The applicant should also identify the impact HIV has had on the priority population(s).
3. Describe how these funds will augment existing HIV prevention services and provide an assurance that the funds being requested will not duplicate or supplant funds received from the Department.

5.2 Organizational Capacity and Staffing (2-Page Limit)

1. The applicant shall provide information about the agency, including history, administrative structure, table of organization, mission, vision, goals, and how they relate to the purposes of their proposed program.
2. The applicant shall describe the last two years of previous experience providing services to the target population including a brief description of projects similar to the one proposed in response to the RFA. This should include: the length of time working with the target population; any services the agency currently provides which focus on the goal of reducing HIV acquisition and transmission within the priority population(s). If the applicant's agency has not been in existence for more than five years, the applicant shall describe relevant experience of key agency staffs' experience providing services to the target population.
3. The applicant shall identify key personnel who will implement the proposed program, including qualifications, a copy of their resumes, email addresses, and phone numbers. This section shall include information about personnel who can address the priority population(s) identified in **Section 5.1** (such as staff who are bilingual or reflective of the population being served). The applicant shall also describe the plan for orientation and on-going training of staff and volunteers involved in the proposed program implementation. Resumes should be submitted in the **Attachments** (see **Section 5.7**) and will not count toward the Project Narrative page limit.

5.3 Program Proposal (15-Page Limit)

The program proposal shall be used to describe the applicant's approach to accomplishing activities related to the selected service category (see **Sections 2.3 and 2.4**). Applicants shall respond, in **narrative form**, to required strategies in each category component. If the Applicant is not proposing to carry out optional activities under the required category strategies, no response is required. The applicant must address how they plan to deliver services in a culturally and linguistically appropriate manner for the selected priority population(s). Applicants must also address how they plan to refer or provide mental health or substance abuse treatment services to the selected priority population(s).

1. Purpose

Applicants must describe specifically how their application will address the issue as described in **Section 5.1**, in two to three sentences.

2. Outcomes

Applicants must clearly identify the project outcomes they expect to achieve by the end of the three-year funding period. Outcomes are the results that the program intends to achieve. All outcomes must indicate the intended direction of change (e.g., increase, decrease, maintain). See **Tables 3, 4, and 5** for a summary of category components and indicators.

3. Strategies and Activities

Applicants must provide a clear and concise description of the strategies and activities they will use to achieve the funding period outcomes for the category they are proposing. Applicants must select existing evidence-based strategies that meet their needs. See **Tables 3, 4, and 5** for a summary of category components and indicators.

5.4 Collaborations (2-Page Limit)

Applicants must describe efforts to partner with local health offices and other organizations within the community to deliver the proposed project as described in the Program Proposal for the benefit of the

identified priority population(s). Describe how current or planned collaborations will support program sustainability once grant funding ends. Applicants should submit MOAs/MOUs as attachments and these will not count toward the page limit.

A letter of support for the proposed project from an authorized official such as the Administrator or Health Officer of the local health office is required. Applicants may choose to submit additional letters of support; however, no more than 10 may be submitted. Letters of support will not count toward the page limit.

Applicants must identify in narrative form the following information:

1. Describe the coordination or collaborative process used to plan the proposed project. Explain who was involved, how these relationships will be maintained, the expected roles and responsibilities, and assurance that there is no duplication or overlap of services.
2. Describe how members of the priority population and the local community will be involved in project implementation.

5.5 Evaluation Plan (2-Page Limit)

Awardees are expected to evaluate implementation and measure the outcomes and objectives of the proposed project. Evaluation activities may also include quantitative and qualitative assessments of service participation; yield from promotional, outreach, and recruitment efforts; and, where possible, increases in knowledge, intended behavior modification, or noted improvements in quality of life measures as a result of participation in the proposed project. See **Tables 3, 4, and 5** for a summary of category components and indicators.

Applicants must submit an evaluation plan for the entire three-year project period that clearly articulates how the applicant will assess program activities. Evaluation activities will be initiated at the beginning of the program and conducted throughout the project period to capture and document actions and assess program outcomes. The evaluation must be able to produce documented results that demonstrate whether and how the strategies and activities funded under the program made an impact. The applicant should identify the expected result (i.e., a particular impact or outcome) for each major objective and activity.

5.6 Work Plan (2-Page Limit)

Applicants must submit a preliminary work plan for the first year of the resulting contract listing the objectives for implementation of proposed activities and strategies which will be conducted to meet each objective each month, methods used to assess whether or not objectives are met, timeframe, and the individual responsible for carrying out each activity. Programmatic objectives should be SMART. All awardees will be expected to submit an updated work plan in the frequency specified in the resulting contract. See **Attachment 7** for Work Plan template.

5.7 Appendices

Applications must contain the following appendices as applicable. All appendices must be clearly referenced and support elements of the project narrative. Include documentation and other supporting information in this section. Appendices do not count toward the **Project Narrative** page limit.

A. **Appendix A** of the application must include:

1. An organizational chart

2. Copy of current Certificate of Incorporation
3. Copies of key personnel's resumes, email addresses, and phone numbers
4. A current roster of the board of directors, including name, address and telephone numbers

B. **Appendix B** of the application must include:

1. MOAs/MOUs with county health department(s) in the service areas in which the proposed services will be provided, outlining any partnerships, referral agreements, and collaborations. Agreements should be signed by the CHD Administrator or Health Officer, or a designee.
2. MOAs/MOUs from other key partners with whom the applicant will work to accomplish the proposed project.

C. **Appendix C** of the application is to be used for letters of support.

D. **Appendix D** of the application must be used for Applicants who are applying as a minority organization and include documentation verifying that the organization is at least 51% owned by minority individuals, board of directors, or, in the case of a publicly-owned business, at least 51% of the stock is owned by minority individuals.

Section 6.0 SUBMISSION OF APPLICATION

6.1 Application Deadline

Applications must be postmarked no later than **4.00 p.m.** Eastern Standard Time, on **September 14, 2018**.

6.2 Submission Methods

Applications must be sent to:

U.S. Mail:

**Florida Department of Health
Office of Contracts
4052 Bald Cypress Way, Bin B-08
Tallahassee Florida, 32399-1715**

Overnight Shipping or Hand Delivered, ONLY (Physical Address):

**Florida Department of Health
Office of Contracts
Attention: Janice Howard
4052 Bald Cypress Way, Front Desk
Tallahassee, FL 32399**

- a. Applicants must submit by mail, carrier, certified mail, or hand delivery; one original, three hardcopies, and one (labeled) thumb drive to the Department at the above address. Applications sent by any other method will not be accepted. Emailed or faxed applications will not be accepted.
- b. It is the responsibility of the applicant to assure its application is submitted at the place and time indicated in the RFA Timeline.

- c. Late applications will not be accepted under any circumstances.
- d. Materials submitted will become property of the state of Florida. The state reserves the right to use any concepts or ideas contained in the application.
- e. The Department is not responsible for improperly marked applications.
- f. Applications received after the deadline will not be eligible for review or consideration.

6.3 Authorized Signatory

The original application must be signed by an individual authorized to act for the applicant and to assume the obligation imposed by the terms and conditions of the grant. The authorized signatory is certifying that these funds will not be used to supplant other resources nor for any other purposes other than the funded program. The applicant also agrees to comply with the terms and conditions of the Department as related to criminal background screening of the Chief Executive Officer, Executive Director, program director, direct-service staff, volunteers, and others as necessary.

Section 7.0 EVALUATION OF APPLICATONS

7.1 Receipt of Applications

Upon receipt, applications will be reviewed for compliance with the requirements in the RFA. Applications that are not complete or that do not conform to or address the criteria of the program will be considered non-responsive and **will not be evaluated**.

Complete applications are those that include the required information listed in **Sections 4.0 and 5.0**. Incomplete applications will be returned with notification that it did not meet the submission requirements and will not be entered into the review process.

7.2 How Applications are Scored

Each application will be evaluated and scored based on the category requirements identified in **Sections 4.0 and 5.0**. Applications will be scored by objective Review Teams using evaluation sheets to designate the point value assigned to each application. The scores of each member of the Review Teams will be averaged with the scores of the other members to determine the final score. Application scores establish a reference point from which to make negotiation decisions. The maximum points possible are **115**. Scoring will be in the following categories up to the maximum points indicated for each category:

STATEMENT OF NEED (20 points)	POINT VALUE
1. How comprehensive was the applicant in identifying the area served by the proposed project, providing a description of the geographic area by ZIP code or neighborhood boundaries that the services and activities will cover and the sites where services will be provided, and indicate why those sites were chosen?	0–5

2. How comprehensive was the applicant in identifying the priority population(s) that the proposed project will target and providing epidemiologic data that supports the selection of the priority population(s)?	0–5
3. How comprehensive was the applicant in describing the impact of HIV/AIDS on the selected priority population(s), by identifying gaps in the scope, reach, coordination, and services for the population(s) and HIV-related disparities within the area, and does their proposal adequately describe the need for the proposed project?	0–5
4. How well does the applicant describe how these funds will augment existing HIV prevention services and provide an assurance that the funds being requested will not duplicate or supplant funds received from the Department?	0–5
	Total Score for Section

ORGANIZATIONAL CAPACITY AND STAFFING (10 Points)	POINT VALUE
1. How well does the applicant provide information about the agency, including history, administrative structure, table of organization, mission, vision, goals, and how they relate to the purposes of their proposed program.	0–5
2. How comprehensive was the applicant in describing the last five years’ experience providing services to the priority population(s); the key personnel who will implement the proposed project; how their agency is prepared to implement the activities of the proposed project; and plans for sustainability once the project period ends?	0–5
	Total Score for Section

PROGRAM PROPOSAL (30 Points)	POINT VALUE
1. How comprehensive was the applicant in describing the strategies and activities to be used in carrying out the required components of the selected service category?	0–15
2. How well did the applicant describe the outcomes they expect to achieve by the end of the funding period?	0–15
	Total Score for Section

COLLABORATIONS (10 Points)	POINT VALUE
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1. How well did the applicant describe the coordination/collaborative process used to plan and implement the proposed project; and explain who was involved, how these relationships will be maintained, the expected roles and responsibilities, and assurance that there is no duplication or overlap of services?	0–5
2. How well did the applicant describe how members of the target population and the local community will be involved in project implementation?	0–5
	Total Score for Section

EVALUATION PLAN (10 Points)	POINT VALUE
1. How well did the applicant’s evaluation plan articulate how the proposed project will be assessed, complete with objectives and measures?	0–10
	Total Score for Section

WORK PLAN (10 Points)	POINT VALUE
1. How well did the applicant’s Year One work plan describe the proposed activities and strategies which will be conducted to meet each objective each month, methods used to assess whether or not activities are contributing to objectives, and the individual responsible for carrying out each activity?	0–10
	Total Score for Section

PROPOSED BUDGET SUMMARY AND BUDGET NARRATIVE (10 Points)	POINT VALUE
1. Does the proposed budget summary identify all proposed costs for the project activities described in this RFA and are they presented in a line-item budget format? (see Attachment 4)	0–5
2. How comprehensive was the applicant in providing a detailed budget justification narrative for all expenditures? (see Attachment 5)	0–5
	Total Score for Section

APPENDICES (15 Points)	POINT VALUE
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1. Does the applicant provide all required documentation for Appendix A: Organizational Capacity Documentation?	0–5
2. Does the applicant provide all required documentation for Appendix B: MOAs/MOUs?	0–5
3. If applying as a Minority Organization, does the applicant provide the required documentation for Appendix D: Minority Organization Status?	0–5
	Total Score for Section

7.3 Grant Awards

Grants will be awarded based on several criteria: available funding; application’s final score; proposed activities; proposed geographic service areas; and organizational capacity to implement the proposed project. The final award amount will be determined through negotiation, and at the sole discretion of the Department, notwithstanding scores. Awards will be posted at:

http://www.myflorida.com/apps/vbs/vbs_www.main_menu

<http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/grant-funding-opportunities/index.html>

Vendor Registration

Each vendor doing business with the State for the sale of commodities or contractual services as defined in section 287.012, Florida Statutes, will register in the MyFloridaMarketPlace system, unless exempted under subsection 60A-1.030(3), Florida Administrative Code. Also, an agency will not enter into an agreement for the sale of commodities or contractual services as defined in section 287.012 Florida Statutes, with any vendor not registered in the MyFloridaMarketplace system, unless exempted by rule. A vendor not currently registered in the MyFloridaMarketPlace system will do so within five days after posting of intent to award. Information about registration is available, and registration may be completed, on the MyFloridaMarketPlace website

https://www.dms.myflorida.com/business_operations/state_purchasing/vendor_resources.

Those lacking internet access may request assistance from the MyFloridaMarketPlace Customer Service at 866-352-3776 or from State Purchasing, 4050 Esplanade Drive, Suite 300, Tallahassee, Florida 32399.

7.4 Award Criteria

Final funding decisions will be determined by the Department with the recommendations and scores of the Review Teams. The Department reserves the right to evaluate the organization’s administrative structure, economic viability, and the ability to deliver services prior to final award and execution of the contract. Funding an award is wholly at the discretion of the Department.

Prior to making final funding decisions, the Department will provide a Review and Recommendation Form to the local health office, to be completed by the Contract Manager and Health Officer/Administrator and returned to the HIV/AIDS Section. One form is for applicants with prior Department funding and the other is for applicants with no prior Department funding. For applicants with prior Department funding, forms will be provided to those counties where the applicant provides services. The CHD Review and Recommendation Forms can be found in **Attachments 8 and 9**.

Recommendation Forms will have no effect on scoring, however information received from these forms will be considered along with application score, geographic location, and proposed priority population(s) to be served when determining awards.

Section 8.0 REPORTING AND OTHER REQUIREMENTS

8.1 Post Award Requirements

Where the resulting contract requires the delivery of reports to the Department, mere receipt by the Department shall not be construed to mean or imply acceptance of those reports. It is specifically intended by the parties that acceptance of required reports shall constitute a separate act. The Department reserves the right to reject reports as incomplete, inadequate, or unacceptable according to the parameters set forth in the resulting contract. The Department, at its option, may after having given the grantees a reasonable opportunity to complete the report, or to make the report adequate or acceptable, declare the agreement to be in default. The grantees shall provide the Department with the following reports:

Monthly Deliverable Report

A properly completed monthly deliverable report shall be submitted within 10 days following the end of each month documenting the deliverables performed during the month. The monthly deliverable report shall be in accordance with the tasks and deliverables set forth in the Department's Standard Contract, Attachment I. The report must be submitted with the monthly invoice and in a format provided by the Department. The Department reserves the right to modify required data variables to align with program evaluation needs or to align more closely with evaluation requirements set forth in CDC's National HIV Prevention Program Monitoring and Evaluation guidance.

CDC EvaluationWeb Reporting

Applicants funded under this RFA will be required to report all non-HIV Testing and non-Partner Services data directly into the CDC EvaluationWeb data collection system. The HIV/AIDS Section will work with all successful applicants to develop user accounts and provide training and technical assistance.

Quarterly Financial Report

Grantees shall submit a quarterly financial report stating, by budget line item, all expenditures made as a direct result of services provided through the funding of the contract to the Department within 15 days following the end of each quarter. Financial reports must be submitted in a format provided by the Department. Each report must be accompanied by a statement signed by an individual with legal authority to bind the grantees certifying that these expenditures are true, accurate, and directly related to the contract.

8.2 Standard Contract

Applicants must review, and become familiar with, the Department's Standard Contract, which contains administrative, financial, and non-programmatic terms and conditions mandated by federal or state law and policy of the Department of Financial Services. Use of the Standard Contract is mandatory for Departmental contracts as they contain the basic clauses required by law. The terms and conditions contained in the Standard Contract are non-negotiable.

Performance Measures

Pursuant to section 215.971(b), Florida Statutes, the resulting Contract must contain performance measures which specify the required minimum level of acceptable service to be performed. These will be established based on final determination of tasks and deliverables.

Financial Consequences

Pursuant to section 215.971(c), Florida Statutes, the Contract resulting from this solicitation must contain financial consequences that will apply if Applicant fails to perform in accordance with the Contract terms. The financial consequences will be established based on final determination of the performance measures and Contract amount.

Section 9.0 REFERENCES

1. Office of National AIDS Policy. National HIV/AIDS Strategy for the United States. 2010. Available at <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>. Accessed May 22, 2018.
2. Office of National AIDS Policy. National HIV/AIDS Strategy for the United States: Updated to 2020. 2015. Available at: <https://aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>. Accessed May 22, 2018.
3. Centers for Disease Control and Prevention. High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. 2012. CDC Division of HIV/AIDS Prevention (DHAP): Atlanta, GA. U.S. Department of Health and Human Services.
4. Horn, T., Sherwood, J., Remien, R.H., Nash, D., Auerbach, J.D. Towards an integrated primary and secondary HIV prevention continuum for the United States: a cyclical process model. *Journal of the International AIDS Society*. 2016; 19:21263
5. Florida Department of Health. Statewide Integrated HIV Prevention and Care Plan, 2017–2021. 2017. Florida Department of Health, Division of Disease Control and Health Protection, Bureau of Communicable Diseases, HIV/AIDS Section: Tallahassee, FL.
6. Centers for Disease Control and Prevention. Dear Colleague Letter: September 27, 2017. CDC DHAP: Atlanta, GA. U.S. Department of Health and Human Services.
7. Centers for Disease Control and Prevention. HIV among Gay and Bisexual Men. February 2017.
8. Centers for Disease Control and Prevention. HIV and African Americans. January 2018.
9. Centers for Disease Control and Prevention. HIV Among Hispanics/Latinos. August 2017.
10. Centers for Disease Control and Prevention. HIV and Transgender People. April 2018.
11. National Alliance of State and Territorial AIDS Directors (NASTAD) and the National Coalition of STD Directors (NCSD). Addressing Stigma: A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black & Latino Gay Men. May 2014. Available at: <https://www.nastad.org/sites/default/files/NASTAD-NCSD-Report-Addressing-Stigma-May-2014.pdf>. Accessed May 25, 2018.
12. Centers for Disease Control and Prevention. CDC-RFA-PS-17-1704, "Comprehensive High-Impact HIV Prevention Projects for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color"

Attachment 1

HIV Prevention Funding Allocation Detail by Area/County

Areas	Counties	PLWH (2016)	% PLWH (2016)		Funding Allocations	
Area 1	Escambia	1,328	0.012	1.20%	\$120,000	\$186,000
	Okaloosa	371	0.003	0.30%	\$30,000	
	Santa Rosa	264	0.002	0.20%	\$20,000	
	Walton	77	0.001	0.10%	\$10,000	
Area 2A	Bay	468	0.004	0.40%	\$40,000	\$125,000*
	Calhoun	21	0.000	0%	\$0	
	Gulf	17	0.000	0%	\$0	
	Holmes	21	0.000	0%	\$0	
	Jackson	280	0.002	0.20%	\$20,000	
	Washington	93	0.001	0.10%	\$10,000	
Area 2B	Franklin	16	0.000	0%	\$0	\$176,000
	Gadsden	255	0.002	0.20%	\$20,000	
	Jefferson	79	0.001	0.10%	\$10,000	
	Leon	1,276	0.011	1.10%	\$110,000	
	Liberty	13	0.000	0%	\$0	
	Madison	107	0.001	0.10%	\$10,000	
	Taylor	114	0.001	0.10%	\$10,000	
	Wakulla	72	0.001	0.10%	\$10,000	
Area 3/13	Alachua	1,016	0.009	0.90%	\$90,000	\$390,000
	Bradford	56	0.000	0%	\$0	
	Citrus	221	0.002	0.20%	\$20,000	
	Columbia	209	0.002	0.20%	\$20,000	
	Dixie	47	0.000	0%	\$0	
	Gilchrist	18	0.000	0%	\$0	
	Hamilton	92	0.001	0.10%	\$10,000	
	Lafayette	8	0.000	0%	\$0	
	Lake	869	0.008	0.80%	\$80,000	
	Levy	87	0.001	0.10%	\$10,000	
	Marion	1,034	0.009	0.90%	\$90,000	
	Putnam	235	0.002	0.20%	\$20,000	
	Sumter	214	0.002	0.20%	\$20,000	
	Suwanee	138	0.001	0.10%	\$10,000	
Union	149	0.001	0.10%	\$10,000		
Area 4	Baker	88	0.001	0.10%	\$10,000	\$640,000
	Clay	349	0.003	0.30%	\$30,000	

	Duval	6,215	0.054	5.40%	\$540,000	
	Nassau	126	0.001	0.10%	\$10,000	
	St. Johns	341	0.003	0.30%	\$30,000	
Area 5	Pasco	1,060	0.009	0.90%	\$90,000	\$506,000
	Pinellas	4,594	0.040	4.00%	\$400,000	
Area 6	Hernando	362	0.003	0.30%	\$30,000	\$755,000
	Hillsborough	6,950	0.061	6.10%	\$610,000	
	Manatee	1,044	0.009	0.90%	\$90,000	
Area 7	Brevard	1,568	0.014	1.40%	\$140,000	\$1,150,000
	Orange	8,682	0.076	7.60%	\$760,000	
	Osceola	1,262	0.011	1.10%	\$110,000	
	Seminole	1,255	0.011	1.10%	\$110,000	
Area 8	Charlotte	316	0.003	0.30%	\$30,000	\$430,000
	Collier	962	0.008	0.80%	\$80,000	
	Desoto	122	0.001	0.10%	\$10,000	
	Glades	63	0.001	0.10%	\$10,000	
	Hendry	120	0.001	0.10%	\$10,000	
	Lee	2,243	0.020	2.00%	\$200,000	
	Sarasota	957	0.008	0.80%	\$80,000	
Area 9	Palm Beach	8,213	0.072	7.20%	\$720,000	\$740,000
Area 10	Broward	20,041	0.175	17.50%	\$1,750,000	\$1,775,000
Area 11A	Miami-Dade	26,975	0.235	23.50%	\$2,350,000	\$2,375,000
Area 11B	Monroe	653	0.006	0.60%	\$60,000	\$125,000*
Area 12	Flagler	189	0.002	0.20%	\$20,000	\$175,000
	Volusia	1,699	0.015	1.50%	\$150,000	
Area 14	Hardee	62	0.001	0.10%	\$10,000	\$236,000
	Highlands	233	0.002	0.20%	\$20,000	
	Polk	2,323	0.020	2.00%	\$200,000	
Area 15	Indian River	377	0.003	0.30%	\$30,000	\$216,000
	Martin	364	0.003	0.30%	\$30,000	
	Okeechobee	109	0.001	0.10%	\$10,000	
	St. Lucie	1,615	0.014	1.40%	\$140,000	
Department of Corrections (FDC)		3,975	0.035	3.50%	\$350,000	\$350,000**
State of Florida		114,772		100%	\$10,000,000	\$10,000,000

*Minimum funding level for any area is \$125,000

** FDC funds redistributed across all areas

Legend

≤ 0.09% PLWH
0.10%-0.49% PLWH
0.50%-1.00% PLWH
1.01%-5.00% PLWH
≥ 5.01% PLWH

Attachment 2

CDC PrEP Program Guidance for HIV Prevention Health Department Grantees May, 2014

Introduction

Pre-exposure prophylaxis (PrEP) provides daily oral antiretroviral drugs to uninfected individuals prior to HIV exposure and has been shown to reduce HIV acquisition among men who have sex with men, heterosexual men and women and people who inject drugs. The new guidelines underscore the importance of counseling that covers around adherence and HIV risk reduction and recommends regular monitoring of HIV infection status, side effects and risk behaviors.

PrEP is a powerful new HIV prevention tool, and can be combined with condoms and other prevention methods to provide even greater protection than when used alone. PrEP has the potential to alter the course of the United States if targeted to the right populations and used as directed.

As an HIV prevention partner, you play a critical role in expanding uptake of PrEP and addressing practical implementation issues. Providing effective prevention options for people at high risk for acquiring HIV is a key priority for CDC and a critical component of your HIV prevention efforts as supported through CDC's flagship HIV Prevention by Health Departments program.

Guiding Principles for using DHAP funding for PrEP-related activities:

- PrEP-related activities to support prevention services for MSM and heterosexually-active men and women must be implemented as part of a comprehensive HIV prevention program that includes, as appropriate, linkage and referral to prevention and treatment services for sexually transmitted diseases (STD) and viral hepatitis, substance abuse and mental health, and other prevention support services.
- To minimize duplication of effort, DHAP health department grantees should coordinate and collaborate with other agencies, organizations, and providers involved in PrEP-related activities, STD, viral hepatitis, and substance abuse prevention and treatment, and HIV prevention activities.
- Funds for PrEP-related activities should ensure that referral and linkage to existing HIV prevention and treatment services are maintained.
- PrEP-related activities are subject to the terms and conditions incorporated or referenced in the grantee's current cooperative agreement or grants.

Funds may be used for, but are not limited to, the following:

- Planning for how to most effectively incorporate PrEP into prevention education and services, including evaluating what collaborations will be needed.
- Educational materials about how to use PrEP in conjunction with other HIV prevention and care services, as well as STD, viral hepatitis, mental health and substance abuse treatment.
- Development and delivery of the HIV risk-reduction counseling and behavioral interventions that must be provided with PrEP.
- Communication activities related to disseminating information about PrEP.
- Evaluation activities for PrEP-related activities.
- Personnel (e.g., program staff) conducting the above PrEP-related activities.

Attachment 2, continued

Funds may *not* be used for:

- PrEP medications (antiretrovirals).
- Laboratory testing related to PrEP (other than HIV tests or hepatitis screening).
- Personnel costs for the provision of PrEP medication and recommended clinical care associated with PrEP.

Applicable cooperative agreements:

Please refer to your respective Funding Opportunity Announcement (FOA) for guidance on submission of programmatic and budget requirements.

For more information on the guidelines and other supporting documents, visit [CDC PrEP Website](#). Should you need additional information, specific to capacity building assistance, or to request training and technical assistance for the health department, please contact your HIV prevention project officer in CDC's Division of HIV/AIDS prevention, Prevention Program Branch.

Attachment 3

Cover Page

Florida Department of Health

HIV/AIDS Section

DOH-RFA-18-001

HIV PREVENTION

Title of Application:	
Legal Name of Applicant:	
Funding Amount Requested (annual):	
Area(s)/County to be Served:	
Name of Contact Person:	
Applicant Mailing Address:	
City, State, ZIP:	
Telephone Number:	
Fax:	
Email Address:	
Federal Employer Identification Number (FEID):	
Name and Title of Authorized Official:	
Signature of Authorized Official:	
Date:	
By signing above, you are attesting that: TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.	
Category Applying for:	<input type="checkbox"/> 1. Community Outreach, Engagement, and Education <input type="checkbox"/> 2. HIV Testing and Linkage to Prevention and Care Services <input type="checkbox"/> 3. Comprehensive HIV Prevention Services

Disclaimer – NOTE: The receipt of applications in response to this grant opportunity does not imply or guarantee that any one or all qualified applicants will be awarded a grant or result in a contract with the Florida Department of Health.
This grant opportunity is not subject to Section 120.57(3), Florida Statutes

Attachment 4
Budget Summary Format

Personnel/Salaries	Based on percentage/time spent working on the High-Impact Prevention project.
Fringe benefits	FICA/Social Security, health, life insurance, workman's compensation, etc.
Staff travel	In accordance with Florida Statutes (Chapter 112, F.S.)
Conference/training travel	Customary and reasonable costs, in state (Out of state travel must be approved by the Department in advance)
Audit	If required by the department
Rent/Telephone/Utilities or use of space	Prorated based on total agency costs
Promotional, media, and marketing materials	Prorated based on total agency costs
Educational/training materials	As related to the contract
Office supplies	As related to the contract
Furniture/equipment/computers	As related to the contract
Equipment rental/maintenance	As related to the contract
Contractual/Consultant	As related to the contract (subject to approval from the Department)
Other	As related to the contract
Total Direct Costs	As related to the contract
Administrative Costs (must not exceed 10%)	As related to the contract
TOTALS	

Attachment 5

Budget Justification Narrative Format

A justification for all costs associated with the proposed program must be provided. The Budget Narrative **must provide detailed** information to support each line item contained in the proposed Budget Summary. The Budget Narrative should include, at a minimum the following:

PERSONNEL (SALARY)

A. Personnel – List each position by title or name of employee (if available). Show the annual salary rate and the percentage of time to be devoted to the program. Compensation paid to employees engaged in grant activities must be consistent with that paid for similar work within the prospective applicant's organization.

Name/Position	Computation of Salary (Annual Salary X % of Time)	Cost
---------------	---	------

B. Fringe Benefits – Fringe benefits should be based on actual known costs or an established formula. Fringe benefits are for the personnel listed in the Personnel category and only for the percentage of time devoted to the program.

Name/Position	Computation of Fringe Benefits (Personnel Cost X % Rate)	Cost
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EXPENSES

C. Staff Travel – Itemize the cost of local travel and mileage expenses for personnel by purpose. Show the basis of the calculation. Travel expenses are limited for reimbursement as authorized in Section 112.061, Florida Statutes. Mileage is reimbursed at \$0.44.5 cents per mile.

Purpose of Travel	Location	Computation	Cost
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D. Training and Meetings – Itemize costs associated with required or anticipated staff training or meeting by purpose, and include associated costs (i.e., mileage, per diem, meals, hotel, registration fees, etc.). Travel expenses are limited for reimbursement as authorized in Section 112.061, Florida Statutes.

Training or Meeting	Location	Computation	Cost
---------------------	----------	-------------	------

E. Office Supplies – Itemize program related supplies separately by type (office supplies, copy paper, postage, etc.) that are expendable or consumed during the course of the program and show the formula used to arrive at total program costs.

Items	Computation	Cost
-------	-------------	------

F. Equipment (Over \$1,000.00) – List each equipment item to be purchased. Indicate whether equipment is to be purchased or leased and why the equipment is necessary for operation of the program.

Items	Computation	Cost
-------	-------------	------

G. Rent/Telephone/Utilities – Itemize program specific costs to implement the program by prorate share or applicable percentage of the total costs of these items. List each item separately and show the formula used to derive at total program costs.

Attachment 5, continued

Items	Computation	Cost
-------	-------------	------

H. Program/Educational Materials – Itemize the costs of program-related educational material proposed to be used by the program.

Items	Computation	Cost
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I. Promotional and Marketing Materials – Itemize the type and costs of materials to be purchased or developed for use in promoting and marketing the program in the local community. Detail the programmatic benefits to be derived from the promotion and marketing materials and how they relate to achievement of the programmatic goals and objectives.

Items	Computation	Cost
-------	-------------	------

J. Insurance – Indicate the cost of maintaining comprehensive liability insurance for the program.

Items	Computation	Cost
-------	-------------	------

K. Other – List and describe any other expenses related to the program that is not specifically listed above. Breakout and show the computation for each line item.

Items	Computation	Cost
-------	-------------	------

TOTAL DIRECT COSTS

TOTAL INDIRECT COSTS

TOTALS

Attachment 6

Budget Format Instructions

General Information

All expenses for your project must be in line item detail on the forms provided. CTG-funded indirect costs may not exceed ten percent of salary and fringe and must be fully itemized and justified.

Assume a 12-month budget, with a period of January 1, 2019–December 31, 2019. Complete **Attachments 4 and 5 (Budget Summary and Budget Justification Narrative)**.

Budget Justification Narrative Form

Use **Attachment 5** to provide a justification or explanation for the expenses included in the Budget Summary. The justification must show all items of expense and the associated cost that comprise the amount requested for each budget category (e.g., if your total travel cost is \$1,000, show how that amount was determined) and, if appropriate, an explanation of how these expenses relate to the goals and objectives of the project.

Personnel Services

Include a description for each position and the annual salary or rate per hour, if non-salaried or if hourly percentage of time spent on various duties where appropriate, on this form. Note: Contracted or per diem staff are not to be included in personnel services; these expenses should be shown as consultant or contractual services under non-personnel services.

Fringe Benefit Rate

Specify the components (FICA, Health Insurance, Unemployment Insurance, etc.) and their percentages comprising the fringe benefit rate, then total the percentages to show the fringe benefit rate used in the budget calculations. If different rates are used for various positions, submit a separate form for each rate and specify which positions are subject to which rate.

Non-Personnel Services

Any item of expense not applicable to the following categories must also be listed along with a justification of need.

1. Supplies and Materials – Delineate the items of expense and estimated cost of each item along with justification of their need.
2. Travel – Delineate the items of expense and estimated costs (i.e. travel costs associated with conferences, including transportation, meals, lodging, and registration fees) along with a justification need.
3. Consultants, Per Diem, or Contractual Services – Provide a justification for each service listed. Justifications should include the name of the proposed consultant or contractor, the specific service to be provided, and the time frame for the delivery of services.
4. Equipment – Delineate each piece of equipment and estimated cost along with a justification of need. Equipment costing less than \$500 should be included in the Supplies and Materials category. Anticipated equipment purchases of \$500 or more should be included in the equipment line.

Attachment 7

Work Plan Template

Please use this template to complete the work plan and include it with the application. Work Plan should be completed for one year only (January 1, 2019–December 31, 2019)

*Assessment Method - details of how each activity under this goal will be measured

Goal 1:			Measures of Effectiveness:	
Objective(s)	Activities Planned to Achieve This objective	*Assessment Method	Timeframe for Assessing Progress	Person/s Responsible
Goal 2:			Measures of Effectiveness:	
Objective(s)	Activities Planned to Achieve This objective	*Assessment Method	Timeframe for Assessing Progress	Person/s Responsible
Goal 3:			Measures of Effectiveness:	
Objective(s)	Activities Planned to Achieve This objective	*Assessment Method	Timeframe for Assessing Progress	Person/s Responsible
Goal 4:			Measures of Effectiveness:	
Objective(s)	Activities Planned to Achieve This objective	*Assessment Method	Timeframe for Assessing Progress	Person/s Responsible

Attachment 8

County Health Department Review and Recommendation Form Agencies with Prior Florida Department of Health (DOH) Funding

Florida Department of Health, HIV/AIDS Section HIV Prevention Request for Applications (RFA)

County Health Departments (CHDs): As part of our evaluation of organizations that are applying for DOH funding for HIV prevention programs, we are soliciting your input regarding the applicant agencies' past performance on other DOH-funded programs. On this form, you will rate past performance with funded programs.

Instructions: It is strongly encouraged that CHDs seek input from the following staff to complete this form: Contract Manager, HIV/AIDS Program Coordinator (HAPC), and Health Officer. To answer each question, double-click on the gray-colored box and complete.

Applying Agency:		Date:	
CHD:		Phone:	
CHD Contact Name:		Email:	
Name(s) of persons completing form:			

Past Performance

1.	Did the CHD receive a copy or summary of the applicant agency's application?	No	Yes
2.	Has the applicant ever been funded by the health department? <i>(If NO, please do not complete this form. Use the form developed for organizations not previously funded, Attachment DOH2 – Agencies with No Prior DOH HIV Prevention Funding.)</i>	No	Yes
2a.	If YES, has the applicant ever been funded by the health department for HIV prevention activities?	No	Yes
2b.	If YES, what services are being provided with the funds the health department provides? (Please list the specific services provided, e.g., HIV Testing, an evidence-based intervention, linkage to care, or other service.)		
2c.	If YES, please indicate the number of years that the applicant has been funded by the health department for HIV prevention activities <i>(years/months)</i> .	< 12 Months	1–5 Years 6–10 Years >10 Years
3.	Has the health department ever de-funded or imposed restrictions on this applicant for any program funding?	No	Yes
3a.	If YES, please explain why this applicant was de-funded or restricted.		

4.	Has the health department ever placed the applicant on corrective action for any program funding?	
	4a.	If YES, please explain why this applicant was placed on corrective action and describe the outcome.
5.	Does the applicant meet established deadlines for submitting financial reports? $\geq 95\%$ of the time 85% to 94% of the time 75% to 85% of the time 65 to 74% of the time $\leq 64\%$ of the time	
6.	Does the applicant meet established deadlines for submitting progress reports? \geq 95% of the time 85% to 94% of the time 75% to 85% of the time 65 to 74% of the time $\leq 64\%$ of the time	
7.	How often does the applicant meet agreed-upon deliverables and tasks? $\geq 95\%$ of goals 85% to 94% of goals 75% to 85% of the goals 65 to 74% of the goals $\leq 64\%$ of the goals	
8.	How would you grade the applicant's Fiscal Management Systems? Excellent Very good Good Fair Poor	
9.	How often does the applicant participate in local HIV/AIDS planning processes (e.g., has representation at local planning meetings)? $\geq 95\%$ of the time 85% to 94% of the time 75% to 85% of the time 65 to 74% of the time $\leq 64\%$ of the time	

CHD Contract Manager (Print Name): _____

Signature: _____

Date: _____

CHD Health Officer (Print Name): _____

Date: _____

Signature: _____

Please return your completed review via email to: Mara.Michniewicz@flhealth.gov

Your participation is important to the review process and your assistance is appreciated.

Attachment 9

County Health Department Review and Recommendation Form Agencies with No Prior Florida Department of Health (DOH) Funding

Florida Department of Health, HIV/AIDS Section HIV Prevention Request for Applications (RFA)

County Health Departments (CHDs): As part of our evaluation of the community-based organizations that are applying for DOH funding for HIV prevention programs, we are soliciting your input regarding the applicant agencies' past performance on other DOH-funded programs. *This form is developed for those agencies that have had no prior DOH funding.*

Instructions: It is strongly encouraged that CHDs seek input from the following staff to complete this form: Contract Manager, HIV/AIDS Program Coordinator (HAPC), and Health Officer.

Applying Agency:		Date:	
CHD:		Phone:	
CHD Contact Name:		Email:	
Name(s) of persons completing form:			

A. Past Performance

1.	Did the CHD receive a copy or summary of the applicant agency's application?	Yes	No
2.	Has the applicant ever worked with the health department in an unfunded capacity (e.g., through Memorandum of Agreement/Memorandum of Understanding, etc.)?	Yes	No
2a.	If YES, please describe.		

B. Background

1.	<p>Has the DOH had the opportunity to determine if this applicant has the capacity to carry out HIV prevention programs? No Yes</p> <p>Does the applicant have the experience and/or ability to implement HIV prevention interventions such as:</p> <p>Evidence-based Interventions (e.g., CLEAR, Healthy Relationships)? No Partial Yes</p> <p>HIV testing? No Partial Yes</p> <p>Linkage to Care? No Partial Yes</p>
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	Social marketing campaigns? No Partial Yes
	Providing appropriate client referrals? No Partial Yes
	Community Engagement and Outreach? No Partial Yes
	Condom Distribution? No Partial Yes
	If you have chosen 'partial' in any of the categories above, please explain why.
3.	Does the applicant participate in the local area's HIV planning process or consortium? No Yes
3a.	If YES, in what capacity (and during what period of time) has the agency participated in the local HIV planning process or consortium? _____

CHD Contract Manager (Print Name): _____

Signature: _____

Date: _____

CHD Health Officer (Print Name): _____

Date: _____

Signature: _____

Please return your completed review via email to: Mara.Michniewicz@flhealth.gov

Your participation is important to the review process and your assistance is appreciated.

Attachment 10

Florida HIV/AIDS Service Areas

